03-23		FC	ORM CMS-2552	-10		4090	(Cont.)
	rt is required by law (42 USC 1395g; 42 CFR 413.20(b)). For made since the beginning of the cost reporting period being of					FORM APPROVI OMB NO. 0938-0 EXPIRES 09-30-2	0050
COMPL	'AL AND HOSPITAL HEALTH CARE EX COST REPORT CERTIFICATION ETTLEMENT SUMMARY			PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S PARTS I, II & III	
PART I	- COST REPORT STATUS						
	use only 1. [] Electronically prepared cost re 2. [] Manually prepared cost report 3. [] If this is an amended report ent 4. [] Medicare Utilization. Enter "F	ter the number of times the p		Time:s cost report			
Contract use only		6. Date Received: 7. Contractor No.: 8. [] Initial Report for the strength of		10. NPR Date: 11. Contractor's Venc 12. [] If line 5, colutimes reopene	mn 1, is 4: Enter numb	er of	
DADTI	- CERTIFICATION BY A CHIEF FINANCIAL C	ACCIDED OF ADMINISTR	A TOD OF BROWINER	(e)			
THE PA	N, FINE AND/OR IMPRISONMENT UNDER FEI YMENT DIRECTLY OR INDIRECTLY OF A KI ONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFI I HEREBY CERTIFY that I have read the above cosubmitted cost report and the Balance Sheet and St cost reporting period beginning	CKBACK OR WERE OTH CER OR ADMINISTRATO certification statement and the atement of Revenue and Exp and ending of the provider in accordance	HERWISE ILLEGAL, COOR OF PROVIDER(S) at I have examined the acpenses prepared byand to the best of my k we with applicable instruct	ecompanying electronica nowledge and belief, thi	D ADMINISTRATIVE ally filed or manually st {Provider Name(s) s report and statement further certify that I are	abmitted cost report and and Number(s)} for the are true, correct, m familiar with the	
	SIGNATURE OF CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR	CHECKBOX	1	ELECTRONIC	,	_
	1	K OK ADMINISTRATION	2		SIGNATURE STATE		
1					ronic signature on this	ation statement. I certify certification be the legally	1
2	Signatory Printed Name:						2
4	Signatory Title: Signature date:						3
	Signature date.						
D + DT H	A CETTY ENGINE CONT. ON A CARRY						
PARTII	II - SETTLEMENT SUMMARY		TITL	E XVIII			_
		TITLE V	PART A	PART B	HIT 4	TITLE XIX 5	
1	HOSPITAL				1	1	1
	HOSPITAL-PARHM or						<u> </u>
1.01	HOSPITAL-CHART						1.01
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING-BED SNF SWING-BED PARHM (CAH ONLY) or						5
5.01	SWING-BED CHART (CAH ONLY) or SWING-BED CHART (CAH ONLY)						5.01
6	SWING-BED NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED RHC						10

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet NO5, is OMB 0938-0425. The time required to complete this information collection is estimated to be 675 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have 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. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

11

12 200

11 HOSPITAL-BASED FQHC
OUTPATIENT REHABILITATION

PROVIDER (Specify)

	AL AND HOSPITAL HEALTH CARE EX IDENTIFICATION DATA						PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-2 PART I	
PART I	- HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX INDENTIFICATION DATA	4							ı	
	and Hospital Health Care Complex Address:									
1	Street:	P.O. Box:								1
2	City:	State:	ZIP Code:	County:						2
Hospital	and Hospital-Based Component Identification:	•	•							
		Component	CCN	CBSA	Provider	Date	P	ayment System (P, T, O	, or N)	
	Component	Name	Number	Number	Type	Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From:	To:						_	20
	Type of control (see instructions)									21
		· ·								
Inpatient	PPS Information						1	2	3	
	Does this facility qualify and is it currently receiving payments for disproportionate share hospita	l adjustment, in accorda	nce with 42 CFR 412.106?	In column 1, enter "Y"	for yes or "N" for no.					22
	Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter				•					
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period			for the portion of the cos	reporting period occurring	g prior to October 1.				22.01
	Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring				1 01	51				
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement			es or "N" for no,						22.02
	for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or				l.					
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB					s or "N" for				22.03
	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes									
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with									
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revise	d OMB delineations for	statistical areas adopted by	CMS in FY 2021? Ente	er in column 1, "Y" for yes	or "N" for				22.04
	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes									
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with				,	,				
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, ent									23
	Is the method of identifying the days in this cost reporting period different from the method used in				no.					
			5 [In-State	In-State	Out-of State	Out-of State	Medicaid	Other	
				Medicaid	Medicaid eligible	Medicaid	Medicaid eligible	HMO	Medicaid	
				paid days	unpaid days	paid days	unpaid days	days	days	
				1	2	3	4	5	6	1
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid	edicaid unpaid days in co	olumn 2, out-of-state	1			1		1	24
	Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicai									
	column 5, and other Medicaid days in column 6.									
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eli	gible unpaid days in colu	umn 2, out-of-state							25
	Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid			5.						
					*		1	2	3	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost report	ting period. Enter "1" fo	r urban or "2" for rural.							26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting pe			ıral.						27
	If applicable, enter the effective date of the geographic reclassification in column 2.						ĺ			
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the	e cost reporting period.					1			35
	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of period		enter subsequent dates.				Beginning:	Ending:		36
	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in eff						1 5 5			37
	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance wi			s or "N" for no. (see inst	ructions)		1			37.01
	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, so						Beginning:	Ending:		38
	,						Y/N	Y/N		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals is	n accordance with 42 Cl	FR 412.101(b)(2)(i), (ii), or	(iii). Enter in column 1	"Y" for yes or "N" for no.					39
	Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii),				•		ĺ			
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for n				for no in column 2,					40
	for discharges on or after October 1. (see instructions)									

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-2 PART I (CONT.)	
			V	XVIII	XIX	T
Prospective Payment System (PPS)-Capital			1	2	3	
45 Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)						45
46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III, and Wkst. L-1, P	t. I, through Pt. III.					46
47 Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no.						47
48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				ļ		48
Teaching Hospitals			1 1	2	3	
16 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for n	o in onlymn 1. For cost r	anautina nauiada	1	2	3	56
beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior.	d in training residents in					30
approved GME programs in the prior year or penulimate year, and you are impacted by K. 11042 (or applicable CRs) MA residents in approved GME programs in the pri and you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	or year or penultimate year	r,				
and you are impacted by CR 11042 (or applicable CRS) MrX direct GME page interest of the process of the CRS of	araarama trainad at this fo	ailitu? Entar "V" for you				57
or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period: Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete West, D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413	lumn 2 is "Y", complete V	/kst. E-4.				37
of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.		nates of which month(s)				
to the cost report the restness were on utility. It the esponses on the 20 is 1 not yes, eline 1 to yes, eline 1 to yes, eline 5 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §21487 If yes, complete Wist, D-5.						58
59 Are costs claimed on line 100 of Worksheet A? If yes, complete West, D-2, Pt. I.						59
37 Alecosts claimed on the 100 of worksheet A. It yes, complete wast, D-2, 1 t. i.			NAHE 413.85	NAHE MA		37
			1	2	3	-
60 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "I	N" for no in column 1. If	column 1 is "Y", are you	-			60
impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.		, ,				
					Pass-Through	
				Worksheet A	Qualification	
				Line#	Criterion Code	
			1	2	3	1
60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						60.01
						_
	Y/N			IME	Direct GME	
	1	2	3	4	5	
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						61
				IME	Direct GME	7
			1	2	Direct GIVIE	-
			1		3	(1.01
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see	na instructions)					61.01
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	æ ilisti uctions)					61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line	61 03) (see instructions)					61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or Fits that are nonprimary care or non-general surgery. (see instructions)	01.05). (see instructions)					61.06
2.100 Earth in amount of 1.101. 32222 armit a mit is being used for expression and of 1.122 and are nonprinted state of 1.01 general state garget, (see manufacture)				Unweighted	Unweighted	01.00
				IME	Direct GME	
		Program Name	Program Code	FTE Count	FTE Count	
		1	2	3	4	1
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions)						61.10
Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE u	nweighted count.					
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions)						61.20
Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE u	nweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					1	
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions)						62
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see in	structions)					62.01
Teachine Hospitals that Claim Residents in Nonprovider Settings				2	1 2	_
1 eacning riospitats that C. nam Kestoents in Nonprovider Settings 63 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64 through 67. (see instr			1		3	63
os rais your facility trained residents in nonprovider settings during this cost reporting period? Enter 1 for yes or N for no. 11 yes, complete lines o4 through o7. (see instr	uctions)					0.5
			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	_
			Nonprovider Site	in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010)		1	2	3	-
64 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotation		ovider settings.	•		,	64
Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.	8 1	8				
Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						
			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	1
	Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	
	1	2	3	4	5	
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary						65
care FTEs for each primary care program in which you trained residents. 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						1
trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

4070 (Cont.)						12-22
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			PROVIDER CCN:	PERIOD FROM	WORKSHEET S-2 PART I (CONT.)	
			II	TO	D.C. C. L.	1
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 ÷ (col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider SettingsEffective for cost reporting periods beginning on or after July 1, 2010			1	ni riospitai 2	3	
66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number	of unweighted non-primar	y care resident				66
FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	r					
	D 31	D 6.1	Unweighted FTEs	Unweighted FTEs	Ratio (col. 3/	
	Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4)) 5	
67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter	1		,	,	,	67
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)						
D						1
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 202	3 IPPS Final Rule 87 FR	19065-49072 (August 10	2022)2		1	6
to 1 to a cost reporting period deginning prior to decode 1, 2022, and you domin permission from your mire to apply the new 20012 formula in decodance with the 1 1 20.	5 II I 5 I mai Ruic, 67 I R	+7005-47072 (Hugust 10	, 2022).		ļ	- '
npatient Psychiatric Facility PPS			1	2	3	
70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.						7
71 If line 70 is yes:						7
Column 1: Did the facility have an approved GME 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.	. (see 42 CFR 412.424(d)(1)(111)(C))				
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, indicate which program year began during this cost reporting period. (see instructions)						
						+
patient Rehabilitation Facility PPS			1	2	3	
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.						7
76 If line 75 is yes:	!!N!!!					7
Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes of 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.	r "N" Ior no.					
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						
					· ·	
ong Term Care Hospital PPS				1	2	
80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no.						8
01 LT 41 LTCH 1 4 1 141 4 1 141 4 1 141 4 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1 1 141 4 1						
81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.						8
				1	2	8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				1	2	8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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.				1	2	8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				1	2	8
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. 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.				Approved for	Number of	8 8
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. 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.				Permanent	Approved Permanent	8 8
FEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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.						8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1	ine 89. (see instructions)			Permanent	Approved Permanent Adjustments	8 8 8
TEFRA Providers Statis a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Bit 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. Bit this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ine 89. (see instructions)			Permanent	Approved Permanent Adjustments 2	8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1	ine 89. (see instructions)			Permanent	Approved Permanent Adjustments 2 Approved Permanent	8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1	ine 89. (see instructions)		What A Line No.	Permanent Adjustment (Y/N)	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount	8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1	ine 89. (see instructions)		Wkst. A Line No.	Permanent	Approved Permanent Adjustments 2 Approved Permanent	8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1	ine 89. (see instructions)		Wkst, A Line No.	Permanent Adjustment (Y/N)	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge	8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N)	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge	8 8 8
EFRA Providers 5 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3	8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	ine 89. (see instructions)		Wkst, A Line No.	Permanent Adjustment (Y/N)	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	8 8
EFRA Providers Statis Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3	88 88 88
St his a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. St his a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. St his hospital an extended neoplastic disease care hospital section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for n	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	88 88 88
EFRA Providers S Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. BO 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. BY Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. BY Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. BY Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. BY Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	888888888888888888888888888888888888888
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Citle V and XIX Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 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 Oses this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	888888888888888888888888888888888888888
EFRA Providers S Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. BO 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. S Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Citle V and XIX Services Oos this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 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. 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. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	888888888888888888888888888888888888888
EFRA Providers \$ Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. \$ 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. \$ 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. \$ Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. \$ Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. \$ Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. It was a XIX Services O Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. O Does this facility have title V and/or XIX through the cost report either in full or in part? Enter "V" for yes or "N" for no in the applicable column. O Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "V" for yes or "N" for no in the applicable column. O Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "V" for yes or "N" for no in the applicable column. O Does this facility operate an ICF/IID facility for purposes of title V and YIX? Enter "V" for yes or "N" for no in the applicable column. O Does this facility operate an ICF/IID facility for purposes of title V and YIX? Enter "V" for yes or "N" for no in the applicable	ine 89. (see instructions)		Wkst, A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	\$ 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
ERA Providers S Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. BO 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. BO 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. BO 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. BO 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. BO Dolumn 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. BO Dolumn 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Intel V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. BY 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. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	ine 89. (see instructions)		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	\$ 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Itle V and XIX 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. 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. 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. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column. 96 Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		uum 2 for title XIX	Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	\$ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
EFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. 80 Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. 81 Statis desired the amount of the approved permanent adjustment to the TEFRA target amount per discharge. 82 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. 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. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "V" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column. 96 Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 97 If line 96 is "Y", enter the reduction percentage in the applicable column. 98 Does title V or XIX follo	umn I for title V, and in co	umn 2 for title XIX.	Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	\$ 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
Statis a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	umn 1 for title V, and in co		Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and 1 Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. (itle V and XIX 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. 19 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. 21 Are title XIX NF patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 23 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 24 Post title XIX Produce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 25 If line 94 is "Y", enter the reduction percentage in the applicable column. 26 If line 96 is "Y", enter the reduction percentage in the applicable column. 27 If line 96 is "Y", enter the reduction percentage in the applicable column. 28 Does title V or XIX follow Medicare (title XVIII) for the interns and r	umn 1 for title V, and in co or title XIX. or title V, and in column 2 f nn 1 for title V, and in colu	or title XIX.	Wkst, A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
Solution	umn 1 for title V, and in co or title XIX. or title V, and in column 2 f nn 1 for title V, and in colu column 2 for title XIX.	or title XIX.	Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8
18	umn 1 for title V, and in coi or title XIX. or title V, and in column 2 f nn 1 for title V, and in colu column 2 for title XIX. d in column 2 for title XIX.	or title XIX.	Wkst. A Line No.	Permanent Adjustment (Y/N) 1 Effective Date 2	Approved Permanent Adjustments 2 Approved Permanent Adjustment Amount Per Discharge 3 XIX	8

HOSPITAL AND HOSPITAL HEALTH CARE		PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPLEX IDENTIFICATION DATA			FROM	PART I (CONT.)	
			TO		
Rural Providers			1	2	
105 Does this hospital qualify as a CAH?					105
106 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)					106 107
107 Column 1: It time 105 is 1, is this latently engine for cost removement for task training programs? Enter 1 to 1 yes or 1 is 107 in on column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train IAR's in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in col	umm 2 (coo inctmu	ations)			107
Column 2. If Column 1 is 1 and time (vol time 7) is 1, to you turn less in an approved medical outcome for program in the CATA excluded 1 is 1 and 1 in (v) to time 7) is 1 in in in column 1 in CATA in a column 1 in a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no.	illili 2. (see ilisii u	etions)			108
100 Is this a tutal nospital quantifing for an exception to the CRONE te sendule: See 42 CTR 412.113(c). Line 1 To Fyes of 18 101 (b).					100
	Physical	Occupational	Speech	Respiratory	7
	1	2	3	4	1
109 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
			,		1
				1	
Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no.					110
If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					
			1		
			1	2	
If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1.	1/ 1/01/0 . 1				111
If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; is	ind/or "C" for tele-	health services.			
		1	2	3	1
112 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column	ic "V" enter in	1	2	- ,	112
column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration. In column 3, the date the demonstration, if applicable.	is 1 , citer in				112
Column 2, the date the nospital organ participating in the definistration. In column 3, that the date the nospital ceased participation in the definistration, it applicable.		1	1		
		1 1	2	3	
113 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.			_		113
				_	
Miscellaneous Cost Reporting Information		1	2	3	
115 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2.					115
If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals					
providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.					
				1	
116 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.					116
117 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.					117 118
Its a lie marpraetice insurance a craims-made of occurrence poncy: Enter 1 if the poncy is craim-made. Enter 2 if the poncy is occurrence.					110
		Premiums	Paid losses	Self insurance	
		1	2	3	1
118.01 List amounts of malpractice premiums and paid losses:					118.01
		•	•		
			1	2	
118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.					118.02
119 What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.					119
120 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a					120
rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.					
Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.					121
122 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the Worksheet A line number with the column 2 the worksheet A line number				$\overline{}$	122 123
Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelate	u organization? Ir	column 1,			123
enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the ma	in hospital CDS AS	In column 2			
enter "Y" for yes or "N" for no.	ш позрна СВЗА	m commi 2,			
Tenter 1 for years in forms.					1

Rev. 18 40-507

4090 (Cont.)	TOKWI CIVIS	-2332-10						12-22
HOSPIT	AL AND HOSPITAL HEALTH CARE					PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPL	EX IDENTIFICATION DATA						FROM	PART I (CONT.)	
							ТО		
Certified	Transplant Center Information						1	2	
125	Does this facility operate a Medicare-certifiedtransplant center? Enter "Y" for yes or "N" for no. If yes, enter certifiedtransplant center?	ification date(s) (mm/dd/yyyy) below.						125
	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination da								126
	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date		•						127
	If this is a Medicare certified liver transplant program, enter the certification date in column 1 and termination date,								128
	If this is a Medicare certified lung transplant program, enter the certification date in column 1 and termination date,								129
	If this is a Medicare certified pancreas transplant program, enter the certification date in column 1 and termination date,		. 2						130
									131
	If this is a Medicare certified intestinal transplant program, enter the certification date in column 1 and termination		1 2.						
	If this is a Medicare certified islet transplant program, enter the certification date in column 1 and termination date,	, if applicable, in column 2.							132
	Removed and reserved								133
134	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and terminati	tion date, if applicable, in colu	ımn 2.						134
All Provi							1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for year	es or "N" for no in column 1.							140
	If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)								
If this fac	cility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter	ter the home office contractor	name and contractor number	er.					
141	Name:		Contractor's Name:			Contractor's Number	:		141
142	Street:	P. O. Box:							142
143	City:	State:	Zip Code:						143
		*	•	•					
							1	2	
144	Are provider based physicians' costs included in Worksheet A?								144
	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for y	ves or "N" for no in column 1.							145
	If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for								
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no								146
140	If yes, enter the approval date (mm/dd/yyyy) in column 2.	o in column 1. (See CIVIS 1 de	b. 13-2, enapter 40, §4020)						140
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147
	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								149
					m:u	3/3/111	1	-	1
D 41						e XVIII	Trid M	T:4 3/13/	
	s facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges?				Part A	Part B	Title V	Title XIX	
	" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13)				1	2	3	4	
	Hospital								155
	Subprovider - IPF								156
	Subprovider - IRF								157
158	Subprovider - Other								158
	SNF								159
160	HHA								160
161	CMHC								161
								•	
Multican	apus								
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for you	yes or "N" for no.							165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in column	nn 3, CBSA in column 4, FTE	E/Campus in column 5. (see	e instructions)	•				166
	Name			County	State	Zip Code	CBSA	FTE/Campus	
	0			1	2.	3	4	5	
ŀ	*				_				-
				1	1				
Health In	nformation Technology (HIT) incentive in the American Recovery and Reinvestment Act						1	2.	
	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.						<u> </u>	2	167
	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incu	urred for the HIT accete (coo	instructions)						168
	If this provider is a CAH (line 103 is 1) and is a meaningful user, does this provider qualify for a hardship exception under §4			atmationa)			+		168.01
	If this provider is a CAH and is not a meaningful user, does this provider quality for a hardship exception under §4. If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor.		or yes or "N" for no. (see in	su ucuons)			+		168.01
							+		
170	Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yy		2 1 (0 E + 6377.0	1 42 m C	1			_	170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans rep	ported on Wkst. S-3, Pt. I, line	e 2, col. 6? Enter "Y" for y	es and "N" for no in colum	n 1.				171

40-508 Rev. 18

	Y/N	Y/N	
Educational Activities	1	2	
Column 1: Are costs claimed for a nursing program?			
Column 2: If yes, is the provider the legal operator of the program?			
Are costs claimed for allied health programs? If yes, see instructions.			
Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period?			
If yes, see instructions.			
Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions.			
Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			
Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A?			
If yes, see instructions.			
		N/AT	1
		Y/N	+
			1
If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.		ł	1
	If yes, see instructions. Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. s Is the provider seeking reimbursement for bad debts? If yes, see instructions. If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for allied health programs? If yes, see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. Is the provider seeking reimbursement for bad debts? If yes, see instructions. If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? Are costs claimed for allied health programs? If yes, see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. Y/N Is the provider seeking reimbursement for bad debts? If yes, see instructions. If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.

		Pa	rt A	Pa	rt B	
		Y/N	Date	Y/N	Date]
PS&R R	eport Data	1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the					16
	paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)					
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?					17
	If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
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

Rev. 18 40-509

- 22	Related Cost		1	-
22	Have assets been relifed for Medicare purposes? If yes, see instructions.			22
23				23
2.4	If yes, see instructions.			2
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			24 25
23				
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			26
21	ras the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			21
	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
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33
rovide	-Based Physicians			
	Were 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			35
	reporting period? If yes, see instructions.			
		Y/N	Date	
	office Costs	1	2	
ome C				36
	Are home office costs claimed on the cost report?			
	Are home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
36	1			
36 37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 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.			
36 37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider?			37 38 39 40

E-mail Address:

Title:

Last name:

Cost Report Preparer Contact Information

41 First name:

42 Employer: 43 Phone number: 42

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-3
STATISTICAL DATA		FROM	PART I
		TO	

PART I	STATISTICAL DATA																
						Inpatie	nt Days / Ou	tpatient Visits	/ Trips	Full	Time Equiva	lents		Discl	narges		
		Worksheet															1
		A							Total	Total	Employees					Total	1
		Line	No. of	Bed Days	CAH		Title	Title	All	Interns &	On	Nonpaid		Title	Title	All	1
	Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents	Payroll	Workers	Title V	XVIII	XIX	Patients	1
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	İ
1	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing																1
	Bed, Observation Bed and Hospice days) (see instructions for																İ
	col. 2 for the portion of LDP room available beds)																İ
2	HMO and other (see instructions)																2
3	HMO IPF Subprovider																3
4	HMO IRF Subprovider																4
	Hospital Adults & Peds. Swing Bed SNF																5
	Hospital Adults & Peds. Swing Bed NF																6
	Total Adults and Peds. (exclude																7
	observation beds) (see instructions)																
- 8	Intensive Care Unit																8
	Coronary Care Unit																9
	Burn Intensive Care Unit																10
	Surgical Intensive Care Unit																11
	Other Special Care																12
	Nursery																13
	Total (see instructions)																14
	CAH visits																15
	Subprovider - IPF																16
	Subprovider - IRF									1							17
	Subprovider - Other									1							18
19	Skilled Nursing Facility																19
	Nursing Facility																20
	Other Long Term Care																21
	Home Health Agency																22
	ASC (Distinct Part)																23
	Hospice (Distinct Part)																24
	Hospice (non-distinct part)																24.10
	CMHC																25
	RHC/FQHC (specify)																26
27	Total (sum of lines 14-26)																27
	Observation Bed Days																28
	Ambulance Trips																29
	Employee discount days (see instructions)																30
	Employee discount days - IRF																31
	Labor & delivery (see instructions)																32
	Total ancillary labor & delivery room																32.01
52.51	outpatient days (see instructions)																52.01
33	LTCH non-covered days																33
	LTCH site neutral days and discharges																33.01
	Temporary Expansion COVID-19 PHE Acute Care																34
																	<u> </u>

	,	CMS-2	332-10					12-22
HOSPIT	CAL WAGE INDEX INFORMATION				PROVIDER CCN:		WORKSHEET	S-3
						FROM	PART II	
						TO		
Part II -	Wage Data							
				Reclassification	Adjusted	Paid Hours	Average	
		Wkst. A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(col. 2 ±	to Salaries	(col. 4 ÷	
		Number	Reported	Wkst. A-6)	col. 3)	in column 4	col. 5)	
	SALARIES	1	2	3	4	5	6	
1	Total salaries (see instructions)							1
2	Non-physician anesthetist Part A			 			+	2
3	Non-physician anesthetist Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching			 			+	4.01
4.01	Physician and Non Physician-Part B			 			+	4.01
6	Non-physician-Part B for hospital-based RHC and FQHC services			 			+	6
7	Interns & residents (in an approved program)			 			+	7
7.01	Contracted interns & residents (in an approved program)			 			+	7.01
7.01	Home office and/or related organization personnel			 			+	7.01
9	SNF							9
10	Excluded area salaries (see instructions)			 			+	10
10	OTHER WAGES AND RELATED COSTS							10
11	Contract labor: Direct Patient Care							11
12	Contract labor: Top level management and other management and							12
12	administrative services							12
13	Contract labor: Physician-Part A - Administrative			 			+	13
13	Home office and/or related organization salaries and wage-related costs			 			+	13
14.01	Home office salaries Home office salaries			 			+	14.01
14.02	Related organization salaries							14.02
14.02	Home office: Physician Part A - Administrative			+				15
16	Home office & Contract Physicians Part A - Teaching			+				16
16.01	Home office Physicians Part A - Teaching			 			+	16.01
16.02	Home office contract Physicians Part A - Teaching							16.02
10.02	WAGE-RELATED COSTS							10.02
17	Wage-related costs (core) (see instructions)							17
18	Wage-related costs (other) (see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A			†				20
21	Non-physician anesthetist Part B			†				21
22	Physician Part A - Administrative			†				22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B			†				23
24	Wage-related costs (RHC/FQHC)			†				24
25	Interns & residents (in an approved program)			†				25
25.50	Home office wage-related (core)			†				25.50
25.51	Related organization wage-related (core)			1				25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)			t	ł			25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)							25.53

11-10		roki	VI CIVIS-23	32-10			T070 (Cont.)
HOSPITA	L WAGE INDEX INFORMATION				PROVIDER CCN:	PERIOD	WORKSHEET	S-3
						FROM	PART II & III	
						TO		
Part II - W	/age Data				•		-	
		Worksheet		Reclassification	Adjusted	Paid Hours	Average	
		A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(column 2 ±	to Salaries	(column 4 ÷	
		Number	Reported	Worksheet A-6)	column 3)	in column 4	column 5)	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department	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 1	Housekeeping	9						32
33 1	Housekeeping under contract (see instructions)							33
34 1	Dietary	10						34
35 1	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 - F	Hospital Wage Index Summary							
1	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3 5	Subtotal salaries (line 1 minus line 2)							3
4 5	Subtotal other wages and related costs (see instructions)							4
5 5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)							6
7	Total overhead cost (see instructions)							7

HOSPIT	AL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD FROMTO	WORKSHEET S-3 PART IV	
Part IV -	Wage Related Cost		10		
Part A -	Core List				
				Amount	
				Reported	
	RETIREMENT COST				
	401k Employer Contributions				1
2	Tax Sheltered Annuity (TSA) Employer Contribution				2
	Nonqualified Defined Benefit Plan Cost (see instructions)				3
	Qualified Defined Benefit Plan Cost (see instructions)				4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):				<u> </u>
- 5	401k/TSA Plan Administration fees				5
	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
8.01	Health Insurance (Self Funded without a Third Party Administrator)				8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)				8.02
8.03	Health Insurance (Purchased)				8.03
9	Prescription Drug Plan				9
	Dental, Hearing and Vision Plan				10
	Life Insurance (If employee is owner or beneficiary)				11
	Accident Insurance (If employee is owner or beneficiary)				12
	Disability Insurance (If employee is owner or beneficiary)				13
	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 FAS	B 106 Noncumulative portion)			16
	TAXES				
	FICA-Employers Portion Only				17
	Medicare Taxes - Employers Portion Only				18
	Unemployment Insurance				19
20	State or Federal Unemployment Taxes				20
- 21	OTHER	-1			21
22	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4	above)(see instructions)			
	Day Care Cost and Allowances Tuition Reimbursement				22
24					24
	Total Wage Related cost (Sum of lines 1 through 23)				24
Part B -	Other than Core Related Cost				
25	Other Wage Related Costs (specify)				25

HOSPITAL CONTRACT LABOR AND BENEFIT COST	PROVIDER CCN:	PERIOD:	WORKSHEET S-3
		FROM	PART V
		TO	

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

		Contract	Benefit	
	Component	Labor	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

4090 ((Cont.)	FORM CMS-2552-1	10						10-12
HOSPIT	AL-BASED HOME HEALTH AGENCY		PROVIDER	R CCN:	PERIOD:			EET S-4	
STATIS	TICAL DATA				FROM				
			HHA CCN:	:	то				
	HOME HEALTH AGENCY STATISTICAL DATA				County	:			
				Title V	Title XVIII	Title XIX	Other	Total	
	Description			1	2	3	4	5	
1	Home Health Aide Hours								1
2	Unduplicated Census Count (see instructions)								2
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
						Nun	nber of Empl	oyees	
	Enter the number of hours in					(Ful	l Time Equiv	alent)	
	your normal work week					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 durin	ig the cost reporting period.							19
20	List those CBSA code(s) serviced during this cost reporting per								20
								•	
	PPS ACTIVITY			Full F	pisodes			Total	
				Without	With	LUPA	PEP only	(columns 1	
				Outliers	Outliers	Episodes	Episodes	through 4)	
				1	2	3	4	5	
21	Skilled Nursing Visits				_				21
22	Skilled Nursing Visit Charges								22
23	Physical Therapy Visits								23
24	Physical Therapy Visit Charges							1	24
25	Occupational Therapy Visits								25
26	Occupational Therapy Visit Charges								26
27	Speech Pathology Visits			i e					27
28	Speech Pathology Visit Charges								28
29	Medical Social Service Visits			i e					29
30	Medical Social Service Visit Charges							1	30
31	Home Health Aide Visits								31

32 Home Health Aide Visit Charges
 33 Total visits (sum of lines 21, 23, 25, 27, 29, and 31)

Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)
 Total Number of Episodes (standard/non-outlier)
 Total Number of Outlier Episodes
 Total Non-Routine Medical Supply Charges

34 Other Charges

	TAL RENAL DIALYSIS DEPA	RTMENT			PROVIDER CCN:	PERIOD:	WORKSHEET S-5	
STATIS	STICAL DATA					FROM		
	RENAL DIALYSIS STATIST	TCS				ТО	1	
	RESULE BILLETONS STITLES		atient	Tra	ining	Н	ome	
				Hemo-	CAPD	Hemo-	CAPD	
		Regular	High Flux	dialysis	CCPD	dialysis	CCPD	
	DESCRIPTION	1	2	3	4	5	6	1
1	Number of patients in program at end of cost							1
	reporting period							
2	Number of times per							2
	week patient receives							
	dialysis							
3	Average patient dialysis							3
	time including setup							
	CAPD exchanges per day Number of days in year							5
3	dialysis furnished							
6	Number of stations							6
7	Treatment capacity per							7
	day per station							
8	Utilization (see instructions)							8
9	Average times							9
- 10	dialyzers re-used							10
10	Percentage of patients re-using dialyzers							10
	re-using diaryzers							
	ESRD PPS					1	2	1
10.01	Is the dialysis facility approved	d as a low-volume facilit	y for this cost reporting	period?			_	10.01
	Enter "Y" for yes or "N" for no	o. (see instructions)						
10.02	Did your facility elect 100% P		2011? Enter "Y" for yes	or "N" for no.				10.02
	(See instructions for "new" pro							
10.03	If you responded "N" to line 10				l and			10.03
	enter in column 2 the year of to	ransition for periods after	r December 31. (see ins	structions)				<u> </u>
	TRANSPLANT INFORMATION	ON						
11	Number of patients on transpla						1	11
12	Number of patients transplante		ing period					12
	•						-	
	EPOETIN						•	
13	Net costs of Epoetin furnished			der				13
14	Epoetin amount from Worksho							14
16	Number of EPO units furnishe Number of EPO units furnishe							15 16
- 10	Number of Er O units furnishe	d relating to the nome di	iarysis department				<u>.</u>	10
	ARANESP							
17	Net costs of ARANESP furnis	hed to all maintenance d	lialysis patients by the pr	rovider				17
18	ARANESP amount from Worl							18
19	Number of ARANESP units fu							19
20	Number of ARANESP units fu	urnished relating to the h	iome dialysis departmen	t				20
	PHYSICIAN PAYMENT MET	THOD (Enter "Y" for an	unlicable method(s))					
21		INITIAL METHOD	pheasic method(3))					21
				Net Cost of	Net Cost of	Number of ESA	Number of ESA	
			ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
			Description	Renal Patients	Home Patients	Dialysis Dept.	Dialysis Dept.	1
	Erythropoiesis-Stimulating Age		1	2	3	4	5	22
22	Enter in column 1 the ESA des Enter in column 2 the net costs	*						22
	to all renal dialysis patients.	s of LSAs furnished						
	Enter in column 3 the net cost	of ESAs furnished						
	to all home dialysis program pa	atients.						
	Enter in column 4 the number							
	furnished to patients in the ren	al dialysis						
	department. Enter in column 5 the number	of unite furnished						
	to patients in the home dialysis							
	(see instructions)	, program.						
	,,							
						CCN	Treatments	
	LOW VOLUME					1	2	
23	If line 10.01 is yes, enter in col				Part I, line 18, and		_	23
	its subscripts. Enter in column	12, the total treatments f	or each CCN. (see instr	ructions)				

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET S-6
COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF	F EMPLOYEES (FULL	TIME EQUIVALENT)	
Check [] CMHC [] OOT			
applicable [] CORF [] OSP			
box: [] OPT			
Enter the number of hours in your normal workweek			

				Total
		Staff	Contract	(col. 1 + col. 2)
		1	2	3
1	Administrator and Assistant Administrator(s)			
2	Director(s) and Assistant Director(s)			
3	Other Administrative Personnel			
4	Direct Nursing Service			

11 12 13

14 15

16 17 18

Rev. 10

5 Nursing Supervisor
6 Physical Therapy Service
7 Physical Therapy Supervisor
8 Occupational Therapy Service
9 Occupational Therapy Supervisor
10 Speech Pathology Service
11 Speech Pathology Supervisor
12 Medical Social Service

13 Medical Social Service Supervisor

17 Psychiatric/Psychological Service Supervisor

14 Respiratory Therapy Service
15 Respiratory Therapy Supervisor
16 Psychiatric/Psychological Service

18 Other (specify)

	1 014.1 01.15 2002 10		.0,0(
PROSPI	ECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7	
STATIS	TICAL DATA		FROM		
			TO		
			Y/N	Date	
			1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medi	care utilization?			1
	Enter "Y" for yes and do not complete the rest of this worksheet.				
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y	Y" for yes or			2
	"N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				

		SNF Swing Bed SNF TOTAL					
	Group	Days	Days	(sum of col. 2+3)			
- 1	1	2	3	4			
3	RUX	2	3	7	3		
4	RUL				3 4 5 6		
5	RVX				- 5		
6	RVL				6		
7	RHX				7		
8	RHL				7 8 9		
9	RMX				0		
10	RML				10		
11	RLX				10		
12	RUC				11 12		
13	RUB				12		
13	RUA				13 14 15		
15	RVC				14		
					15		
16	RVB				16		
17	RVA				17 18		
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				19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 40 41 42 43 44 45		
41	LC2				41		
42	LC1				42		
43	LB2				43		
44	LB1				44		
45	CE2				45		
46	CE1				46 47		
47	CD2				47		
48	CD1				48		
49	CC2				48 49 50 51 52 53		
50	CC1				50		
51	CB2				51		
52	CB1				52		
53	CA2				53		
54	CAI				54		
54							

STATISTIC	IVE PAYMENT FOR SNF AL DATA	PROVIDER CO	FROM TO _	(CONT.)	
	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	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

		CBSA at	CBSA on/after	,
		Beginning of	October 1 of the	
		Cost Reporting	Cost Reporting	
		Period	Period (if applicable)	
		1	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			201
	cost reporting period.			
	Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			

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)

				Associated with	
				Direct Patient Care	
		Expenses	Percentage	and Related Expenses?	
		1	2	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

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)

Total

Visits

5

15

XVIII

3

Y/N

1

XIX

4

PROVIDER CCN:

PERIOD:

WORKSHEET S-9

				HOSPICE CCN:	TO	PARTS I THROUGH	1 IV
PART I - ENROLLMENT DAYS FOR COST REP	ORTING PERIODS E	BEGINNING BEFORE	OCTOBER 1, 2015				
			Un	duplicated Days			
			Title XVIII	Title XIX		Total	
			Skilled Nursing	Nursing	All	(sum of	

		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
		1	2	3	4	5	6	
1	Hospice Continuous Home Care							1
2	Hospice Routine Home Care							2
3	Hospice Inpatient Respite Care							3
4	Hospice General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

				Title XVIII	Title XIX	A 11	Total	
		Title XVIII	Title XIX	Skilled Nursing Facility	Nursing Facility	All Other	(sum of cols. 1, 2 and 5)	
		1	2	3	4	5	6	1
6	Number of patients receiving							6
	hospice care							
7	Total number of unduplicated contin-							7
	uous care hours billable to Medicare							
8	Average length of stay (line 5/line 6)							8
9	Unduplicated census count							9

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days							
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)				
		1	2	3	4	i			
10	Hospice Continuous Home Care					10			
11	Hospice Routine Home Care					11			
12	Hospice Inpatient Respite Care					12			
13	Hospice General Inpatient Care					13			
14	Total Hospice Days					14			

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

				Total (sum of	
	Title XVIII	Title XIX	Other	cols. 1 through 3)	
	1	2	3	4	
15 Hospice Inpatient Respite Care					15
16 Hospice General Inpatient Care					16

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

12-22 F	FORM CMS-2552-10			4090 ((Cont.)
HOSPITAL UNCOMPENSATED AND INDIGENT	PR	OVIDER CCN:	PERIOD:	WORKSHEET S-10	
CARE DATA			FROM	PART I	
			TO		
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA	-			•	
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1 Cost to charge ratio (see instructions)					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 and/or supplemental payments	from Medicaid?				4
5 If line 4 is no, enter DSH and/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 (see instr	ructions)				8
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9 Net revenue from stand-alone CHIP					9
10 Stand-alone CHIP charges					10
11 Stand-alone CHIP cost (line 1 times line 10)					11
12 Difference between net revenue and costs for stand-alone CHIP (see instr	ructions)				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 line					13
14 Charges for patients covered under state or local indigent care program (no	ot 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 p	rogram (see instructions)				16
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local in	digent care programs (see instruct	ions for each line)			
17 Private grants, donations, or endowment income restricted to funding char					17
18 Government grants, appropriations or transfers for support of hospital oper	rations				18
19 Total unreimbursed cost for Medicaid, CHIP, and state and local indigent	care programs (sum of lines 8, 12,	and 16)			19
Uncommoncated one aget (age instructions for each line)					
Uncompensated care cost (see instructions for each line)		Uninsured	Insured	Total	1
		patients	patients	(col. 1 + col. 2)	
		1	2	3	1
20 Charity care charges and uninsured discounts (see instructions)					20
21 Cost of patients approved for charity care and uninsured discounts (see in	structions)				21
					22
Payments received from patients for amounts previously written off as cha	rity care				
Payments received from patients for amounts previously written off as cha 23 Cost of charity care (see instructions)	rity care				23
23 Cost of charity care (see instructions)		a motionto covianad			
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyon		n patients covered			
Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyone by Medicaid or other indigent care program?	d a length-of-stay limit imposed or		<u> </u>		24
 Cost of charity care (see instructions) Does the amount on line 20, col. 2, include charges for patient days beyon by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care 	d a length-of-stay limit imposed or				24
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care 25.01 Charges for insured patients' liability (see instructions)	d a length-of-stay limit imposed or				24 25 25.01
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care Charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions)	d a length-of-stay limit imposed or				24 25 25.01 26
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care 25.01 Charges for insured patients 'liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions)	d a length-of-stay limit imposed or				24 25 25.01 26 27
Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care 25.01 Charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions) 28 Medicare allowable bad debts (see instructions)	d a length-of-stay limit imposed or				24 25 25.01 26 27 27.01
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care 25.01 Charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions) 28 Non-Medicare bad debt amount (see instructions)	d a length-of-stay limit imposed or e program's length-of-stay limit (so				24 25 25.01 26 27 27.01 28
23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care care considered to the constructions of the constructions and debt amount (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions) 28 Medicare allowable bad debts (see instructions)	d a length-of-stay limit imposed or e program's length-of-stay limit (so				23 24 25 25.01 26 27 27.01 28 29

4090 ((Cont.) FORM CMS-	-2552-10			12-22
HOSPIT	TAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10,	
CARE I	DATA		FROM	PART II	
			ТО		
PART II	I - HOSPITAL DATA			•	
Uncomp	pensated and Indigent Care Cost-to-Charge Ratio				
1	Cost to charge ratio (see instructions)				1
	d (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 and/or supplemental payments from Medicaid?				4
5	If line 4 is no, enter DSH and/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 (see instructions)				8
Children	n's Health Insurance Program (CHIP) (see instructions for each line)				
Children 9					9
10	Stand-alone CHIP charges				10
11	Stand-alone CHIP cost (line 1 times line 10)				11
12	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12
- 12	Difference between her revenue and costs for stand alone Criti (see instructions)				12
Other sta	ate or local government indigent care program (see instructions for each line)				
	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	s 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 (see instru	uctions)			16
Grants, o	donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care progra	ms (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, CHIP, and state and local indigent care programs (sur	m of lines 8, 12, and 16)			19
Uncomp	pensated care cost (see instructions for each line)	77 . 1	Y 1	T . 1	
		Uninsured	Insured	Total	
		Patients	Patients 2	(col. 1 + col. 2) 3	-
20	Charity care charges and uninsured discounts (see instructions)	1		3	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)		+		21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (see instructions)				23
	Cost of thanky that (see instructions)				
24	Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay	limit imposed on patients covered			24
	by Medicaid or other indigent care program?				
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-	of-stay limit (see instructions)			25
25.01	Charges for insured patients' liability (see instructions)				25.01
26	Bad debt amount (see instructions)				26
27	Medicare reimbursable bad debts (see instructions)				27
27.01	Medicare allowable bad debts (see instructions)				27.01
28	Non-Medicare bad debt amount (see instructions)				28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29
30	Cost of uncompensated care (line 23, col. 3, plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	<u> </u>			31

40-522.2 Rev. 18

This page is reserved for future use.

HOSPI	TAL-BASED FQHC ID	ENTIFICATION DATA					PROVIDER CCN:	PERIOD: FROM:	WORKSHEET S-11 PART I	
							COMPONENT CCN:			
PART	i - HOSPITAL-BASED F	QHC IDENTIFICATION DATA					•			
						Type of control	Date	V/I	Date of	
						(see instructions)	Decertified	Decertification	CHOW	
		1				2	3	4	5	
1	Site Name:		1							1
2	Street:		P.O. Box:							2
	City:	State:	ZIP Code:	County:	Designation - Enter "F	" for rural or "U" for ur	ban:			3
4	Is this hospital-based F enter the entity's inform		s or controls multiple FQH	Cs? Enter "Y" for yes or "N" for no. If yes,						4
5	Name of Entity:									5
6	Street:	P.O. Box:		HRSA Award Number:						6
7	City:	State:		ZIP Code:						7
						Y/N	Date Requested	Date Approved	Number of FQHCs	
Consol	idated Cost Report					1	2	3	4	
8				pter 9, §30.8? Enter "Y" for yes or "N" for n If column 1 is no, leave line 9 blank. (see ins						8
				,	•	CCN	CBSA	Date Requested	Date Approved	
		1				2	3	4	5	1
9	List of Consolidated Pr	roviders:								9
9.01	Site Name:							1		9.01
Hospita	al-Based FQHC Operation	ns				•	1	2	3	
10	What type of organizat	ion is this hospital-based FQHC? If yo	ou operate as more than or	e sub-type of an organization, enter only the	applicable alpha					10
	characters in column 2.	. (see instructions)								
11	Did this hospital-based	FQHC receive a grant under §330 of t	he PHS Act during this co	st reporting period? If this is a consolidated	cost report, did the hospital-ba	sed FQHC reported				11
	on line 1, column 1, re-	ceive a grant under §330 of the PHS A	ct during this cost reportin	g period? Enter "Y" for yes or "N" for no. (c	complete line 12)					
12	If the response to line !	I1 is yes, indicate in column 1, the type	of HRSA grant that was a	warded (see instructions). Enter the date of	the grant award in				1	12
	column 2, and enter the	e grant award number in column 3. If y	you received more than on	e grant subscript this line accordingly.						
	al Malpractice									
13				n for medical malpractice coverage under the	e FTCA with HRSA? Enter "	Y" for				13
		lumn 1. If column 1 is yes, enter the e	ffective date of coverage in	n column 2.						
	and Residents						•			_
14				C of Title VII of the PHS Act from HRSA?					1	14
	1.			at your hospital-based FQHC trained and rec						
	_		r the total number of visits	performed by residents funded by the THC $\boldsymbol{\varrho}$	grant in this cost reporting				1	
	pariod (can instruction	(20					1	1	1	

40-523.1 Rev. 18

11-16 FORM CMS-2552-10 4090 (Cont.) HOSPITAL-BASED FOHC IDENTIFICATION DATA PROVIDER CCN: PERIOD: WORKSHEET S-11 FROM PART II COMPONENT CCN: TO SUBCOMPONENT CCN: PART II - HOSPITAL-BASED FOHC CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA Date Date Date of Type of control Certified (see instructions) Decertified Decertification CHOW 6 1 Site Name: 2 Street: P.O. Box: 3 City: State: ZIP Code: County: Designation - Enter "R" for rural or "U" for urban: Hospital-Based FQHC Operations What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions) Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 6) If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly. Medical Malpractice Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2. Interns and Residents Did this hospital-based FOHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)

Rev. 10 40-523.2

TU/U ((Cont.)		I OIGNI CIV	115-2332-10				11-10
HOSPIT	TAL-BASED FQHC IDENTIFICATION	DATA			PROVIDER CCN:	PERIOD:	WORKSHEET S-11	
						FROM	PART III	
					COMPONENT CCN:	TO		
PART I	II - HOSPITAL-BASED FQHC STATIST	TICAL DATA			•	•		
							Total	
		COMPONENT		Title	Title		All	
		CCN	Title V	XVIII	XIX	Other	Patients	
		0	1	2	3	4	5	-
1	Medical Visits							1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4

40-523.3 Rev. 10

This page is reserved for future use.

Rev. 17 40-523.4

RECLAS	SSIFICATI	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM	WORKSHEET A	
								TO		
			1	1	1	T	RECLASSIFIED	10	NET EXPENSES	
	COS	T CENTER DESCRIPTIONS			TOTAL	RECLASSIFI-	TRIAL BALANCE		FOR ALLOCATION	
	COS	(omit cents)	SALARIES	OTHER	(col. 1 + col. 2)	CATIONS	(col. $3 \pm \text{col. 4}$)	ADJUSTMENTS	(col. $5 \pm \text{col. } 6$)	l
		(omit cents)	SALARIES 1	2	3	4	(coi. 3 ± coi. 4)	ADJUSTMENTS 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 Department								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 Program								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23		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		Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46		Other Long Term Care								46

RECLAS	SSIFICAT	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD:	WORKSHEET A	
								FROM		
								TO		
							RECLASSIFIED		NET EXPENSES	
	COS	ST CENTER DESCRIPTIONS			TOTAL	RECLASSIFI-	TRIAL BALANCE		FOR ALLOCATION	
		(omit cents)	SALARIES	OTHER	(col. 1 + col. 2)	CATIONS	$(col. 3 \pm col. 4)$	ADJUSTMENTS	$(col. 5 \pm col. 6)$	_
			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	Radioisotope								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, & Trans.								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	07500	Other Ancillary (specify)								76
77	07700	Allogeneic HSCT Acquisition								77
78	07800	CAR T-Cell Immunotherapy								78
70	07000	OUTPATIENT SERVICE COST CENTERS								70
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	09200	Other Outpatient Service (specify)								93
93.99	09399	Partial Hospitalization Program								93.99
95.99	09399	гания поѕрнанzанов Program		1		1				93

RECLAS	SSIFICAT	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A	
	COS	ST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		OTHER REIMBURSABLE COST CENTERS	1	2	3	4	3	0	/	
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97		Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
102		Opioid Treatment Program								102
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition				1				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 through 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 through 199)				- 0 -				200

10 12				1 OIGN	CIVID 2332 I	,						1050 (Cont.
RECLASSIF	FICATIONS							PROVIDER	CCN:	PERIOD: FROMTO	WORKSE	EET A-6	
				INCRE.	ASES				DECRE				
		CODE		WKST. A					WKST. A			WKST. A-7	ĺ
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	COST C	ENTER	LINE #	SALARY	OTHER	REF.	İ
		1	2	3	4	5	6		7	8	9	10	ĺ
1													1
2													2
3													3
4													4
5													5
6													6 7
7													7
8													8
9													9
10													10
11													11
12													12 13 14 15 16 17 18
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20 21 22
21													21
22													22
23													23
24													24
25													25
26													26 27
27													27
28													28
29													28 29 30 31
30													30
31													31
32													32
2.2													2.2

500 Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)

34 35

⁽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.

RECON	NCILIATION OF CAPITAL COSTS CENTERS					PROVIDER CCN:	PERIOD: FROM_	WORKSHEET A-7, PARTS I, II & III	
							ТО		
PART	I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
				Acquisitions		Disposals		Fully	1
		Beginning				and	Ending	Depreciated	1
	Description	Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
		1	2	3	4	5	6	7	
	Land								1
	Land Improvements								2
	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
	HIT-designated Assets								7
- 8	Subtotal (sum of lines 1 through 7)								8
9	Reconciling Items								9
10	Total (line 7 minus line 9)								10
					-	-			
PART	II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 A	ND 2							
					SUMMARY OF CAPIT	AL			
					Insurance	Taxes	Other Capital- Related Costs	Total ⁽¹⁾ (sum of	
	Description	Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	1
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
	Total (sum of lines 1 and 2)								3
								-	

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

PART III - RECONCILIATION OF	CAPITAL COSTS CENTERS

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

				SUMMARY OF CAPIT	AL			
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 and 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.)

⁽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,

ADJUS	TMENTS TO EXPENSES		PROVIDER O	CCN:	PERIOD:	WORKSHEET	A-8	
					FROM	_		
					TO			
					EXPENSE CLASSIFIC			
	DESCRIPTION (1)				VORKSHEET A TO/FR		Wkst.	
		BASIS /		T	HE AMOUNT IS TO BI		A-7	
		CODE (2)	AMOUNT		COST CENTER			
		1	2	3		4	5	
1	Investment income - buildings and fixtures (chapter 2)				gs and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable	e 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)							
6	Rental of provider space by suppliers (chapter 8)							(
7	Telephone services (pay stations excluded) (chapter 21)			1				
8	Television and radio service (chapter 21)			1				8
9	Parking lot (chapter 21)	777 1 1	_					Ģ
10	Provider-based physician adjustment	Worksheet A-8-2						10
11	Sale of scrap, waste, etc. (chapter 23)	*** 1 1 0 1						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1						12
13	Laundry and linen service							13 14
15	Cafeteria-employees and guests Rental of quarters to employee and others							15
16	Sale of medical and surgical							10
10								10
17	supplies to other than patients Sale of drugs to other than patients							17
18	Sale of medical records and abstracts		.				-	18
19	Nursing and allied health education (tuition,							19
19	fees, books, etc.)							15
20	Vending machines							20
21	Income from imposition of interest,		•					21
	finance or penalty charges (chapter 21)							
22	Interest expense on Medicare overpayments and							22
	borrowings to repay Medicare overpayments							
23	Adjustment for respiratory therapy							23
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respirat	tory Therapy	65		
24	Adjustment for physical therapy costs							24
	in excess of limitation (chapter 14)	Worksheet A-8-3		Physical	l Therapy	66		
25	Utilization review - physicians' compensation (chapter 21)			Utilizati	on Review - SNF	114		25
26	Depreciation - buildings and fixtures			Building	gs and Fixtures	1		26
27	Depreciation - movable equipment			Movable	e Equipment	2		27
28	Non-physician Anesthetist			Nonphy	sician Anesthetist	19		28
29	Physicians' assistant							29
30	Adjustment for occupational therapy costs							30
	in excess of limitation (chapter 14)	Worksheet A-8-3			tional Therapy	67		
30.99	Hospice (non-distinct) (see instructions)			Adults a	and Pediatrics	30		30.99
31	Adjustment for speech pathology costs							31
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech !	Pathology	68		
32	CAH HIT adjustment for depreciation							32
33	Other adjustments (specify) (3)							33
50	TOTAL (sum of lines 1 through 49)							50
	(Transfer to Worksheet A, column 6, line 200)							

 $^{^{\}left(1\right)}$ Description - all chapter references in this column pertain to CMS Pub. 15-1

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

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

 $^{^{\}left(3\right)}$ Additional adjustments may be made on lines 33 through 49 and subscripts thereof.

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

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	/	
1								1
2								2
3								3
4								4
5	TOTALS	(sum of lines 1 through 4) Transfer co	olumn 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.

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

 $^{^{\}left(1\right)}$ Use the following symbols to indicate interrelationship to related organizations:

- 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

10-12			F	ORM CMS-2552	-10		4090 (Co			
PROVIE	DER-BASED PHYSICIAN	NS ADJUSTMENTS					PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A-8-2	!
							•		_	
	Wkst. A	Cost Center/ Physician	Total	Professional	Provider	RCE	Physician/ Provider	Unadjusted	5 Percent of Unadjusted	
	Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200
			Cost of	Provider	Physician	Provider		<u> </u>		
		Cost Center/	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line #	Identifier	Education	col. 12	Insurance	col. 14	RCE Limit	Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11		_								11
200	TOTAL									200

4090 (Co	ont.) FORM CMS-255	2-10					10-12			
REASONA	ABLE COST DETERMINATION FOR THERAPY SERVICES ED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A-8-3 PARTS I & II	,			
Check applie	cable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology									
PART I - GI	ENERAL INFORMATION									
1 To	otal number of weeks worked (excluding aides) (see instructions)						1			
2 Li	ine 1 multiplied by 15 hours per week						2			
3 N	fumber of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3			
4 N	lumber of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see in	nstructions)					4			
	5 Number of unduplicated offsite visits - supervisors or therapists (see instructions)									
	6 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which									
	supervisor and/or therapist was not present during the visit(s)) (see instructions)									
	tandard travel expense rate						7			
8 O	ptional travel expense rate per mile						8			
		•	7		•					
		Supervisors	Therapists	Assistants	Aides	Trainees				
0.1.		1	2	3	4	5				
	otal hours worked						9			
	HSEA (see instructions)						10			
	tandard travel allowance (columns 1 and 2, one-half of column 2,						11			
	ine 10; column 3, one-half of column 3, line 10) fumber of travel hours (see instructions)						12			
	fumber of travel nours (see instructions)						12			
13 IN	tumber of miles driven (see instructions)			<u>L</u>			13			
	ALARY EQUIVALENCY COMPUTATION									
	upervisors (column 1, line 9 times column 1, line 10)						14			
	herapists (column 2, line 9 times column 2, line 10)						15			
	ssistants (column 3, line 9 times column 3, line10)						16			
	ubtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17			
	ides (column 4, line 9 times column 4, line 10)						18			
	rainees (column 5, line 9 times column 9, line 10)						19			
20 To	otal allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	·	·	·	·		20			

If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 2, and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.

21	weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	2
23	Total salary equivalency (see instructions)	2

	ETERMINATION FOR THERAPY SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-3,
FURNISHED BY OUTSID	DE SUPPLIERS		FROM	PARTS III & IV
			TO	
Check applicable box:	[] Occupational [] Physical [] Respiratory [] Speech Pathology			
11				
PART III - STANDARD AN	ND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
Standard Travel Allowance	ee			
24 Therapists (line 3	times column 2, line 11)			24
25 Assistants (line 4 t	times column 3, line 11)			25
26 Subtotal (line 24 f	for respiratory therapy or sum of lines 24 and 25 for all others)			26
27 Standard travel ex	xpense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			27
28 Total standard trav	evel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			28
	ee and Optional Travel Expense			
	nn 2, line 10 times the sum of columns 1 and 2, line 12)			29
	an 3, line 10 times column 3, line 12)			30
	for respiratory therapy or sum of lines 29 and 30 for all others)			31
	spense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			32
	llowance and standard travel expense (line 28)			33
	lowance and standard travel expense (sum of lines 27 and 31)			34
35 Optional travel all	lowance and optional travel expense (sum of lines 31 and 32)			35
	ND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
Standard Travel Expense				
	times column 2, line 11)			36
	times column 3, line 11)			37
38 Subtotal (sum of l				38
39 Standard travel ex	xpense (line 7 times the sum of lines 5 and 6)			39
	e and Optional Travel Expense			
	of columns 1 and 2, line 12.01 times column 2, line 10)			40
	m 3, line 12.01 times column 3, line 10)			41
42 Subtotal (sum of l	,			42
43 Optional travel ex	xpense (line 8 times the sum of columns 1-3, line 13.01)			43
Total Travel Allowance an	nd Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate.			
	llowance and standard travel expense (sum of lines 38 and 39) (see instructions)			44
	lowance and standard travel expense (sum of lines 39 and 42) (see instructions)			45
	lowance and optional travel expense (sum of lines 42 and 43) (see instructions)			46

Rev. 9 40-533

REASONABLE COST DETERMINATION FOR THERAPY SERVICES			PROVIDER CCN:	PERIOD:	WORKSHEET A-8	3-3,
FURNISHED BY OUTSIDE SUPPLIERS				FROM	PARTS V-VI	
				TO		
Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology						
PART V - OVERTIME COMPUTATION						
	Therapists	Assistants	Aides	Trainees	Total	
	1	2	3	4	5	
47 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or great 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
is a second containing and a second containing a second containing and a second containing a second contai		1	1	_1		
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)	i					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						55
line 47 times line 52)						
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						56
therapy, and columns 1 through 3 for all others.)						
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57 Salary equivalency amount (from line 23)					$\overline{}$	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 A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST		TTAL D COSTS						
COS	T CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	GENERAL SERVICE COST CENTERS	U	1	2	4	4A	3	б	/	_
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department									4
										5
	Maintenance and Repairs	i								6
	Operation of Plant									7
- 8	*									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
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	1 (1 5/									42
43										43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

COST AI	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST		TTAL D COSTS						
COST	CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	4	4A	5	6	/	
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology	1								53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									82
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76 77
70	Allogeneic HSCT Acquisition									78
	CAR T-Cell Immunotherapy OUTPATIENT SERVICE COST CENTERS									/8
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)	+								89
	Clinic	+					1	1		90
	Emergency	+								91
	Observation Beds									92
	Other Outpatient Service (specify)									93
	Partial Hospitalization Program	†					1	1	1	93.99

COST A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST	CAP RELATE							
COS	T CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	4	4A	5	6	7	1
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
102	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
	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
	Hospice									116
117	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
201	Negative Cost Centers									201
	TOTAL (sum lines 118 through 201)							1		202

COST A	LLOCATION - GENERAL SERVICE COSTS	•							PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS	0	,	10	- 11	12	13	11	13	10	17	
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
	Employee Benefits Department											4
	Administrative and General											5
	Maintenance and Repairs											6
	Operation of Plant											7
	Laundry and Linen Service											8
9	Housekeeping			1								9
	Dietary											10
	Cafeteria											11
12	Maintenance of Personnel											12
13	Nursing Administration											13
14	Central Services and Supply								1			14
	Pharmacy									7		15
16	Medical Records & Medical Records Library											16
17	Social Service											17
18	Other General Service (specify)											18
19	Nonphysician Anesthetists											19
20	Nursing Program											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
	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											35
	Subprovider IPF											40
	Subprovider IRF											41
	Subprovider (specify)											42
	Nursery											43
	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46

COST AL	LOCATION - GENERAL SERVICE COSTS		T	ı	1	T		1	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	8	9	10	11	12	13	14	15	16	17	_
	Operating Room											50
51	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope							İ				56
	Computed Tomography (CT) Scan											57
	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
	Electrocardiology											69
	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											82
73	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
77	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

COST ALLOCATION - GENERAL SERVICE COSTS								PROVIDER CCN:	PERIOD: FROMTO_	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	
OTHER REPORTED AND GOOD GENERAL	8	9	10	11	12	13	14	15	16	17	-
OTHER REIMBURSABLE COST CENTERS											_
94 Home Program Dialysis											94
95 Ambulance Services											
96 Durable Medical Equipment-Rented					ļ		ļ				96
97 Durable Medical Equipment-Sold					ļ		ļ				97
98 Other Reimbursable (specify)					ļ		ļ				98
99 Outpatient Rehabilitation Provider (specify)											
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
101 Home Health Agency											101
102 Opioid Treatment Program											102
SPECIAL PURPOSE COST CENTERS											4
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											11
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 through 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											20
202 TOTAL (sum lines 118 through 201)											202

COST ALI	OCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART I	
									TO TO	TAKTI	
		1	T .	Ī	1	1	1		INTERN &		
			NON-		INTERNS &	INTERNS &			RESIDENT		
		OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	PARAMEDICAL		COST & POST		
COST	ENTER DESCRIPTIONS			MINGDIG							
COST C	ENTER DESCRIPTIONS	GENERAL	ANES-	NURSING	SALARY AND	PROGRAM	EDUCATION	GUDTOTAL	STEPDOWN	TOTAL	
		SERVICE	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	SUBTOTAL 24	ADJUSTMENTS	TOTAL	4
G	ENERAL SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	
	Capital Related Costs-Buildings and Fixtures										1 1
	Capital Related Costs-Movable Equipment										2
	Employee Benefits Department										4
	Administrative and General										5
	Maintenance and Repairs										6
	Operation of Plant	7									7
	aundry and Linen Service	7									8
	Housekeeping										9
10 I											10
	Cafeteria										11
	Maintenance of Personnel										12
	Jursing Administration										13
	Central Services and Supply										14
	harmacy										15
16 N	Medical Records & Medical Records Library										16
17 S	ocial Service										17
18 0	Other General Service (specify)		1								18
19 N	Jonphysician Anesthetists										19
20 N	Jursing Program										20
21 I	ntern & Res. Service-Salary & Fringes (Approved)										21
	ntern & Res. Other Program Costs (Approved)										22
	aramedical Education Program (specify)										23
	NPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)										30
	ntensive Care Unit										31
	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	ubprovider IPF										40
	ubprovider IRF										41
	subprovider (specify)										42
	Vursery										43
	killed Nursing Facility										44
	Jursing Facility										45
46 (Other Long Term Care										46

COST A	LLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD:	WORKSHEET B,	
									FROM	PART I	
									TO		
									INTERN &		
			NON-		INTERNS &	INTERNS &			RESIDENT		
		OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	PARAMEDICAL		COST & POST		
COST	CENTER DESCRIPTIONS	GENERAL	ANES-	NURSING	SALARY AND	PROGRAM	EDUCATION		STEPDOWN		
		SERVICE	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	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
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catheterization										59
	Laboratory										60
	PBP Clinical Laboratory Services-Program Only										61
	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
70	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										82
	Drugs Charged to Patients										73
74	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition		İ				İ				77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic		ĺ								90
	Emergency		1								91
92	Observation Beds										92
	Other Outpatient Service (specify)										93
	Partial Hospitalization Program		1								93.99

COST A	LLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROM TO _	WORKSHEET B, PART I	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	16	19	20	21	ZZ	23	24	23	20	_
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)								1	+	98
	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	Opioid Treatment Program										102
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
	Heart Acquisition										106
	Liver Acquisition										107
108	Lung Acquisition										108
	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers										193
	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		TTAL D COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	_
	GENERAL SERVICE COST CENTERS	Ü	I	2	2A	4	5	6	/	_
	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department						1			4
	Administrative and General							-		5
- 6	Maintenance and Repairs								-	6
7	Operation of Plant									7
- 8	Laundry and Linen Service									8
9	Housekeeping									9
	Dietary					+				10
11	,									11
12										12
13	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
17	Social Service									17
										18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
22										22
	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									-
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									36
	Subprovider IPF									40
	Subprovider IRF									41
										42
	Nursery									43
	· ·									44
	· ,									45
	Other Long Term Care									46

ALLOC <i>i</i>	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		PITAL ED COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	2A	4	5	6	7	+-
	Operating Room									50
	Recovery Room	+								51
	Labor Room and Delivery Room	+						+		52
	Anesthesiology									52 53
	Radiology-Diagnostic									54
	Radiology-Therapeutic	1								55
	Radioisotope									55
	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
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
77	Allogeneic HSCT Acquisition									77
	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									00
	Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC)				 	+	-	+	-	88
	Clinic Clinic					-		 		90
	Emergency					-		 		91
	Observation Beds									91
	Other Outpatient Service (specify)									93
	Partial Hospitalization Program				+	+		+		93.99

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		ITAL D COSTS	gymmom y	EV (EV OVER	1.D. M. H.	Mary		
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	2A	4	5	6	7	
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									113
	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
	Negative Cost Centers									201
	TOTAL (sum lines 118 through 201)						Ì			202

ALLOCAT	ION OF CAPITAL-RELATED COSTS			_	_			_	PROVIDER CCN:	PERIOD: FROM TO _	WORKSHEET B, PART II	
COST CE	ENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
G	ENERAL SERVICE COST CENTERS	8	,	10	- 11	12	13	14	13	10	17	
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
	Employee Benefits Department											- 4
	Administrative and General											5
	Maintenance and Repairs											6
	Operation of Plant	1										7
	aundry and Linen Service											- 8
	Iousekeeping											9
	Dietary											10
	Cafeteria											11
12 N	Maintenance of Personnel											12
13 N	Jursing Administration							1				13
14 (Central Services and Supply								1			14
15 F	harmacy									1		15
16 N	Medical Records & Medical Records Library										7	16
17 S	ocial Service											17
18 (Other General Service (specify)											18
19 N	Jonphysician Anesthetists											19
20 N	Jursing Program											20
21 I	ntern & Res. Service-Salary & Fringes (Approved)											2
22 I	ntern & Res. Other Program Costs (Approved)											22
23 F	aramedical Education Program (specify)											2.
II	NPATIENT ROUTINE SERVICE COST CENTERS											
30 A	Adults and Pediatrics (General Routine Care)											3
	ntensive Care Unit											3
	Coronary Care Unit											32
	Burn Intensive Care Unit											33
	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											30
	Subprovider IPF											40
	Subprovider IRF											4
	subprovider (specify)											42
	Vursery											4.
	killed Nursing Facility											4
	Vursing Facility											4:
46 (Other Long Term Care											46

ALLOCA	ATION OF CAPITAL-RELATED COSTS			1				1	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	9	10	11	12	13	14	13	16	17	_
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
53	Anesthesiology											53
54	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy											66
	Occupational Therapy											67
	Speech Pathology											68
	Electrocardiology											69 70
	Electroencephalography Madical Specific Character Patients											70
	Medical Supplies Charged to Patients Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis				-				-			74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy								†			78
	OUTPATIENT SERVICE COST CENTERS											76
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)			1	†			1	1			89
	Clinic				<u> </u>							90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
	Partial Hospitalization Program											93.99

ALLOCATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROMTO_	WORKSHEET B, PART II	`
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											0.4
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. tchng. prgm.)											100
101 Home Health Agency											101
102 Opioid Treatment Program											102
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											113
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1 through 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 through 201)											202

ALLOCA	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART II	
									ТО		
		OTHER	NON-		INTERNS & RESIDENTS	INTERNS &	DAD AMEDICAL		INTERN & RESIDENT		
COST	CONTER DESCRIPTIONS	OTHER	PHYSICIAN	MIDONIC		RESIDENTS	PARAMEDICAL		COST & POST		
COST	CENTER DESCRIPTIONS	GENERAL	ANES- THETISTS	NURSING PROGRAM	SALARY AND	PROGRAM	EDUCATION	CLIDTOTAL	STEPDOWN	TOTAL	
		SERVICE 18	19	20	FRINGES 21	COSTS 22	(SPECIFY)	SUBTOTAL 24	ADJUSTMENTS 25	TOTAL 26	-
	GENERAL SERVICE COST CENTERS	16	19	20	21	22	23	24	23	20	
	Capital Related Costs-Buildings and Fixtures										1
	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department			1							4
- 5	Administrative and General			1							5
- 6	Maintenance and Repairs			1							6
7	Operation of Plant										7
- 8	Laundry and Linen Service										8
9											9
	Dietary										10
	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
	Central Services and Supply										14
	Pharmacy										15
16	Medical Records & Medical Records Library			1							16
	Social Service			1							17
18	Other General Service (specify)			1							18
19	Nonphysician Anesthetists			1							19
20	Nursing Program										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
	Intern & Res. Other Program Costs (Approved)						1				22
23	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit										31
	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										36
	Subprovider IPF										40
	Subprovider IRF										41
	Subprovider (specify)										42
	Nursery										43
	Skilled Nursing Facility										44
	Nursing Facility										45
46	Other Long Term Care										46

ALLOCA	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	23	20	_
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
	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
	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
92	Observation Beds										92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program										93.99

ALLOCAT	ON OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST C	ENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	THER REIMBURSABLE COST CENTERS	18	19	20	21	22	23	24	25	26	_
	ome Program Dialysis										94
	mbulance Services										95
	urable Medical Equipment-Rented										96
	urable Medical Equipment-Sold										97
	ther Reimbursable (specify)										98
	utpatient Rehabilitation Provider (specify)										99
	tern-Resident Service (not appvd. tchng. prgm.)										100
	ome Health Agency										101
	pioid Treatment Program										101
	PECIAL PURPOSE COST CENTERS										
	idney Acquisition										105
	eart Acquisition										106
	iver Acquisition										107
	ung Acquisition										108
	ancreas Acquisition										109
110 Ir	itestinal Acquisition										110
	let Acquisition										111
	ther Organ Acquisition (specify)										112
115 A	mbulatory Surgical Center (Distinct Part)										115
116 H	ospice										113
117 O	ther Special Purpose (specify)										117
118 S	UBTOTALS (sum of lines 1 through 117)										118
N	ONREIMBURSABLE COST CENTERS										
190 G	ift, Flower, Coffee Shop, & Canteen										190
191 R											191
	hysicians' Private Offices							_			192
	onpaid Workers										193
	ther Nonreimbursable (specify)										194
	ross Foot Adjustments										200
	egative Cost Centers										201
202 T	OTAL (sum lines 118 through 201)										202

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM	-	
					_		ТО		
			ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	GENERAL SERVICE COST CENTERS								
	Capital Related Costs-Buildings and Fixtures								1
	Capital Related Costs-Movable Equipment								2
	Employee Benefits Department								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
	Social Service								17
18	Other General Service (specify)								18
	Nonphysician Anesthetists								19
20	Nursing Program								20
	Intern & Res. Service-Salary & Fringes (Approved)								21
	Intern & Res. Other Program Costs (Approved)								22
	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
	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
	Subprovider (specify)								42
	Nursery								43
	Skilled Nursing Facility								44
	Nursing Facility								45
	Other Long Term Care								46

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM		
							ТО		
			LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
	Operating Room								50
	Recovery Room								51
	Labor Room and Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
									60
	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
77	Allogeneic HSCT Acquisition								77
78	CAR T-Cell Immunotherapy								78
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
	Observation Beds								92
93	Other Outpatient Service (specify)								93
	Partial Hospitalization Program								93.99
		•						•	

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM	_	
							TO		
		CAPITAL RE	LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	OTHER REIMBURSABLE COST CENTERS								
	Home Program Dialysis								94
	Ambulance Services								95
	Durable Medical Equipment-Rented								96
	Durable Medical Equipment-Sold								97
	Other Reimbursable (specify)								98
	Outpatient Rehabilitation Provider (specify)								99
	Intern-Resident Service (not appvd. tchng. prgm.)								100
	Home Health Agency								101
	Opioid Treatment Program								102
	SPECIAL PURPOSE COST CENTERS								
	Kidney Acquisition								105
	Heart Acquisition								106
107	Liver Acquisition								107
	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
	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1 through 117)								118
	NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
	Physicians' Private Offices								192
193	Nonpaid Workers								193
	Other Nonreimbursable (specify)								194
	Cross foot adjustments								200
	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
	Unit cost multiplier (Worksheet B, Part II)								205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)								206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207

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

COST ALLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									TO		
	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
	SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
COST CENTER DESCRIPTIONS	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	
	LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	SPENT)	
	8	9	10	11	12	13	14	15	16	17	-
ANCILLARY SERVICE COST CENTERS			10			13			10	17	
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				1	 		 	1	1	1	73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)					i e		ł –				75
75 ASC (Non-Distinct Fait) 76 Other Ancillary (specify)					i e		ł –				76
77 Allogeneic HSCT Acquisition					 		 				77
78 CAR T-Cell Immunotherapy											78
OUTPATIENT SERVICE COST CENTERS											10
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)					i e		ł –				89
90 Clinic					 		 		 	 	90
91 Emergency				1	 		 		 	 	91
92 Observation Beds											92
93 Other Outpatient Service (specify)											93
93.99 Partial Hospitalization Program				1	 		 		 	 	93.99
75.97 Faruai Hospitanzation Program							l				95.99

COST A	LLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
										FROM		
										TO		
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
		& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
COST	CENTER DESCRIPTIONS	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	
		LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	SPENT)	
		8	9	10	11	12	13	14	15	16	17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
	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
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
	Heart Acquisition											106
	Liver Acquisition											107
	Lung Acquisition											108
	Pancreas Acquisition											109
	Intestinal Acquisition											110
	Islet Acquisition					1						111
	Other Organ Acquisition (specify)					1						112
115						1						115
	Hospice					1						116
	Other Special Purpose (specify)					•						117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											110
	Gift, Flower, Coffee Shop, & Canteen											190
	Research											191
												192
	Nonpaid Workers					i e						193
	Other Nonreimbursable (specify)											194
	Cross foot adjustments											200
	Negative cost centers											200
202	Cost to be allocated (per Worksheet B, Part I)											202
	Unit cost multiplier (Worksheet B, Part I)					i e						202
	Cost to be allocated (per Worksheet B, Part II)					 						203
	Unit cost multiplier (Worksheet B, Part II)					 						204
	NAHE adjustment amount to be allocated (per Wkst. B-	2)										203
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	-/										200
207	NAME unit cost muluplier (wkst. D, rans III and IV)											207

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									TO		
			NON-		INTERNS &	RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
		(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	7
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										
6	Maintenance and Repairs										(
	Operation of Plant	7									
	Laundry and Linen Service	7									8
	Housekeeping	7									9
	Dietary	7									10
	Cafeteria	7									11
12	Maintenance of Personnel	7									12
		7									13
	Central Services and Supply	7									14
	Pharmacy	7									1:
	Medical Records & Medical Records Library	7									10
	Social Service	7									1
	Other General Service (specify)										13
	Nonphysician Anesthetists										19
	Nursing Program				1						20
	Intern & Res. Service-Salary & Fringes (Approved)					1					2
	Intern & Res. Other Program Costs (Approved)										2:
	Paramedical Education Program (specify)										2:
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)										30
31	Intensive Care Unit										3
32	Coronary Care Unit										32
	Burn Intensive Care Unit										3:
	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										3:
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										4:
43	Nursery										4:
	Skilled Nursing Facility										44
	Nursing Facility										4:
46	Other Long Term Care										46

4090 (Cont.)			FORM C	VIS-2332-10						12-22
COST ALLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B-1	
	Ī	NON-		INTEDNIC &	RESIDENTS	PARA-		INTERN &		$\overline{}$
	OTHER GENERAL	PHYSICIAN ANES-	NURSING PROGRAM	SALARY AND FRINGES	PROGRAM COSTS	MEDICAL EDUCATION		RESIDENT COST & POST		
COST CENTER DESCRIPTIONS	SERVICE (SPECIFY)	THETISTS (ASGND TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	SUBTOTAL	STEPDOWN ADJUSTMENTS	TOTAL	
ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	_
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 Electrocardiology		.								70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										71
73 Drugs Charged to Patients		.								73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
77 Allogeneic HSCT Acquisition										
78 CAR T-Cell Immunotherapy						-				77 78
OUTPATIENT SERVICE COST CENTERS										/8
										00
88 Rural Health Clinic (RHC) 89 Federally Qualified Health Center (FQHC)						1				88
										90
90 Clinic										
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93
93.99 Partial Hospitalization Program										93.99

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									TO		
			NON-		INTERNS &	RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
		(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		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. tchng. prgm.)										100
	Home Health Agency										101
102	Opioid Treatment Program										102
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
	Liver Acquisition										107
108	Lung Acquisition										108
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										110
	Gift, Flower, Coffee Shop, & Canteen										190
191											191
	Physicians' Private Offices				1						191
	Nonpaid Workers				1						193
	Other Nonreimbursable (specify)				1						194
200	Cross foot adjustments										200
201	Negative cost centers										201
	Cost to be allocated (per Worksheet B, Part I)										202
	Unit cost multiplier (Worksheet B, Part I)				1						202
	Cost to be allocated (per Worksheet B, Part II)				+						203
	Unit cost multiplier (Worksheet B, Part II)				+						204
	NAHE adjustment amount to be allocated (per Wkst. B-2)										203
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										206
207	NAME unit cost multiplier (WKst. D, Parts III and IV)										207

DESCRIPTION QUID LINK NO AMOUNT	12-22	WORKSHEET B-2			PERIOD: FROM TO	PROVIDER CCN:	1 OKW CM5-2332-10	POST STEPD
DESCRIPTION CODE INN NO. AMOUNT			-+	CHEET				1
1 Adjustment for EPO costs in Renal Dialysis cost center		AMOUNT	NIO	SHEET	CODE		DESCRIPTION	
1 74 Adjustment for EPO costs in Renar Displays cost center	_		NO.					
2 Adjustment for IPO costs in Home Program Dulysis cost center 1 Adjustment for ARANTSP costs in Home Program Dulysis cost center 1 Adjustment for ARANTSP costs in Home Program Dulysis cost center 1 Adjustment for ARANTSP costs in Home Program Dulysis cost center 2 Adjustment for IPOA costs in End Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis cost center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adjustment for IPOA costs in Home Program Dulysis center (see instructions) 1 Adj	+	4	_				I	1 4 1
3 Adjustment for ARANSP costs in Renal Dialysis cost center 1 74 4 Adjustment for ARANSP costs in Illean Program Dialysis cost center 1 94 5 Adjustment for ESA costs in Renal Dialysis cost center (see instructions) 1 74 6 Adjustment for ESA costs in Illean Program Dialysis cost center (see instructions) 1 94 7	1							
4 Adjustment for ARA-NEPC costs in Home Program Dialysis cost center (see instructions) 1 74	2		_				enter	2 Adju
3 Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)	3							
A Aljustment for ISSA costs in Home Program Dialysis cost center (see instructions) 1 94 8	5							
8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	5			74			instructions)	5 Adju
8 9 9 9 9 9 9 9 9 9	6			94	1		enter (see instructions)	6 Adju
9	7							7
101 112 113 114 115 116 117 118 119 119 120 121 121 122 123 124 125 126 127 128 129 129 130 131 131 131 131 131 131 131 131 131	8							8
11	9							9
11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 51 52 53 54 55 55 55 55 55 55 55 55 55 55 55	10							10
12 14 15 16 17 17 18 19 19 19 19 19 19 19	11							
13 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 90 51 52 53 53 54 55 55 55 55 55 55 55 55 55 55 55 55 55	12							
114 115 116 117 118 119 120 121 121 121 122 123 124 125 125 125 126 127 127 128 129 129 120 120 120 121 121 121 122 123 124 125 125 126 127 127 128 129 129 129 120 120 120 120 120 120 120 120 120 120	13		-	1				
115 117 118 119 120 121 121 122 123 124 125 126 127 128 129 130 131 131 131 132 132 133 134 141 135 136 137 137 138 139 141 141 141 141 141 141 141 141 141 14	14		-	l				
116	15		\dashv	1				
117 119 120 131 132 231 241 242 253 266 277 28 29 30 30 31 31 31 32 32 33 34 44 35 36 37 37 38 38 39 40 40 41 41 42 42 42 43 44 44 44 44 44 44 44 44 44 44 44 44	16		\dashv	1	1			
18 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49	17			1	 			
19	1/		_					
20	18							
2 2 2 2 2 2 2 2 2 2	19							
22	20							
23	21							21
24	22 23							22
25 26 27 28 29 29 29 20 20 20 20 20	23							23
25 26 27 28 29 29 29 20 20 20 20 20	24 25							24
26	25							
27 28 29 30 30 31 31 32 33 34 35 36 37 38 39 40 41 41 42 42 43 44 45 56 66 47 48 49 50 51 52 53 54	26							
28	27							
29 30 31 31 32 33 33 34 35 36 37 38 39 40 41 41 42 43 43 44 45 46 47 48 49 50 51 55 52 53 54 55 55 55 56 57 58 58	28							
30 31 32 33 34 34 35 36 37 38 39 39 39 39 39 30 31 31 31 32 33 34 34 34 34 34 34	29							
31 32 33 34 34 35 35 36 37 37 38 38 39 40 40 41 41 42 42 43 44 4 4 4 5 44 5 5 5 5 5 5 5 5 5 5 5	30							
32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58	31			†				
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58	31		-	<u> </u>				
34 35 36 37 38 39 40 41 42 42 43 44 44 45 45 50 50 51 52 53 53 54 55 56 57 58	32 33							
35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 51 52 53 54 55 56 57 57	33		_					
36 37 37 38 38 39 40 40 41 41 42 42 43 44 44 44 45 45 46 46 47 48 48 49 50 50 50 50 50 51 52 53 55 56 56 57 57 58	34 35							
37 38 39 40 41 41 42 43 43 44 45 46 47 48 49 50 51 52 53 53 54 55 56 57 57	35							
38 39 40 41 41 42 43 44 45 46 47 48 49 50 51 51 52 53 53 53 54 55 56 57 57	36 37							
39 40 40 41 42 43 44 45 46 47 48 49 50 51 51 52 53 54 55 55 56 56 57 58	37							
40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 55	38							
41 42 43 44 44 45 46 47 48 49 50 50 51 52 53 54 55 55 56 57 58 58	39							
42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58	40							
43 44 45 46 47 48 49 50 51 51 52 53 54 55 55 6 57	41							
43 44 45 46 47 48 49 50 51 52 53 54 55 55 57	42							42
44 45 46 47 48 49 50 51 52 53 54 55 56 57 58	43		一	Ì				
45 46 47 48 49 50 51 52 53 54 55 56 57 58	44							
46 47 48 49 50 51 52 53 54 55 56 57 58	45			t	i			
47 48 49 50 51 52 53 54 55 56 57 58	46		-	1				
48 49 50 51 52 53 54 55 55 56 57 58	47		-	l				
49 50 51 52 53 54 55 56 57 58	48	-	-	 	 			
50 51 52 53 54 55 56 57 58	49		\dashv	1				
51 52 53 54 55 56 57 58				1	 			
52 53 54 55 56 57 58	50 51			1	 			
53 54 55 56 57 58	51			!	 			
54 55 56 57 58	52			 				
55 56 57 58	53							
56 57 58	54 55			<u> </u>				
57 58	55			<u> </u>				
58	56							
	57							
	58							58
59	59			Ì				59

COMPU	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD:		WORKSHEET O	3
										FROM		PART I	
				T			T			ТО			
					Costs			Charges					
		Total Cost	Therapy		RCE				Total		TEFRA	PPS	
COST	CENTER DESCRIPTIONS	(from Wkst. B,	Limit	Total	Dis-	Total			(column 6	Cost or	Inpatient	Inpatient	
		Part I,, col. 26)	Adj.	Costs	allowance	Costs	Inpatient	Outpatient	+ column 7)	Other Ratio	Ratio	Ratio	1
		1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)												30
	Intensive Care Unit												31
	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
	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
	Other Long Term Care												46
	ANCILLARY SERVICE COST CENTERS												
	Operating Room												50
	Recovery Room												51
	Labor Room and Delivery Room												52
	Anesthesiology												53
	Radiology-Diagnostic												54
	Radiology-Therapeutic												55
	Radioisotope												56
	Computed Tomography (CT) Scan												57
	Magnetic Resonance Imaging (MRI)												58
	Cardiac Catheterization	+ +										†	59
	Laboratory	+ +										†	60
	PBP Clinical Laboratory Services-Prgm. Only												61
	Whole Blood & Packed Red Blood Cells	+											62
	Blood Storing, Processing, & Trans.	+											63
	Intravenous Therapy	+ +										+	64
	Respiratory Therapy	+										+	65
	Physical Therapy											+	66
	Occupational Therapy												67
	Speech Pathology	+ +		-			-	-		-		+	68
08	Speech ramology			J			J	J		J			08

Rev. 18 40-563

COMPU'	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET (С
COST	ENTER DESCRIPTIONS	Total Cost (from Wkst. B,	Therapy Limit	Total	Costs RCE Dis-	Total		Charges	Total (column 6	Cost or	TEFRA Inpatient	PPS Inpatient	
		Part I., col. 26)	Adj.	Costs 3	allowance 4	Costs 5	Inpatient 6	Outpatient	+ column 7)	Other Ratio	Ratio 10	Ratio	—
69	Electrocardiology	1		3	4	3	0	,		,	10	11	69
	Electroencephalography								†				70
	Medical Supplies Charged to Patients								†				71
72	Implantable Devices Charged to Patients												72
													73
74	Renal Dialysis								†				74
	ASC (Non-Distinct Part)								†				75
													76
	Allogeneic HSCT Acquisition												77
	CAR T-Cell Immunotherapy												78
	OUTPATIENT SERVICE COST CENTERS												- 70
	Rural Health Clinic (RHC)												88
	Federally Qualified Health Center (FQHC)												89
	Clinic								.				90
91	Emergency												91
	Observation Beds (see instructions)												92
	Other Outpatient Service (specify)												92
	Partial Hospitalization Program												93.99
													93.99
	OTHER REIMBURSABLE COST CENTERS												0.4
_	Home Program Dialysis												94 95
95	Ambulance Services												
	Durable Medical Equipment-Rented												96
	Durable Medical Equipment-Sold												97
	Other Reimbursable (specify)												98
	Outpatient Rehabilitation Provider (specify)												99
	Intern-Resident Service (not appvd. tchng. prgm.)												100
	Home Health Agency												101
													102
	SPECIAL PURPOSE COST CENTERS												
	Kidney Acquisition												105
	Heart Acquisition												106
107	Liver Acquisition												107
	Lung Acquisition						<u> </u>						108
109	Pancreas Acquisition						<u> </u>						109
	Intestinal Acquisition						<u> </u>						110
	Islet Acquisition						<u> </u>						111
	Other Organ Acquisition (specify)						<u> </u>						112
	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
	Other Special Purpose (specify)												117
200	Subtotal (see instructions)												200
201	Less Observation Beds												201
202	Total (see instructions)												202

CALCULATION OF OUTPATIE	NT SERVICE COST T	0	PROVIDER CCN:	PERIOD:	WORKSHEET C,
CHARGE RATIOS NET OF REI	DUCTIONS FOR MEDI	CAID ONLY		FROM	PART II
				TO	
Check applicable box:	[] Title V	[] Title XIX			

	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	1
	ANCILLARY SERVICE COST CENTERS									
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
53	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									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
77	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78

CALCULATION OF OUTPATI	ENT SERVICE COST	TO		PROVIDER CCN:	PERIOD:	WORKSHEET C.
CHARGE RATIOS NET OF RE	DUCTIONS FOR MEI	DICAID ONLY			FROM	PART II (CONT.)
					TO	
Check applicable box:	[] Title V	[] Title XIX				

	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 4	Operating Cost Reduction Amount 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
	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
93.99	Partial Hospitalization Program									93.99
	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. tchng. prgm.)									100
101	Home Health Agency									101
102	Opioid Treatment Program									102
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
	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
117	Other Special Purpose (specify)									117
	Subtotal (sum of lines 50 through 199)									200
	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

	TIONMENT OF INPATIENT ROUTINE E CAPITAL COSTS		PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET D, PART I		
Check applicabl boxes:	[] Title V [] Hospital [] Title XVIII, Part A [] PARHM De [] Title XIX [] CHART Mo		[]PPS []TEFRA	•					
		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)	
(A)	Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	4	5	6	7	
	Adults & Pediatrics								
30	(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 (lines 30 through 199)								200

⁽A) Worksheet A line numbers

	FIONMENT OF INPATIENT ANCILLARY E CAPITAL COSTS		PROVIDER CCN:	PERIOD: FROM	WORKSHEET D PART II		
				COMPONENT CCN:	то	_	
Check applicable boxes:	[] Title V	F [] PARHM Der	nonstration	[] PPS [] TEFRA			
		Capital Related Cost (from Wkst. B Part II, col. 26)	Total Charges (from Wkst. C, Pt .I, col. 8)	Ratio of Cost to Charges (col .1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50							50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	27 1						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
60	Cardiac Catheterization						60
61	Laboratory 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
77	Allogeneic HSCT Acquisition						77
78	17						78
	OUTPATIENT SERVICE COST CENTERS						0.0
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90 91
91	Emergency Observation Beds						91
93	Other Outpatient Service (specify)			+			93
93.99	Partial Hospitalization Program			1	-		93.99
73.77	OTHER REIMBURSABLE COST CENTERS						75.77
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)				İ		98
200	Total (sum of lines 50 through 199)						200

(A) Worksheet A line numbers

		F INPATIENT ROUTINE SS-THROUGH COSTS							PROVIDER CC	V:	PERIOD FROM TO		WORKSHEET D PART III),
Check applicab boxes:	le	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] PARHM Der [] CHART Mod			[] PPS [] TEFRA [] Other								
			Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1, 2, and 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)	
(A)	Cost Center De	ROUTINE SERVICE COST CENTERS	1A	1	2A	2	3	4	5	6	7	8	9	<u> </u>
30	Adults & Pedia (General Rout	atrics												30
31	Intensive Care	Unit												31
	Coronary Care													32
33	Burn Intensive	Care Unit												33
34	Surgical Intens	sive Care Unit												34
35	Other Special	Care Unit (specify)												35
40	Subprovider II	PF												40
41	Subprovider II	RF												41
42	Subprovider (Other)												42
43	Nursery													43
44	Skilled Nursin	g Facility												44
45	Nursing Facili	ty												45
200	Total (sum of	lines 30 through 199)												200

⁽A) Worksheet A line numbers

	ONMENT OF INPATIENT/O							PROVIDER CCN:	PERIOD: FROM	WORKSHEET D, PART IV	
SERVICE	OHER PASS-HIROUGH C	0313						COMPONENT CCN:		- TAKI IV	
Check applicable boxes:	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed S	SNF	[] PARHM Demoi [] PARHM CAH S [] CHART Model [] CHART CAH S	bwing Bed-SNF	[] PPS [] TEFRA [] Other	I	L	L	-
	•		Non Physician Anesthetist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST	CENTERS									
	Operating Room										50
	Recovery Room										51
	Labor room and Delivery Roon	1									52
	Anesthesiology										53
	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Se	can									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 Bl	ood Cells									62
63	Blood Storing, Processing, & T	ransfusing									63
64	Intravenous Therapy	-									64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged To F	atients									71
	Implantable Devices Charged to										72
73 1	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
77	Allogeneic HSCT Acquisition										77
78	CAR T-Cell Immunotherapy										78
(OUTPATIENT SERVICE COST	T CENTERS									
	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Cent	ter (FQHC)								1	89
	Clinic			1			İ		1	1	90
	Emergency									1	91
	Observation Beds									1	92
	Other Outpatient Service (speci	fy)								1	93
	Partial Hospitalization Program								Ī	1	93.99

										,	()
	MENT OF INPATIENT/OUTPA							PROVIDER CCN:	PERIOD:	WORKSHEET D,	
SERVICE OT	THER PASS THROUGH COSTS	3							FROM	PART IV (Cont.)	
								COMPONENT CCN:	TO		
Check	[] Title V	[] Hospital	[] SNF		[] PARHM Demor	stration	[] PPS				
applicable	[] Title XVIII, Part A	[] IPF	[] NF		[] PARHM CAH S	wing-Bed SNF	[] TEFRA				
boxes:	[] Title XIX	[] IRF	[] ICF/IID		[] CHART Model		[] Other				
[] Subprovider (Other) [] Swing-Bed SNF				SNF	[] CHART CAH S	wing Bed-SNF	. ,				
								All		Total	
			Non	Nursing		Allied		Other		Outpatient	
			Physician	Program		Health		Medical	Total cost	Cost	
			Anesthetist	Post-Stepdown	Nursing	Post-Stepdown	Allied	Education	(sum of cols. 1, 2	(sum of cols. 2,	
			Cost	Adjustments	Program	Adjustments	Health	Cost	3, and 4)	3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
OTH	IER REIMBURSABLE COST C	ENTERS									
94 Hon	ne Program Dialysis										94
95 Am	bulance Services										95
96 Dur	able Medical Equipment-Rented										96
97 Dur	able Medical Equipment-Sold										97
98 Oth	er Reimbursable (specify)										98
200 Tota	al (sum of lines 50 through 199)										200

⁽A) Worksheet A line numbers

	IONMENT OF INPATIENT/OUTF E OTHER PASS THROUGH COST			PROVIDER CCN:	PERIOD: FROM	WORKSHEET D, PART IV (Cont.)					
SLKVICE	OTILKT ASS TIMOUGH COST	3						COMPONENT CCN:		- TAKT IV (Cont.)	
Check applicable boxes:	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed S	NF	[] PARHM Demon [] PARHM CAH S [] CHART Model [] CHART CAH S	wing-Bed SNF	[] PPS [] TEFRA [] Other	1	L		
				Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	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	
I	ANCILLARY SERVICE COST CE	NTERS									
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 (MR)	I)									58
	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory ServPrgr	n. Only									61
62	Whole Blood & Packed Red Blood	Cells									62
63	Blood Storing, Processing, & Trans	fusing								1	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									1	70
	Medical Supplies Charged To Patie										71
72	Implantable Devices Charged to Pa	tients								1	72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
77	Allogeneic HSCT Acquisition										77
	CAR T-Cell Acquisition										78
	DUTPATIENT SERVICE COST CI	ENTERS									
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)									89
	Clinic	•									90
	Emergency										91
	Observation Beds	•									92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program			1	1		1		1		93.99

APPORTIO	NMENT OF INPATIENT/OUTP	ATIENT ANCILLARY						PROVIDER CCN:	PERIOD:	WORKSHEET D,	
SERVICE O	THER PASS THROUGH COST	S							FROM	PART IV (Cont.)	
								COMPONENT CCN:	TO		
Check	[] Title V	[] Hospital	[] SNF		[] PARHM Demon	stration	[] PPS		•	•	
applicable	[] Title XVIII, Part A	[] IPF	[] NF		[] PARHM CAH S	wing Bed-SNF	[] TEFRA				
boxes:	[] Title XIX	[] IRF	[] ICF/IID		[] CHART Model	•	Other				
		[] Subprovider (Other)	[] Swing-Bed S	NF	[] CHART CAH S	wing Bed-SNF					
	•							Inpatient		Outpatient	
						Outpatient		Program		Program	
				Total	Ratio	Ratio		Pass-		Pass-	
				Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
				(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
				Part I, col. 8)	(col. 5 ÷ col. 7)	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A)	Cost Center Description			7	8	9	10	11	12	13	
OT	HER REIMBURSABLE COST C	CENTERS									
94 Hc	ome Program Dialysis										94
95 An	nbulance Services										95
96 Du	rable Medical Equipment-Rented	i									96
97 Du	rable Medical Equipment-Sold										97
98 Ot	her Reimbursable (specify)										98
200 To	tal (sum of lines 50 through 199)										200

⁽A) Worksheet A line numbers

1020 ((Cont.)		10	1011 01110 200	2 10				12 22
APPOR	TIONMENT OF MEDICAL AND OTHER				PROVIDER CCN:	PERIO	D:	WORKSHEET D,	,
HEALTI	H SERVICES COSTS							PART V	
					COMPONENT CO	CN: TO			
Check	[] Title V - O/P [] Hospita	al	[] Subprovide	r (Other)	[] Swing-Bed SN		RHM Demonstratio		
applicab			[] SNF		[] Swing-Bed NI		RHM CAH Swing-I	3ed SNF	
boxes:	[] Title XIX - O/P [] IRF		[] NF		[] ICF/IID		IART Model		
DADEL	A PROPERTY OF MEDICAL AND OTHER	IED HEAT TH	SERVICES COST	7		[] CH	IART CAH Swing-E	sed SNF	
PART V	/ - APPORTIONMENT OF MEDICAL AND OTH	HER HEALTH	SERVICES COST		1		Duo onoma Coot		
		Cost		Program Charges Cost	Cost		Program Cost Cost	Cost	-
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
()	ANCILLARY SERVICE COST CENTERS		_						
50	Operating Room								50
51									51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic							1	54
55	Radiology-Therapeutic							1	55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	,								60
61	PBP Clinical Laboratory ServPrgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63									63
64	4.5								64
65	Respiratory Therapy								65
66 67	Physical Therapy Occupational Therapy								66 67
68	Speech Pathology	1							68
69	Electrocardiology								69
70									70
71		1							71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74									74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic HSCT Acquisition								77
78	17								78
	OUTPATIENT SERVICE COST CENTERS								
88	` /								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency							<u> </u>	91
92	Observation Bed			1				<u> </u>	92
93	Other Outpatient Service (specify)								93
	Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS								93.99
	Home Program Dialysis								94
95		1							95
	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center							<u> </u>	98
200							1		200
201									201
-	Only Charges			l .			I	· '	
202									202

12 22	1 ORM CMB 2332 10	1070 (Cont.)
COMPU	UTATION OF INPATIENT PROVIDER CCN: PERIOD:	WORKSHEET D-1,
OPERA	ATING COST FROM FROM	PART I
	COMPONENT CCN: TO	
Check	[] Title V - I/P	-
applicat	ble [] Title XVIII, Part A [] IPF [] ICF/IID [] TEFRA	
boxes:	[] Title XIX - I/P [] IRF [] PARHM Demonstration [] Other	
	[] Subprovider (other) [] CHART Model	
	[] SNF	
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). If you have only private room days, do not complete this line.	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	6
	calendar year, enter 0 on this line)	
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	8
	calendar year, enter 0 on this line)	
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9
10		10
	cost reporting period (see instructions).	
11		11
	cost reporting period (if calendar year, enter 0 on this line)	
12		12
- 12	the cost reporting period.	- 12
13		13
	cost reporting period (if calendar year, enter 0 on this line)	- 14
14	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,	14
15	J J (J)	15
16		16
17	SWING BED ADJUSTMENT 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		19
20		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		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		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 and observation bed 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		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	37

	TATION OF INPATIENT FING COST				PROVIDE	R CCN:	PERIOD: FROM	WORKSHEET D-1, PART II	
OLLKA	ind cosi				COMPON	ENT CCN:		IAKI II	
Check	[] Title V - I/P	[] Hospital	[] DADII	M Demonstration		f 1 DDC			
applicabl		[] Hospital [] IPF	[] CHAR			[] PPS [] TEF			
boxes:	Title XVIII, Fait A	[] IRF	[] CHAK	1 Model		[] Oth			
boxes.	[] Tide XIX - I/I	[] Subprovider (of	har)			[] Out	C1		
DADTII	- HOSPITAL AND SUBPROVIDERS ONLY		ille1)						
	PROGRAM INPATIENT OPERATING COS								
	PASS-THROUGH COST ADJUSTMENTS	I DEFUKE						1	
			-\					1	38
	Adjusted general inpatient routine service cos		s)						39
40	Program general inpatient routine service cos		4 10 25)						40
40	Medically necessary private room cost applic		+ x line 33)						40
41	Total Program general inpatient routine servi	ce cost (line 39 + line 40)	1				Ī		41
			Total	Total		erage	D	D C	
						Diem	Program	Program Cost	
			Inpatient Cost	Inpatient Days		÷ col. 2)	Days	(col. 3 x col. 4)	4
- 40	N (Cd V 0 VIV 1)		I	2	_	3	4	5	- 12
	Nursery (title V & XIX only)								42
	Intensive Care Type Inpatient								
	Hospital Units								- 12
	Intensive Care Unit				_				43
	Coronary Care Unit				+				44
	Burn Intensive Care Unit				+				45
46	Surgical Intensive Care Unit				+				46
47	Other Special Care Unit (specify)								47
- 10	In	11	200)					1	40
	Program inpatient ancillary service cost (Wor								48
48.01	Program inpatient cellular therapy acquisition							_	48.01
49	Total Program inpatient costs (sum of lines 4	1 through 48.01) (see instr	uctions)						49
	DAGG THROUGH COST ADDITION THE								
	PASS-THROUGH COST ADJUSTMENTS	-t't(6	. W 1 - 1 4 D 6 D -	I 1 III)				1	- 50
	Pass through costs applicable to Program inp Pass through costs applicable to Program inp								50 51
52			oni worksneet D, sum of r	arts II and IV)					
53	Total Program excludable cost (sum of lines			di-1-4	1: 40 :	1: 52)			52
- 33	Total Program inpatient operating cost exclude	ling capital related, nonpny	sician anesthetist, and me	edical education costs (line 49 minus	line 52)			53
	TARGET AMOUNT AND LIMIT COMPUT.	ATION							
		ATION						1	- 54
54	Program discharges Target amount per discharge								54 55
									55.01
55.02	Permanent adjustment amount per discharge	. 1100 00111							55.02
55.02	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55.							-	55.02
57	Difference between adjusted inpatient operati		(line 56 minus line 52)						57
58	Bonus payment (see instructions)	ing cost and target afficult	(mic 50 minus mic 55)						58
59	Trended costs (lesser of line 53 ÷ line 54, or	line 55 from the cost reserve	ting period ending 1004	indated and composed	ad by the med	ret hacket)			59
60	Expected costs (lesser of line 53 ÷ line 54, or				a by the mark	ci vaskei)			60
61	Continuous improvement bonus payment (if				ina 60 antan	ha laccar at	50% of the	-	61
01	amount by which operating costs (line 53) are								01
62	Relief payment (see instructions)	c icas man expected costs (I	mics 5+ x 00j, 01 1 70 01 II	ic target amount (IIIIe 3)	oj, ouici wise	CINCI ZCIO.	(see instructions)		62
63	Allowable Inpatient cost plus incentive paym	ant (see instructions)							63
0.5	Amorrable inpatient cost plus incentive payin	em (see monucuous)							0.5
	PROGRAM INPATIENT ROUTINE SWING	RED COST							1
			f the east nonentine nearies	(aaa inatmaatiana)					64
04	Medicare swing-bed SNF inpatient routine co	osis unough December 31 (n me cost reporting period	(see instructions)					04
	(title XVIII only)	oto often Deac121 Cd		an imptopration-1					
65	Medicare swing-bed SNF inpatient routine co	osis after December 31 of th	ie cost reporting period (s	ee instructions)					65
	(title XVIII only)	tina aasta (lina 64 ml; 1:	(5) (title VVIII enly: for (TAIL and impternations					
66	Total Medicare swing-bed SNF inpatient rout								66
68	Title V or XIX swing-bed NF inpatient routing Title V or XIX swing-bed NF inpatient routing							-	68
69	Total title V or XIX swing-bed NF inpatient to			u (mie 13 x mie 20)					69

01-22			FORM CMS-253	2-10		4090 ((Cont.)
	TATION OF INPATIENT TING COST			PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET D-1, PARTS III & IV	
Check applicable boxes:	[] Title V - I/P [] Title XVIII, Part A [] Title XIX - I/P	[] Hospital [] IPF [] IRF [] Subprovider (Otl	[] SNF [] NF	[]:	ICF/IID	[] PPS [] TEFRA [] Other	
PART II	I - SNF, NF, AND ICF/IID ONLY		,		•		
70	SNF / NF / ICF/IID routine service cos	(line 37)					70
71	Adjusted general inpatient routine service	ce cost per diem (line 70 ÷ line 2))				71
72	Program routine service cost (line 9 x li	ne 71)					72
73	Medically necessary private room cost a	applicable to Program (line 14 x l	line 35)				73
74	Total Program general inpatient routine						74
75	Capital-related cost allocated to inpatien	nt routine service costs (from Wo	orksheet B, Part II, column 2	6, line 45)			75
76	Per diem capital-related costs (line 75 ÷			,			76
77	Program capital-related costs (line 9 x l	ine 76)					77
78	Inpatient routine service cost (line 74 m						78
79	Aggregate charges to beneficiaries for e	,	ds)				79
80	Total Program routine service costs for	comparison to the cost limitation	n (line 78 minus line 79)				80
81	Inpatient routine service cost per diem l	•	,				81
82	Inpatient routine service cost limitation	(line 9 x line 81)					82
83	Reasonable inpatient routine service cos	sts (see instructions)					83
84	Program inpatient ancillary services (se	e instructions)					84
85	Utilization review - physician compensa	tion (see instructions)					85
86	Total Program inpatient operating costs	(sum of lines 83 through 85)					86
PART IV	V - COMPUTATION OF OBSERVATION	ON BED PASS-THROUGH CO	ST				
87	Total observation bed days (see instruc	tions)					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 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
90	Capital-related cost						90
91	Nursing Program cost						91
92	Allied Health cost						92
02	All d. M.E. IEL .c.						02

40-575

	,			
,	APPORTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,
	SERVICES RENDERED BY		FROM	PARTS I-III
	INTERNS AND RESIDENTS		TO	

TAKII.	- NOT IN APPROVED TEACHING PROGRAM				
		Percent of	Expense	Total Inpatient Days	
	Cost Centers	Assigned Time	Allocation	All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			
2	Hospital Inpatient Routine Services: Adults & pediatrics (general routine care)				
3	Intensive care unit				
4	Coronary care unit				-
5	Burn Intensive Care Unit				
6	Surgical Intensive Care Unit				
7	Other Special Care (specify)				
8	Nursery				
9	Subtotal (sum of lines 2 through 8)				
10	IPF - Inpatient routine service				10
11	IRF - Inpatient routine service				1
12	Subprovider (Other) - Inpatient routine service				13
13	Skilled Nursing Facility				1.
14	Nursing Facility				14
15	Other Long Term Care	+			1:
16 17	Home Health Agency Outpatient Rehabilitation Providers	+			10
18	Ambulatory Surgical Center	+			1
19	Hospice				19
20	Subtotal (sum of lines 9 through 19)	+			20
	. 9 :/			Total Charges	
				(from Wkst. C, Pt. I,	
				col. 8, lines 88	
	Hospital Outpatient Services:			through 93)	
21	Rural Health Clinic (RHC)				2
22	Federally Qualified Health Center (FQHC)				2:
23	Clinic				2:
24 25	Emergency Observation beds				2:
26	Other Outpatient Service (specify)				2.
27	Subtotal (sum of lines 21 through 26)				2
28	Total (sum of lines 20 and 27)	100.00			2
	- IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE				
		Expenses Allocated			
		to cost centers			
		on Wkst. B, Pt. I	Swing Bed	Net Cost	
		on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
20.1	Hospital Inpatient Routine Services:	on Wkst. B, Pt. I	-		•
29	Adults & Pediatrics (general routine care)	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	29
30	Adults & Pediatrics (general routine care) Swing Bed - SNF	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	3
30 31	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	3
30 31 32	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30
30 31	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	3
30 31 32 33	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	3: 3: 3:
30 31 32 33 34	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 33 33 34 33 36
30 31 32 33 34 35 36 37	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36)	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 31 32 33 33 33 33 33
30 31 32 33 34 35 36 37 38	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 33 33 34 33 33 33 33
30 31 32 33 34 35 36 37 38 39	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 33 33 33 36 33 33 33 33 33
30 31 32 33 34 35 36 37 38 39	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 33 33 33 33 33 33 34
30 31 32 33 34 35 36 37 38 39 40	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	33 33 33 33 33 33 34 44 44
30 31 32 33 34 35 36 37 38 39 40 41	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	on Wkst. B, Pt. 1 cols. 21 and 22	Amount	(col. 1 plus col. 2)	30 33 33 33 33 33 33 34
30 31 32 33 34 35 36 37 38 39 40 41	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2	(col. 1 plus col. 2) 3	33 33 33 33 33 33 34 44 44
30 31 32 33 34 35 36 37 38 39 40 41	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved	(col. 1 plus col. 2) 3 Teaching Program	33 33 33 33 33 33 34 44 44
30 31 32 33 34 35 36 37 38 39 40 41	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II AI	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2	(col. 1 plus col. 2) 3	33 33 33 33 33 33 34 44 44
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II All Hospital	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved (from Part I) 1	(col. 1 plus col. 2) 3 Teaching Program Amount	33 33 33 33 33 33 33 44 44
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II AI	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved	(col. 1 plus col. 2) 3 Teaching Program Amount	33 33 33 33 33 33 34 44 44
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II AI Hospital Inpatient	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved (from Part I) 1 col. 9, line 9	(col. 1 plus col. 2) 3 Teaching Program Amount	36 33 33 33 36 31 33 34 44 44 44
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II Al Hospital Inpatient Outpatient	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved (from Part I) 1 col. 9, line 9	(col. 1 plus col. 2) 3 Teaching Program Amount	33 33 33 33 33 33 33 33 34 44 44 44 44 4
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II Al Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved (from Part I) 1 col. 9, line 9 col. 9, line 27 col. 9, line 10 col. 9, line 11	(col. 1 plus col. 2) 3 Teaching Program Amount	3(3) 3(3) 3(3) 3(3) 3(4) 4(4) 4(4) 4(4)
30 31 32 33 34 35 36 37 38 39 40 41 42 PART II	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) I - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II Al Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	on Wkst. B, Pt. 1 cols. 21 and 22	Amount 2 Not In Approved (from Part I) 1 col. 9, line 9 col. 9, line 27 col. 9, line 10	(col. 1 plus col. 2) 3 Teaching Program Amount	33 33 33 33 33 33 33 33 34 44 44 44 44 4

			. ,
APPORTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,
SERVICES RENDERED BY		FROM	PARTS I-III (Cont.)
INTERNS AND RESIDENTS		TO	

DIDEL	NOT BY ARREST	TEL GUNIG PROGRAM	,					
PARTI	- NOT IN APPROVED			Dava	Title V	Title XVIII	Title XIX	1
	Average Cost Per Day	Title V	th Care Program Inpatient Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)	
	4	5	6	7	8	9	10	
1	7	3	Ü		8	,	10	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 20								19 20
20		Ti+1	es V and XIX Outpatient	and	T:+1.	es V and XIX Outpatient	and	20
	Ratio of Cost		es v and XIX Outpatient: Title XVIII Part B Charge		1111	Title XVIII Part B Cost	and	
	to Charges	Title	Title XVIII Fait B Charge	Title	Title	Title XVIII Fait B Cost	Title	
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX	
21	(coi. 2 · coi. 3)	v	TaltB	AIA	V	T alt D	AIA	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
PART II	I - IN AN APPROVED T	TEACHING PROGRAM	I (TITLE XVIII, PART B	INPATIENT ROUTINI	E COSTS ONLY)			
				Expenses				
	Total	Average Cost	Title XVIII	Applicable				
	Inpatient Days -	Per Day	Part B	to Title XVIII				
	All Patients	(col. 3 ÷ col. 4)	Inpatient Days	(col. 5 x col. 6)				
	4	5	6	7				
29								29
30								30
31								31
32								32
33								33
34 35	-		-					34 35
36	+		 					36
37								37
38								38
39								39
			1					40
40								
40			-					41
								41 42
40 41 42	II - SUMMARY FOR TI	TLE XVIII (TO BE CO	MPLETED ONLY IF BO	TH PARTS I AND II A	RE USED)			41
40 41 42		TLE XVIII (TO BE CO	MPLETED ONLY IF BO Total Title 2		RE USED)			41 42
40 41 42					RE USED)			41 42
40 41 42	In Approved To	eaching Program	Total Title 2	KVIII Costs	RE USED)			41 42
40 41 42 PART II	In Approved To (from Part II, col. 7)	eaching Program Amount	Total Title 2 (to Wkst. E, Part B)	(col. 2 + col. 4)	RE USED)			42
40 41 42 PART II 43 44	In Approved To (from Part II, col. 7)	eaching Program Amount	Total Title 2 (to Wkst. E, Part B)	(col. 2 + col. 4)	RE USED)			43 44
40 41 42 PART II 43 44 45	In Approved To (from Part II, col. 7) 3 line 37	eaching Program Amount	Total Title 2 (to Wkst. E, Part B) 5	(col. 2 + col. 4)	RE USED)			43 44 45
40 41 42 PART II 43 44 45 46	In Approved To (from Part II, col. 7) 3 line 37	eaching Program Amount	Total Title 2 (to Wkst. E, Part B) 5 line 22 line 22	(col. 2 + col. 4)	RE USED)			43 44 45 46
40 41 42 PART II 43 44 45 46 47	In Approved To (from Part II, col. 7) 3 line 37 line 38 line 39	eaching Program Amount	Total Title 2 (to Wkst. E, Part B) 5 line 22 line 22 line 22	(col. 2 + col. 4)	RE USED)			43 44 45 46 47
40 41 42 PART II 43 44 45 46	In Approved To (from Part II, col. 7) 3 line 37	eaching Program Amount	Total Title 2 (to Wkst. E, Part B) 5 line 22 line 22	(col. 2 + col. 4)	RE USED)			43 44 45 46

4090 (Cont.) FORM	CIVIS-2.	332-10				03-23
INPATII	ENT ANCILLARY SERVICE			PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST A	PPORTIONMENT				FROM	-	
				COMPONENT CCN:	ТО		
	Tarana and Tarana and Tarana						
Check	[] Title V [] Hospital [] SNF		CF/IID		[] PPS		
applicab			ARHM Dem		[] TEFRA		
boxes:	[] Title XIX [] IRF [] Swing-Bed SNF [] Subprovider (Other) [] Swing-Bed NF		HART Mode	I Swing-Bed SNF	[] Other		
	[] Subprovider (Other) [] Swing-Bed NF			Swing-Bed SNF			
		[]0	HAKI CAH	Ratio of Cost	Inpatient	Inpatient Program Cost	te
	COST CENTER DESCRIPTION			to Charges	Program Charges	(col. 1 x col. 2)	ì
(A)	COST CENTER BESCRIFTION			1	2	3	-
	INPATIENT ROUTINE SERVICE COST CENTERS			•	2	,	
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						
	Operating Room						50
	Recovery Room Labor Room and Delivery Room						51
52 53	Anesthesiology						52 53
	Radiology-Diagnostic						54
55	Radiology-Diagnostic 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 69	Speech Pathology						68 69
	Electrocardiology Electroencephalography						70
	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)				1		75
	Other Ancillary (specify)				1		76
77	Allogeneic HSCT Acquisition						77
78	CAR T-Cell Immunotherapy						78
	OUTPATIENT SERVICE COST CENTERS						
	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 93.99	Other Outpatient Service (specify)						93 93.99
	Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS						93.99
94	Home Program Dialysis						94
94	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 94 and 96 through 98)						200
							201
	Net charges (line 200 minus line 201)						202

(A) Worksheet A line numbers

COMPUTATION	COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES					PROVIDER CCN:	PERIOD:	WORKSHEET D-4,		
FOR A TRANSP	LANT HOSPITAL W	ITH A MEDICARE-CE	RTIFIED				FROM	PART I		
TRANSPLANT I	PROGRAM					OPO CCN:	то	-		
Check applicable box:	[]HEART []KIDNEY	[] LIVER [] LUNG	[] PANCRI		ISLET			1		
PART I - COMP	PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)									
				Inpatient			Organ			
Computation of	f Inpatient			Routine Organ		Per Diem Costs	Acquisition	Cost		
Routine Service	e Costs			Charges	(from Wkst. D-1, Part II)	Days	(col. 2 x col. 3)		
Applicable to C	Organ Acquisition			1	D	2	3	4	1	
1 Adults a	and Pediatrics				38				1	
2 Intensiv	e Care				43				2	

44 45

46

47

			Ratio of Cost	Organ	Organ	
			to Charges	Acquisition	Acquisition	
Comp	utation of Ancillary		(from	Ancillary	Ancillary	
Servic	e Costs Applicable		Wkst. C)	Charges	Costs	
to Org	an Acquisition	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 through 40)					41

C = Worksheet C line numbers D = Worksheet D-1 line numbers

Coronary Care

4 Burn Intensive Care Unit5 Surgical Intensive Care Unit

6 Other Special Care (specify)
7 TOTAL (sum of lines 1 through 6)

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM	PROVIDER CCN: OPO CCN:	PERIOD: FROM TO	WORKSHEET D-4, PART II		
Check [] HEART [] LIVER [] PANCREAS [] ISLI	ET	-	•		
applicable box: [] KIDNEY [] LUNG [] INTESTINE					
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTANCILLARY SERVICE COSTS)					
	Average Cost		Organ		
Computation of the Cost of Inpatient	Per Day		Acquisition	i	
Services of Interns and Residents Not	(from Wkst. D-2,	Organ	Costs	ĺ	

		I	Average Cost		Organ	
	Computation of the Cost of Inpatient		Per Day		Acquisition	
	Services of Interns and Residents Not			Organ	Costs	
	In Approved Teaching Program	Part I, col. 4)		Acquisition Days	(col. 1 x col. 2)	
		D	1	2	3	
42	Adults & Pediatrics (General routine care)	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
	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)	ı				55

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

05 25	1 Oldwi Ci	VID 2332 10			1070	(Cont.)
COMPU	JTATION OF ORGAN ACQUISITION COSTS AND CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR A	TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED			FROM	PARTS III & IV	
TRANS	PLANT PROGRAM		OPO CCN:	ТО	_	
Check	[] HEART [] LIVER [] PANCREAS	[] ISLET				
applicab		[] 10221				
	II - SUMMARY OF COSTS AND CHARGES					
			Cost	(Charges	T
		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 physicians' services in a teaching hospital (see instructions)					60
61	Total (see instructions)					61
			Usable Organs			
		1	2	3	4	
62	Total usable organs (see instructions)					62
63	Medicare usable organs (see instructions)					63
64	Ratio of Medicare usable organs to total usable organs (see instructions)					64
		T			al .	
			Cost		Charges	4
		Part A	Part B	Part A	Part B	4
		1	2	3	4	
65	Medicare Cost and Charges (see instructions)					65
66	Revenue for organs sold (see instructions)					66
66.01	Partial primary payor amounts applicable to organ acquisition					66.01
66.02	Partial primary payor amounts applicable to transplants (informational only)					66.02
67	Subtotal (see instructions)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69
DADTI	V - STATISTICS					
TAKTI	v - STATISTICS		Living Related	Cadaveric	Revenue	T
			1	2	3	-
70	Organs excised in provider (1)		1	† 		70
71	Organs purchased from other transplant hospitals (2)			+		71
72	Organs purchased from non-transplant hospitals					72
73	Organs purchased from OPOs (see instructions)					73
74	Total (sum of lines 70 through 73)					74
75	Organs transplanted					75
75.01	Organs transplanted into Medicare beneficiaries					75.01
75.02	Kidneys transplanted into MA beneficiaries					75.02
75.03	Organs transplanted, Medicare secondary payer					75.03
75.04	Organs transplanted, Other (see instructions)					75.04
76	Organs sold to other hospitals					76
77	Organs sold to OPOs					77
78	Organs sold to transplant hospitals			1	1	78
79	Organs sold to MRTC without an agreement or VA hospitals					79
79.01	Kidneys sold to MRTC with an agreement					79.01
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 (see instructions)

84 Total (see instructions)

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 from your center are included in the count.

APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL		PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET D-5, PART I			
Check a	pplicable box: [] Hospital Staff [] Medical Staff							
	- REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS	S ENDING BEFORE JUNE 30	, 2014					
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	<u> </u>
1	General Practitioner Family Practice							<u> </u>
2	Internal Medicine							
3	Surgery							⊢
4	Pediatrics							<u> </u>
	Obstetrics-Gynecology							-
	Radiology Psychiatry							-
	Anesthesiology							Η.
	Pathology	+			+	+	+	-
	All Other							10
	Total	+						1
11	1000							
		Cost of Membership	Professional	Cost of Physician	Professional		Adjust Cost of Physician's	
Line	Specialty	& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	l
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	l
9	10	11	12	13	14	15	16	1
	General Practitioner Family Practice							
2	Internal Medicine							
3	Surgery							
4	Pediatrics							1 4
5	Obstetrics-Gynecology							
	Radiology							
7	Psychiatry							
8	Anesthesiology							
9	Pathology							<u> </u>
								10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)	I				1		- 1

			Medical School	Total	
		Hospital Staff	Faculty	(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)	i			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 30 to Worksheet D-4, Part III, line 60

40-583 Rev. 6

JUCUT	Cont.)	·	ORIVI CIVID-2332	-10					0)-1-
APPOR	ΓΙΟΝΜΕΝΤ	OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-5, PART III	
							TO_	_	
PART II	I - REASON	ABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS E	NDING ON OR AFTER	JUNE 30, 2014					
						Physician/		5 Percent	
	Wkst. A		Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	1
	Line #	Cost Center / Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	Ì
	1	2	3	4	5	6	7	8	1
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total							200
									,
			Cost of		Cost of			Adjust Cost	
			Membership	Professional	Physician	Professional		of Physician's	1
	Wkst. A		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	1
	Line #	Cost Center / Physician Identifier	Education	Share of Column 11	Insurance	Share of Column 13	RCE Limit	Surgical Services	1
	9	10	11	12	13	14	15	16	
1									1
2									2
3									3
4									4
5									5
6									- 6
7									7
8									8
9									9
10									10
200		Total (transfer the amount in column 16, line 200, to Part IV, line 1)	ľ	1					200

APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART IV
Check applicab box:	[] Hospital [] IPF [] IRF	<u> </u>	10	
PART I	V - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPIT	'AL FOR COST REPORTING P	ERIODS ENDING	ON OR AFTER JUNE 30, 2014
1	Adjusted cost of physicians' 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			
	Title V - Inpatient			4
	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
	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 autpatient islet acquisition			16
17				17
17.01	Inpatient allogeneic HSCT acquisition			17.01
17.02	Outpatient allogeneic HSCT acquisition			17.02
	HEALTH CARE PROGRAM REIMBURSABLE COST			
1.8	Title V - Inpatient (line 3 x line 4)			18
	Title V - Outpatient (line 3 x line 4)			19
	Title XVIII - Part A (line 3 x line 6)			20
21	Title XVIII - Part B (line 3 x line 7)			21
	Title XIX - Inpatient (line 3 x line 8)			22
	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				31
31.01	Inpatient allogeneic HSCT acquisition (line 3 x line 17.01)			31.01
31.02	Outpatient allogeneic HSCT acquisition (line 3 x line 17.02)	•	•	31.02

Transfer amounts as follows:

Add lines 18 and 19, and transfer to Worksheet E-3, Part VII, line 20 (title V hospital or component)
Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF);

Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 5 (LTCH); or, Worksheet E-3, Part IV, line 17 (cost reimbursement)

Line 21 to Worksheet E, Part B, line 23 (Medicare Part B Medical and Other Health Services)

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, line 20 (title XIX hospital or component)

Sum of lines 24 through 30 to Worksheet D-4, Part III, line $60\,$

Line 31.01 to Worksheet D-6, Part III, line 5, col. 1

Line 31.02 to Worksheet D-6, Part III, line 5, col. 2

4090 (Cont.) FORM CMS-2552-10 12-22							12-22		
	UTATION OF CELLULAR THERA	APY ACQUISITION	COSTS			PROVIDER CCN:	PERIOD:	WORKSHEET D-6,	
COM	CITTION OF CEEECES IN THERE	ii i nequisimon	CODID			TROVIDER CCIV.	FROM	PARTS I & II	
							TO TO	TARCIS I & II	
PART	I - INPATIENT ROUTINE AND AN	JCII I ARV SERVIC	ES CELI	III AR THERAPV ACOI	HISTION COSTS		10		
TAKI	1- INTATIENT ROUTINE AND AL	Routine Services	LSCLLI	LOLAK IIILKAI I ACQU	Inpatient	1			
		Acquisition		Per Diem Costs	Acquisition	Acquisition Costs			
Immo	tient Routine Services	Charges		(see instructions)	Days	(col. 2 x col. 3)			
	uisition Costs	Charges	D-1	(see instructions)	Days 3	(coi. 2 x coi. 3)	-		
Acq	Adults and Pediatrics	1	38	2	3	4			1
2	Intensive Care	-	43			+			2
3	Coronary Care		44						3
	Burn Intensive Care Unit		44						4
	Surgical Intensive Care Unit		46						5
			46						6
- 0	Other Special Care (specify)	+	4/						
	Total (sum of lines 1 through 6)								7
			1	T	T	0: -: -:	Y 25 4	0-4 11 1	
				D. C. C.	Inpatient	Outpatient	Inpatient	Outpatient	
				Ratio of Cost	Ancillary Services	Ancillary Services	Ancillary Services	Ancillary Services	
				to Charges	Acquistion	Acquistion	Acquistion	Acquistion	
				rom Wkst. C, Pt. I, col. 9)	Charges	Charges	Cost	Cost	
	illary Services Acquisition Costs		C	1	2	3	4	5	
8	1 8		50						8
9	Recovery Room		51						9
10	·		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 (MR	I)	58						16
17	Cardiac Catheterization		59						17
18	Laboratory		60						18
19	PBP Clinical Laboratory Services-P		61						19
20	Whole Blood & Packed Red Blood		62						20
21	Blood Storage, Processing, & Trans	sfusing	63						21
22	IV Therapy		64						22
23	Electrocardiology		69						23
24	Medical Supplies Charged to Patier	nts	71						24
25	Drugs Charged to Patients		73						25
26	ASC (non-distinct part)		75						26
27	Other Ancillary (specify)		76						27
28	Total (sum of lines 8 through 27)								28
	Total (sum of lines 8 through 27) II - INTERNS AND RESIDENTS N	OT IN AN APPROV	ED TEA						28
				Average Cost Per Day	Inpatient	Inpatient Part B			
	15 11 . 37 . 1			(from Wkst. D-2,	Acquisition	Acquisition Costs	1		
	rns and Residents Not in Approved To	eaching		Pt. I, col. 4)	Days	(col. 1 x col. 2)	4		
	gram Acquisition Costs		D-2	1	2	3			
1	Adults & Pediatrics		2						1

Interns and Residents Not in Approved Teaching Program Acquisition Costs		(from Wkst. D-2, Pt. I, col. 4)	Acquisition Days	Acquisition Costs (col. 1 x col. 2)		
<u> </u>	D-2	1	2	3		—
1 Adults & Pediatrics	2					1
2 Intensive Care Unit	3					2
3 Coronary Care Unit	4					3
4 Burn Intensive Care Unit	5					4
5 Surgical Intensive Care Unit	6					5
6 Other Special Care (specify)	7					6
7 Total (sum of lines 1 through 6)						7

40-583.3 Rev. 18 1 Number of recipients intended for allogeneic HSCT where the acquisition cost was incurred but the transplant did not occur (see instructions)

PART IV - STATISTICS

Rev. 18 40-583.4

	JLATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTL	EMENT		FROM	PART A	
		COMPONENT CCN:	ТО		
Check	applicable box: [] Hospital [] PARHM Demonstration [] CHART Model				
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
	DRG amounts other than outlier payments				1
	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instr	ructions)			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see in	structions)			1.04
2	Outlier payments for discharges (see instructions)				2
2.01	Outlier reconciliation amount				2.01
-	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
	Outlier payments for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals				4
- 5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/3	1/1006 (see instructions)			5
	FTE count for an opacine and osteopathic programs for the most recent cost reporting period ending on or before 12/3 FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)	17/1990 (see ilistructions)			5.01
	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in	accordance with 42 CFR	413 79(e)		6
	Rural track program FTE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 20.		115.77(0)		6.26
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)	21 (see instructions)			7
	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report s	straddles July 1, 2011, see	instructions.		7.01
	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with				7.02
	programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in	n accordance			8
	with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report stradd	les July 1, 2011, see instru	ctions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of AC	CA. (see instructions)			8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				8.21
9	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus	ıs/minus line 8,			9
	plus lines 8.01 through 8.27 (see instructions)				
	FTE count for allopathic and osteopathic programs in the current year from your records				10
-	FTE count for residents in dental and podiatric programs				11
-	Current year allowable FTE (see instructions)				12
	Total allowable FTE count for the prior year				13
	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise ente	r zero.			14
	Sum of lines 12 through 14 divided by 3				15 16
	Adjustment for residents in initial years of the program (see instructions) Adjustment for residents displaced by program or hospital closure				17
	Adjusted rolling average FTE count				18
	Current year resident to bed ratio (line 18 divided by line 4)				19
	Prior year resident to bed ratio (see instructions)				20
-	Enter the lesser of lines 19 or 20 (see instructions)				21
	IME payment adjustment (see instructions)				22
	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA				•
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).				23
24	IME FTE resident count over cap (see instructions)				24
	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
$\overline{}$	Resident to bed ratio (divide line 25 by line 4)				26
	IME payments adjustment factor (see instructions)				27
	IME add-on adjustment amount (see instructions)			<u> </u>	28
	IME add-on adjustment amount - Managed Care (see instructions)				28.01
	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
20	Disproportionate Share Adjustment				20
	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions)				30 31
-	Sum of lines 30 and 31				32
-	Allowable disproportionate share percentage (see instructions)				33
	Disproportionate share adjustment (see instructions)				34
57	Uncompensated Care Payment Adjustment		Prior to October 1	On or after October 1	54
35	Total uncompensated care amount (see instructions)		11101 10 0010001 1	Sh of all of October 1	35
$\overline{}$	Factor 3 (see instructions)		†	†	35.01
	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)		†	†	35.02
	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)				35.03
	Pro rata share of the MDH's UCP, including supplemental UCP (see instructions)				35.04
	Pro rata share of the SCH's UCP, including supplemental UCP (see instructions)				35.05
36	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)				36

CALCU	JLATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTL	EMENT		FROM	PART A (Cont.)	
		COMPONENT CCN:	TO		
	applicable box: [] Hospital [] PARHM Demonstration [] CHART Model				
PART A	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)				
- 40	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				- 10
	Total Medicare discharges (see instructions)				40
	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instructions)				41.01
	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			- 	42
43	Total Medicare ESRD inpatient days (see instructions)				43
	Ratio of average length of stay to one week (line 43 divided by line 41.01 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 41.01)				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 (see instructions)				49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)				50
	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).				52
	Nursing and allied health managed care payment				53
	Special add-on payments for new technologies				54
	Islet isolation add-on payment				54.01
	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)				55
	Cellular therapy acquisition cost (see instructions)				55.01
	Cost of physicians' services in a teaching hospital (see instructions)				56 57
	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35) Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
	Total (sum of amounts on lines 49 through 58)				59
	Primary payer payments				60
_	Total amount payable for program beneficiaries (line 59 minus line 60)				61
	Deductibles billed to program beneficiaries				62
	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
	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
	Other adjustments (specify) (see instructions)				70
	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)				70.50
70.75	N95 respirator payment adjustment amount (see instructions)				70.75
	Demonstration payment adjustment amount before sequestration				70.87
	SCH or MDH volume decrease adjustment (contractor use only)				70.88 70.89
	Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)				70.89
	HSP bonus payment HRR adjustment amount (see instructions)				70.91
	Bundled Model 1 discount amount (see instructions)			-	70.92
	HVBP payment adjustment amount (see instructions)				70.93
	HRR adjustment amount (see instructions)				70.94
	Recovery of accelerated depreciation				70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)				70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)				70.97
70.99	HAC adjustment amount (see instructions)				70.99
71	Amount due provider (see instructions)				71
	Sequestration adjustment (see instructions)				71.01
	Demonstration payment adjustment amount after sequestration				71.02
	Sequestration adjustment-PARHM or CHART pass-throughs				71.03
	Interim payments				72
	Interim payments-PARHM or CHART				72.01
73	Tentative settlement (for contractor use only) Tentative settlement PARIM or CHART (for contractor use only)				73
	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)				73.01 74
	Balance due provider/program (line /1 minus lines /1.01, /1.02, /2, and /3) Balance due provider/program-PARHM or CHART (see instructions)				74.01
	Balance due provider/program-PARTIVI of CHART (see instructions)				74.01

CALCU	LIATION OF REIMBURSEMENT EMENT	PROVIDER CCN:	PERIOD: FROM	WORKSHEET E, PART A	
SEIIL	LIVELVI	COMPONENT CCN:	TO	TAKIA	
Chaok	applicable box: [] Hospital [] PARHM Demonstration [] CHART Model				
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)				
TAKT	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90					90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	*				94
95	Time value of money for operating expenses (see instructions)				95
96					96
- 70	HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1	70
100	HSP bonus amount (see instructions)		11101 to 10/1	Oli of After 10/1	100
100	HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	100
101	HVBP adjustment factor (see instructions)		11101 to 10/1	Oli di Altei 10/1	101
	HVBP adjustment amount for HSP bonus payment (see instructions)				101
102	HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	102
102	HRR adjustment factor (see instructions)		F1101 to 10/1	Oli of After 10/1	103
			+	_	103
104	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				104
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y"	for you on "NI" for mo		<u> </u>	200
200	Cost Reimbursement	for yes of IN for no.			200
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			1	201
201	Medicare discharges (see instructions)				201
202	Case-mix adjustment factor (see instructions)				202
203	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstrat	dan arada 40			203
204	Medicare target amount	ion period)		1	204
	Case-mix adjusted target amount (line 203 times line 204)				204 205
205	Medicare inpatient routine cost cap (line 202 times line 205)				203
206	Adjustment to Medicare Part A Inpatient Reimbursement				206
207	Program reimbursement under the §410A Demonstration (see instructions)			1	207
207	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				207
209	Adjustment to Medicare IPPS payments (see instructions)			_	208
210	Reserved for future use				210
211	Total adjustment to Medicare IPPS payments (see instructions)				210
211	Comparison of PPS versus Cost Reimbursement				211
212	Total adjustment to Medicare Part A IPPS payments (from line 211)				212
	Low-volume adjustment (see instructions)				212
213		212) (_
218	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line)	ne 2131 (see instructions)		I	218

This page is reserved for future use.

CALCU		N OF MENT SETTLEMEN	IT.						PROVIDER CCN:	PERIOD: FROM	WORKSHEET E, PART B	
KEIMB	UKSEN	TENT SETTLEMEN							COMPONENT CCN:		PART B	
Check		[] Hospital		Subprovider (O	her) [] (CHART Mode	el					
applicab	le	[] IPF	[] SNF] PARHM Demoi								
box:	- MED	[] IRF DICAL AND OTHER	L R HEAI	TH SERVICES	istration							
1		cal and other services										1
2		cal and other services	reimbu	rsed under OPPS	(see instruction	ons)						2
3		payments										3
4 01		er payment (see instru										4.01
5		er reconciliation amou the hospital specific p			e instructions)							4.01
6		2 times line 5	paymer	ii to cost fatto (se	e instructions)							6
7		of lines 3, 4, and 4.01										7
8		itional corridor paym	_									8
10		ary service other pass acquisition	s throu	gh costs from Wks	t. D, Pt. IV, c	ol. 13, line 20	0					9
11		cost (sum of lines 1 a	and 10)	(see instructions)								11
		PUTATION OF LES										
	Reason	nable charges										
12	_	ary service charges										12
13		acquisition charges			, col. 4, line 6	9)						13
14		reasonable charges (s mary charges	sum oi	lines 12 and 13)								14
15		egate amount actually	collec	ted from patients l	able for paym	ent for service	s on a charge ba	sis				15
16		ints that would have b										16
	_	had such payment bee			th 42 CFR §4	13.13(e)						
17	_	of line 15 to line 16 (17
18		customary charges (s of customary charg			complete only	if line 18 eve	eeds line 11) (se	e instructions)				18 19
20		s of reasonable cost of										20
21		r of cost or charges (1		-7 (/				21
22		s and residents (see										22
23		of physicians' services				s)						23
24		prospective payment PUTATION OF REIN	_									24
25		ctibles and coinsurance										25
26		ctibles and Coinsuran				24 (see instruc	ctions)					26
27		tal [(lines 21 and 24 a						e instructions)				27
28		t graduate medical ed				50)						28
30		direct medical educated (sum of lines 27 t			-4, line 36)							29 30
31		ry payer payments	illougi	1 29)								31
32		tal (line 30 minus line	e 31)									32
		WABLE BAD DEB		CLUDE BAD DE	BTS FOR PR	OFESSIONA	L SERVICES)					
33	_	osite rate ESRD (fro										33
34		rable bad debts (see i ted reimbursable bad										34 35
36		able bad debts for du			see instruction	s)						36
37	_	tal (see instructions)	_									37
38		LCC reconciliation as										38
39	_	adjustments (specify	_									39
39.50 39.75		er ACO demonstration respirator payment and)						39.50 39.75
		enstration payment ad										39.73
39.98		l or full credits receiv			<u> </u>	vices (see inst	ructions)					39.98
39.99	Recov	very of Accelerated d	eprecia	tion								39.99
40		tal (see instructions)										40
40.01		estration adjustment (onstration payment ad			wastration							40.01
40.02		stration payment ad										40.02
41	_	m payments		. c. cm act pass-	un Jugns							40.03
41.01		m payments-PARHM	or CH	ART								41.01
42		tive settlement (for co										42
42.01		tive settlement-PARI			actors use onl	y)						42.01
43.01		ce due provider/prog ce due provider/prog			(see instruction	ons)						43.01
43.01		sted amounts (nonallo					ih 15-2 chanter	1 8115 2				43.01

Rev. 18 40-587

	OF PAYMENTS TO PRO	OVIDERS					PROVIDER CCN:	PERIOD:	WORKSHEET E-1,	
FOR SERVIC	ES RENDERED							FROM	PART I	
							COMPONENT CCN:	ТО	_	
Check applicable box:	[] Hospital [] IPF [] IRF	[] Subprovider (Other) [] SNF [] Swing-Bed SNF	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF [] CHART Model [] CHART CAH Swing-Bed SNF						.1	
	•					Inpa	atient			
						Pa	rt A	P	art B	
						mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Descrip						1	2	3	4	
	al interim payments paid									1
		individual bills, either submitted or to be s								2
		cost reporting period. If none, write "NON	E" or enter a zero							
	separately each retroactive			Program to Provider	.01					3.01
	p sum adjustment amoun				.02					3.02
	ubsequent revision of the				.03					3.03
	rim rate for the cost repor				.04					3.04
	show date of each paym				.05					3.05
If no	one, write "NONE" or en	iter a zero. (1)		Provider to Program	.50					3.50
					.51					3.51
					.52					3.52
					.53					3.53
					.54					3.54
		3.49 minus sum of lines 3.50-3.98)			.99					3.99
	al interim payments (sum								A .	4
	nsfer to Wkst. E or Wkst.	. E-3, line							A .	
and o	column as appropriate)									
z I r · ·	separately each tentative			In . n . 1	.01		1			5.01
	separately each tentative nent after desk review. A			Program to Provider	.01					5.01
	of each payment.	AISO SHOW			.02				+	5.03
	one, write "NONE" or en	stan a zana (1)		Provider to Program	.50				+	5.50
11 110	one, write NONE of en	ner a zero. (1)		Flovider to Flogram	.51				+	5.51
					.52		<u> </u>		 	5.52
Cyslet	tatal (asses of linea 5.01.5	5.49 minus sum of lines 5.50 -5.98)		I	.99					5.99
	ermined net settlement ar			Program to Provider	.01				-	6.01
	based on the cost report			Provider to Program	.02				+	6.02
	al Medicare program liab			1 TOVIGET TO 1 TOGISHI	.02				 	7
	ne of Contractor	my (see monucuons)				Contractor Number		NPR Date (Month/Da	v/Year)	8
O Ivan	or continuous					Communication Francisco		R Date (Month Da	<i>j.</i> 1 0 <i>j</i>	
										1

⁽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.

	LATION OF REIMBURSEMENT MENT FOR HIT	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET E-1, PART II	
Check	[] Hospital		-		
applicab	e []CAH				
box:					
HEALT	HINFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			_	
1	Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)				1
2	Medicare days (see instructions)				2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)				3
4	Total inpatient days (see instructions)				4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)				5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)				6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wks	st. S-2, Pt. I, line 168)			7
8	Calculation of the HIT incentive payment (see instructions)				8
9	Sequestration adjustment amount (see instructions)				9
10	Calculation of the HIT incentive payment after sequestration (see instructions)				10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s).	30
31	Initial/interim HIT payment adjustments (see instructions)	31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	32

^{*} This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may may complete this worksheet for a standard cost reporting period.

CALCU	LATION OF EMENT - SV	REIMBURSEN	IENT		1 01011 01115 2552	. 10	PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-2	12 22
SETTE	LIVILIVI SV	VIIVO BEBS					COMPONENT CCN:			
Check		Title V		Swing-Bed SNF	[] CHART CAH Sv	ving-Be	ed SNF			
applicab		Title XVIII	l l	Swing-Bed NF	JE.					
boxes:		Title XIX		[] PARHM CAH Swing-Bed Si	NF			1	1	т —
								PART A	PART B	
	COMPUTA	TION OF NET (COST	OF COVERED SERVICES				1	2	1
1	Inpatient rou	utine services - s	wing l	bed-SNF (see instructions)						1
2	Inpatient rou	utine services - s	wing l	bed-NF (see instructions)						2
3		,		3, col. 3, line 200, for Part A; and						3
				(For CAH and swing-bed pass-						
3.01				-PARHM or CHART (see instru	· · · · · · · · · · · · · · · · · · ·					3.01
	Program day		i resid	lents not in approved teaching pr	ogram (see instructions)					5
6			nnrov	ved teaching program (see instru	ctions)					6
7				pensation - SNF optional method						7
- 8				plus lines 6 and 7)	,					8
9	Primary pay	er payments (se	e instr	ructions)						9
10	Subtotal (lin	ne 8 minus line 9)							10
11				ients (exclude amounts applicable	to physician professional services)					11
12		ne 10 minus line								12
13					clude coinsurance for physician profe	essional	services)			13
14		B costs (line 12	x 80%	%)						14 15
16		tments (specify)	(see	instructions)						16
16.50				nent adjustment (see instructions)						16.50
16.55					ration) payment adjustment (see instr	uctions	:)			16.55
16.99				nt amount before sequestration	/13 3		/			16.99
17		ad debts (see in								17
17.01				(see instructions)						17.01
18			l eligil	ble beneficiaries (see instructions	(3)					18
19	Total (see in									19
19.01		on adjustment (s								19.01
19.02				nt amount after sequestration or CHART pass-throughs						19.02 19.03
19.03				d amounts (see instructions)						19.03
20	Interim payr		buse	d difficults (see instructions)						20
20.01		ments-PARHM	or CH	ART						20.01
21		ttlement (for cor								21
21.01	Tentative se	ttlement-PARH!	M or 0	CHART (for contractor use only	7)					21.01
22			_	ne 19 minus lines 19.01, 19.02, 1						22
22.01		1 1 0		ARHM or CHART (see instruction						22.01
23	Protested an	nounts (nonallov	vable	cost report items) in accordance	with CMS Pub. 15-2, chapter 1, §11:	5.2				23
	Rural Comm	unity Hospital D	emon	stration Project (§410A Demons	tration) Adjustment					
200					er the 21st Century Cures Act? Ente	r "Y" fo	or yes or "N" for no			200
200	Cost Reimbu		ciit	5 Jam demonstration period und	or the 21st century cures ret: Ente		51 jes 01 14 101 110.	1		200
201			patien	t routine service costs (from Wk	st. D-1, Pt. II, line 66 (title XVIII ho	spital))				201
202					kst. D-3, col. 3, line 200 (title XVIII		bed SNF))			202
203	Total (sum	of lines 201 and	202)							203
204				ges (see instructions)						204
					first year of the current 5-year demor	stration	n period)	1		
205		ving-bed SNF ta			- I 204)			 		205
206				t routine cost cap (line 205 time				<u> </u>		206
207				ving-Bed SNF Inpatient Reimbur § §410A Demonstration (see inst				T		207
208				t service costs (from Wkst. E-2,				 		208
209				d SNF PPS payments (see instru						209
210	Reserved for		0 - 2	1 , (222 mont	,					210
		of PPS versus C	ost Re	eimbursement						
215	Total adjust	ment to Medicar	e swii	ng-bed SNF PPS payment (line 2	209 plus line 210) (see instructions)					215

			(_
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
		FROM	PART I	
		TO		

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

1	Inpatient hospital services (see instructions)	1
1.01	Nursing and allied health managed care payment (see instructions)	1.01
2	Organ acquisition	2
3	Cost of physicians' services in a teaching hospital (see instructions)	3
4	Subtotal (sum of lines 1 through 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 Wkst. 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
17.50	Pioneer ACO demonstration payment adjustment (see instructions)	17.50
17.99	Demonstration payment adjustment amount before sequestration	17.99
18	Total amount payable to the provider (see instructions)	18
18.01	Sequestration adjustment (see instructions)	18.01
18.02	Demonstration payment adjustment amount after sequestration	18.02
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program (line 18 minus lines 18.01, 18.02,19, and 20)	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22

4090 ((Cont.) FORM CN	MS-2552-10			04-20
CALCU	JLATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART II	
		COMPONENT CCN	10		
Check	[] Hospital	1		•	
applicab	ble [] Subprovider IPF				
box:					
PART II	I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IP.	PF PPS			
1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments	s)			1
	Net IPF PPS Outlier payment				2
	Net IPF PPS ECT payment				3
	Unweighted intern and resident FTE count in the most recent cost report filed on or before		/		4
4.01	1				4.01
5	that would not be counted without a temporary cap adjustment under 42 CFR §412.424(New teaching program adjustment (see instructions)	(d)(1)(iii)(F)(1) or (2) (see instructions)			5
6		h period			6
Ü	of a "new teaching program" (see instructions)	ii period			
7		period			7
	of a "new teaching program" (see instructions)	•			
8	2 \				8
9	g, ()				9
10					10
11					11 12
12					12
13					13
15	8 1				15
16	81 (16
17					17
18	Subtotal (line 16 less line 17).				18
19					19
20					20
21					21
22	('				22
23	1				23 24
25	y ,				25
26	· /				26
27	,)			27
28		,			28
29	Outlier payments reconciliation				29
30					30
30.50	17 7				30.50
30.99	17 7				30.99
31	Total amount payable to the provider (see instructions)				31.01
31.01	1 ,				31.01
31.02	1 7 7				31.02
33	1 7				33
	27				34
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	chapter 1 8115.2			35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	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

04-20	FORM CM	MS-2552-10		4090 (Cont.)
CALCU	JLATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART III
		COMPONENT CCN:	то	
Check	[] Hospital			
applicab				
box:				
PARTI	II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IR	F PPS		
17110111	a CAECOLATION OF MEDICARE REIMBORDEMENT SETTEMENT CADER IN			
	Net Federal PPS payment (see instructions)			1
2				2
3	Inpatient Rehabilitation LIP payments (see instructions)			3
4	1 7			4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending	ng		5
5.01	on or prior to November 15, 2004 (see instructions)	P 1 11 1 5 1		5.01
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were d			5.01
6	closure, that would not be counted without a temporary cap adjustment under 42 CFR §4 New teaching program adjustment (see instructions)	+12.424(d)(1)(III)(F)(1) or (2)		6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth	neriod		7
,	of a "new teaching program" (see isntructions)	period		,
8	Current year unweighted I&R FTE count for residents within the new program growth pe	eriod		8
	of a "new teaching program" (see isntructions)			
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)			10
11				11
12				12
13	Total PPS Payment (see instructions)			13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)			17
18	71 7 1 7			18
19	Subtotal (line 17 less line 18)			19
20	Deductibles			20
21	Subtotal (line 19 minus line 20)			21
22	Coinsurance			22
23				23
24	1 / /			24
25				25
26	·			26
27 28	Subtotal (sum of lines 23 and 25) Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions			27
29		2)		28
30	1 5 \			30
31	1 7			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
31.99				31.99
32	Total amount payable to the provider (see instructions)			32
32.01				32.01
32.02				32.02
33				33
34				34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			35
36		chapter 1, §115.2		36
	TO BE COMPLETED BY CONTRACTOR			
50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
51	Outlier reconciliation adjustment amount (see instructions)			51

50	Original outlier amount from Wkst. E-3, Pt. 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

.050 (2011)	1 014/1 01/10 2002 1	•			· ·
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART IV	
			TO		

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	1
1.01	Full standard payment amount	1.01
1.02	Short stay outlier standard payment amount	1.02
1.03	Site neutral payment amount - Cost	1.03
1.04	Site neutral payment amount - IPPS comparable	1.04
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 DO NOT USE THIS LINE	5
6	Cost of physicians' services in a teaching hospital (see instructions)	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 Wkst. E-4, line 49)	18
19	Other pass through costs (see instructions)	19
20	Outlier payments reconciliation	20
21	Other adjustments (specify) (see instructions)	21
	Pioneer ACO demonstration payment adjustment (see instructions)	21.50
21.99	Demonstration payment adjustment amount before sequestration	21.99
22	Total amount payable to the provider (see instructions)	22
22.01	Sequestration adjustment (see instructions)	22.01
22.02	Demonstration payment adjustment amount after sequestration	22.02
23	Interim payments	23
24	Tentative settlement (for contractor use only)	24
25	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24)	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	26

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount (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

12-22	FORM CMS-2552-10			4090 (Cont)
CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	_
			FROM	PART V	
			TO		
Check	[] Hospital			<u> </u>	_
applicab	le [] PARHM Demonstration				
box:	[] CHART Model				
	- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES	- COST REIMBURSE	MENT		
1	Inpatient services				1
2	Nursing and allied health managed care payment (see instructions)				2
3	Organ acquisition				3
3.01	Cellular therapy acquisition cost (see instructions)			3.0	_
4	Subtotal (sum of lines 1 through 3.01)				4
5	Primary payer payments				5
6	Total cost (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			I	0
- 11	Customary charges				_
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				1
12	Amounts that would have been realized from patients liable for payment for services on				12
1.2	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				_
13 14	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
15	Total customary charges (see instructions)	vations)			14
16	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions).				16
17	Cost of physicians' services in a teaching hospital (see instructions)	uctions)			17
1 /	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1	
18	Direct graduate medical education payments			1	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 lines 20 and 21)				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
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			29.5	0
29.99	Demonstration payment adjustment amount before sequestration			29.9	19
30	Subtotal (see instructions)			3	30
30.01	Sequestration adjustment (see instructions)			30.0	1
30.02	Demonstration payment adjustment amount after sequestration			30.0	12
30.03	Sequestration adjustment-PARHM or CHART			30.0	13
31	Interim payments			3	31
31.01	Interim payments-PARHM or CHART			31.0)1
32	Tentative settlement (for contractor use only)	-			32
32.01	Tentative settlement-PARHM or CHART (for contractor use only)			32.0	_
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)				33
33.01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01,			33.0	_
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1	15.2		3	34

1050 (201111)	1 014.1 01.12 2002 10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: PERIOD:	WORKSHEET E-3,
	FROM	PART VI
	COMPONENT CCN.: TO	
DART VI. CALCUL ATION OF DEIMBURGEMENT SETTLEMEMENT. T	ITH E VIVII DADT A DDG GNE GEDVIGEG	

 ${\tt PART\,VI-CALCULATION\,OF\,REIMBURSEMENT\,SETTLEMEMENT-TITLE\,XVIII\,PART\,A\,PPS\,SNF\,SERVICES}$

	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. Do not use this line. (see instructions)	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	Adjusted reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	14.50
14.99	Demonstration payment adjustment amount before sequestration	14.99
15	Subtotal (see instructions)	15
15.01	Sequestration adjustment (see instructions)	15.01
15.02	Demonstration payment adjustment amount after sequestration	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	15.75
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

12 22			1 Oldvi	CIVID 2332 10			1070 (00	111.
CALCULATIO	N OF REIMBURSEME	NT SETTLEMENT			PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
						FROM	PART VII	
					COMPONENT CCN:	TO		
Check	[] Title V	[] Hospital	[] NF	[] PPS				
applicable	[] Title XIX	[] Subprovider	[] ICF/IID	[] TEFRA				
boxes:		[] SNF		[] Other				

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

		Inpatient Title V or	Outpatient Title V or	
	COMPUTATION OF NET COST OF COVERED SERVICES	Title XIX	Title XIX	
	Inpatient hospital/SNF/NF services			1
	Medical and other services			2
	Organ acquisition (certified transplant programs only)			3
	Subtotal (sum of lines 1, 2 and 3)			4
	Inpatient primary payer payments			5
	Outpatient primary payer payments			6
	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
	Routine service charges			8
	Ancillary service charges			ç
	Organ acquisition charges, net of revenue			10
	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			14
	on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15	Ratio of line 13 to line 14 (not to exceed 1.000000)			1.5
16	Total customary charges (see instructions)			10
17	Excess of customary charges over reasonable cost (complete only if line 16			1'
	exceeds line 4) (see instructions)			
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 physicians' service in a teaching hospital (see instructions)			20
	Cost of covered services (enter the lesser of line 4 or line 16)			2
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			2:
	Program capital payments			24
	Capital exception payments (see instructions)			2:
	Routine and ancillary service other pass through costs			20
	Subtotal (sum of lines 22 through 26)			2
	Customary charges (title V or XIX PPS covered services only)			28
	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
	Excess of reasonable cost (from line 18)			30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			3
	Deductibles			3:
	Coinsurance			33
	Allowable bad debts (see instructions)			34
	Utilization review	_		3:
	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
	Other adjustments (specify) (see instructions)	_		37
	Subtotal (line 36 ± line 37)			38
	Direct graduate medical education payments (from Wkst. E-4)			31
	Total amount payable to the provider (sum of lines 38 and 39)			4
	Interim payments			4
	Balance due provider/program (line 40 minus line 41)			4
44	Datance due provider/program (fille 40 fillilus fille 41)			4.

4090 (Colli.) FORWI	CIVIS-2332-10				12-22
DIRECT	GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
	OUTPATIENT DIRECT MEDICAL			FROM		
	TION COSTS			TO	-	
Check	[] Title V [] Hospital		CAH-Based IPF			
applicabl		nonetration	[] CAH-Based IRF			
box:	[] Title XIX [] CHART Mod		[] CAII-Based IICI			
OOA.	COMPUTATION OF TOTAL DIRECT GME AMOUNT	Ci				
	Unweighted resident FTE count for allopathic and osteopathic programs for cost re	norting periods ending on or	hefore December 31 10	06	I	1
1.01	FTE cap adjustment under \$131 of the CAA 2021 (see instructions)	porting periods ending on or	before December 31, 17,	70		1.01
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see	instructions)				2
2.26	Rural track program FTE cap limitation adjustment after the cap-building window c		A 2021 (can instructions)	1		2.26
3	Amount of reduction to Direct GME cap under §422 of MMA	losed under §127 of the CA.	A 2021 (see instructions)		+	3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §	412.70 (m) (and instruction				3.01
3.01	for cost reporting periods straddling 7/1/2011)	415.79 (III). (see instruction	IS			3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for	munal tanale mana amama verith a	munal tracals Madisona CM	E		3.02
3.02			rurai track Medicare GM	E		3.02
4	affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 20 Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs					4
4		due to a medicare GME				4
4.01	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		1)			4.01
4.01	ACA \$5506 number of additional direct GME FTE cap (see instructions for cost reporting		/			4.01
	ACA §5506 number of additional direct GME FTE cap slots (see instructions for co					
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the					4.21
5	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, mir	ius illies 3 and 5.01, pius or	minus line 5.02, plus of it	iinus		3
	line 4, plus lines 4.01 through 4.27 Unweighted resident FTE count for allopathic and osteopathic programs for the cur	t	(annimatorations)			6
7		rent year from your records	(see instructions)			7
/	Enter the lesser of line 5 or line 6		Duimoury Come	Other	Total	/
			Primary Care	Other		4
0	Waishted ETE asset for absolutions in an allowable and extremethic management for		1	2	3	8
٥	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year					0
	,					9
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times					9
	the result of line 5 divided by the amount on line 6. For cost reporting periods begin					
10	on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instruct	IOIIS.				10
10.01	Weighted dental and podiatric resident FTE count for the current year					10.01
10.01	Unweighted dental and podiatric resident FTE count for the current year					10.01
12	Total weighted FTE count					12
13	Total weighted resident FTE count for the prior cost reporting year (see instruction Total weighted resident FTE count for the penultimate cost reporting year (see inst					13
		г.)				
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)					14
15 01	Adjustment for residents in initial years of new programs					15 01
15.01	Unweighted adjustment for residents in initial years of new programs					15.01
16 01	Adjustment for residents displaced by program or hospital closure					16 01
16.01	Unweighted adjustment for residents displaced by program or hospital closure					16.01
17	Adjusted rolling average FTE count					17
18 01	Per resident amount					18.01
18.01	Per resident amount under §131 of the CAA 2021					
19	Approved amount for resident costs		2(-)(4)			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slot	is received under 42 §413.79	7(0)(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 Multiply line 22 time line 23)				23
	Total direct GME amount (sum of lines 19 and 24)					
25	Total direct GIVIE amount (sum of mics 19 and 24)	Inpatient Part A	Managed Care	Managed Care	Total	25
		працені ган А	Prior to 1/1	On or after 1/1	10181	1
•	COMPUTATION OF PROGRAM PATIENT LOAD	1	2	2.01	3	1
26	Inpatient days (see instructions)	1		∠.01	3	26
27	Total inpatient days (see instructions)	+		1		27
28	Ratio of inpatient days (see instructions)		1	1		28
29	Program direct GME amount		1	1		29
29.01	Percent reduction for MA DGME			1		29.01
30	Reduction for direct GME payments for Medicare Advantage			1		30
31	Net Program direct GME amount					31
31	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TI	ITI E YVIII ONI V OII IBC	ING PROGRAM AND			31
	PARAMEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - 11	LLE AVIII ONE I (NURS	ING I ROGRAM AND			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 an	d 23 lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74				+	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	· · · · · / · / · /			+	34
35	Medicare outpatient ESRD charges (see instructions)				+	35
33	Treateur companient Dordo charges (see instructions)				+	33

DIRECT	GRADUATI	E MEI	DICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4
& ESRD	OUTPATIE	NT DI	IRECT MEDICAL			FROM	
EDUCA'	TION COSTS	3				ТО	
Check		[] Title V	[] Hospital	[] CAH-Based IPF		
applicabl	le	[] Title XVIII	[] PARHM Demonstration	[] CAH-Based IRF		
box:		[] Title XIX	[] CHART Model			
	APPORTION	IMEN	T OF MEDICARE REASONABLE COST	OF GME			
	Part A Reaso	nable	Cost				
37	Reasonable of	cost (see instructions)				37
38	Organ acqui	sition	and HSCT acquisition costs (see instruction	ons)			38
39	Cost of phys	icians'	services in a teaching hospital (see instruct	tions)			39
40	Primary paye	er pay	ments (see instructions)				40
41	Total Part A	reaso	nable cost (sum of lines 37 through 39 minu	is line 40)			41
	Part B Reaso	nable	Cost				
42	Reasonable of	cost (see instructions)				42
43	Primary paye	er payı	ments (see instructions)				43
44	Total Part B	reaso	nable cost (line 42 minus line 43)				44
45	Total reason	able c	ost (sum of lines 41 and 44)				45
46	Ratio of Part	A rea	asonable cost to total reasonable cost (line 4	1 ÷ line 45)			46
47	Ratio of Part	B rea	asonable cost to total reasonable cost (line 4-	4 ÷ line 45)			47
	ALLOCATIO	ON OI	F MEDICARE DIRECT GME COSTS BET	TWEEN PART A AND PART B			
48	Total progra	m GN	ME payment (line 31)	_			48
49	Part A Medi	care C	GME payment (line 46 x 48) (title XVIII on	ly) (see instructions)		•	49
50	Part B Medi	care G	GME payment (line 47 x 48) (title XVIII onl	ly) (see instructions)		•	50
			· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·

1070	(Cont.)	2332 10			05 25
OUTL	ER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCI	FROM	WORKSHEET E-5	
	TO BE COMPLETED BY CONTRACTOR		ТО		
1	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				1
2	Capital outlier from Wkst. L, Pt. I, line 2				2
3	Operating outlier reconciliation adjustment amount (see instructions)				3
4	Capital outlier reconciliation adjustment amount (see instructions)				4
5	The rate used to calculate the time value of money (see instructions)				5
6	Time value of money for operating expenses (see instructions)				6
7	Time value of money for capital related expenses (see instructions)				7

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-1425 EXPIRES 02-28-2025				
PAYMENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PROVIDER CO			PROVIDER CCN:	PERIOD: FROM TO_	WORKSHEET E-95	
PART I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAYMEN.	T ADJUSTMENT ELI	GIBILITY AND DATA				
				DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS 2	_
1 Did the hospital or hospital healthcare complex purchase domestic (column 1) "N" for no in each column. If "Y" for either column, complete line 2.	or non-domestic (colu	mn 2) respirators? Ent	er "Y" for yes or	1		1
		DOMESTIC	RESPIRATORS	NON-DOMESTI	C RESPIRATORS	_
		TOTAL COST	NUMBER PURCHASED 2	TOTAL COST	NUMBER PURCHASED 4	
2 Enter the total cost of domestic respirators purchased in column 1 and the num respirators purchased in column 2. Enter the total cost of non-domestic respirators purchased in column 3 and the non-domestic respirators purchased in column 4.	·					2
PART II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-APPI	ROVED SURGICAL N	195 RESPIRATORS				_
			DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS	COST DIFFERENTIAL 3	
1 Total cost of NIOSH-approved surgical N95 respirators purchased			I	2		1
2 Number of NIOSH-approvied surgical N95 respirators purchased						2
3 Average cost per respirator						3
4 Hospital-specific unit cost differential for domestic respirators 5 Total cost differential for domestic respirators						5
Total cost afferential for domestic respirators						
PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIOSH-A	APPROVED SURGICA	AL N95 RESPIRATORS		_		
	HOSPITAL PART A I	HOSPITAL PART B 2	IPF SUBPROVIDER PART B 3	IRF SUBPROVIDER PART B 4	TOTAL 5	
1 Medicare costs						1
2 Total facility costs						2
3 Medicare percentage						3

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 number for this information collection is OMB 0938-1425. The time required to complete this information collection is estimated to be 0.50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have 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. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

40-599.2

4090 (Cont.)	FORM CMS-2552-10					
BALANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G		
(If you are nonproprietary and do not maintain fund-type			FROM			
accounting records, complete the General Fund column only)			TO			
		Specific				
	General	Purpose	Endowment	Plant		
Assets	Fund	Fund	Fund	Fund		
(Omit cents)	1	2	3	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					6	
accounts receivable						
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 through 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	İ				26	
27 HIT designated Assets	İ				27	
28 Accumulated depreciation	İ				28	
29 Minor equipment-nondepreciable	İ				29	
30 Total fixed assets (sum of lines 12 through 29)	İ				30	
OTHER ASSETS	•	•		•	•	
31 Investments					31	
32 Deposits on leases	İ				32	
33 Due from owners/officers	İ				33	
34 Other assets	İ				34	
35 Total other assets (sum of lines 31 through 34)	İ				35	
36 Total assets (sum of lines 11, 30, and 35)	İ				36	

10-12	FORM CMS-255	4090	4090 (Cont.		
BALANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type			FROM	(CONT.)	
accounting records, complete the General Fund column only)			TO		
		Specific			
Liabilities and Fund	General	Purpose	Endowment	Plant	
Balances	Fund	Fund	Fund	Fund	
(Omit cents)	1	2	3	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					45
lines 37 thru 44)					
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					50
lines 46 thru 49)					
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					54
balance - restricted					
55 Donor created - endowment fund					55
balance - unrestricted					
56 Governing body created - endowment					56
fund balance					
57 Plant fund balance - invested in plant					57
58 Plant fund balance - reserve for plant					58
improvement, replacement, and expansion					1
59 Total fund balances (sum of lines 52 thru 58)					59
60 Total liabilities and fund balances (sum of	İ				60
lines 51 and 59)					

STATE	MENT OF CHANGES IN FUND BALANCES						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET G-1	
		GENER.	AL FUND	SPECIFIC PU	RPOSE FUND	ENDOWN	IENT FUND	PLA	NT FUND	
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net income (loss) (from Worksheet G-3, line 29)									2
3	Total (sum of line 1 and line 2)									3
4	Additions (credit adjustments) (specify)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4 through 9)									10
	Subtotal (line 3 plus line 10)									11
12	Deductions (debit adjustments) (specify)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12 through 17)									18
	Fund balance at end of period per balance sheet (line 11 minus line 18)									19

STATEMENT OF PATIENT REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-2,
AND OPERATING EXPENSES		FROM	PARTS I & II
		то	

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	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 through 9)				10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES	•	•		•
	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				16
	of lines 11-15)				
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
	Total patient revenues (sum of lines 17 through 27) (transfer column 3 to				28
	Worksheet G-3, line 1)				

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 through 35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37 through 41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)			43

Rev. 17 40-603

STATE	MENT OF REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-3	
AND EX	XPENSES		FROM		
			ТО		
				•	
	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
	Net patient revenues (line 1 minus line 2)				3
	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				
	OTHER INCOME				
6	Contributions, donations, bequests, etc				6
7	Income from investments				7
8	Revenues from telephone and other miscellaneous communication services				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
24.50	COVID-19 PHE Funding				24.50
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

	SIS OF HOSPITAL-BASED HEALTH AGENCY COSTS							PROVIDER CCN: HHA CCN:	PERI FROI 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	RECLASS TRIAL BALAN (col. 6 + c	L ICE ol. 7) ADJUSTMEN		
	CENTED IN GERMAN COOK OF WINDS	1	2	3	4	5	6	7	8	9	10	_
	GENERAL SERVICE COST CENTERS											1
1	Capital Related-Bldgs. and Fixtures								ļ			1
2	Capital Related-Movable Equipment								ļ			2
3	Plant Operation & Maintenance								ļ			3
4	Transportation (see instructions)											4
5	Administrative and General											5
	HHA REIMBURSABLE SERVICES											4
6	Skilled Nursing Care											6
7	Physical Therapy											7
	Occupational Therapy											8
	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
	Private Duty Nursing											17
18	Clinic											18
19	Health Promotion Activities											19
	Day Care Program											20
	Home Delivered Meals Program	†		†	1	†	t	1	1		$\overline{}$	21
	Homemaker Service								t			22
	All Others								t			23
	Total (sum of lines 1 through 23)											24

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

4090 (Colli.)		FO	KIVI CIVIS-2332-	10						11-10
COST ALLOCATION - HHA GENERAL SERVICE COST					PROVID HHA CC	ER CCN:	PERIOD: FROM TO		WORKSHEET H-1 PART I	
	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)		PITAL ED COSTS MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTA (cols. 0-4)	L TRA	MINIS- ATIVE ENERAL	TOTAL (cols. 4a + 5)	
GENERAL SERVICE COST CENTERS	0	1	2	3	4	4a		3	6	
Capital Related-Bldgs. and Fixtures									_	1
Capital Related-Movable Equipment										2
3 Plant Operation & Maintenance										3
4 Transportation (see instructions)										4
5 Administrative and General										5
HUA DEIMDIDGADI E CEDVICEC										

6 Skilled Nursing Care 7 Physical Therapy

Occupational Therapy
 Speech Pathology
 Medical Social Services

15 Home Dialysis Aide Services

19 Health Promotion Activities

24 Totals (sum of lines 1 through 23)

HHA NONREIMBURSABLE SERVICES

11 Home Health Aide12 Supplies (see instructions)

16 Respiratory Therapy

17 Private Duty Nursing

20 Day Care Program21 Home Delivered Meals Program

22 Homemaker Service 23 All Others

13 Drugs

14 DME

18 Clinic

8 9 10

11

12

13

14

15

16

17

18

19 20 21

22 23 24

COST ALLOCATION - HHA STATISTICAL BASIS			PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-1, PART II		
		DITAL ED COSTS MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATION & MAINTENANCE (SQUARE FEET) 3	TRANS- PORTATION (MILEAGE)	RECONCIL- IATION 5a	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	
GENERAL SERVICE COST CENTERS	ı	-	,	T	Ja	,	
Capital Related-Bldgs. and Fixtures							
2 Capital Related-Movable Equipment							
3 Plant Operation & Maintenance							
4 Transportation (see instructions)							
5 Administrative and General							
HHA REIMBURSABLE SERVICES							
6 Skilled Nursing Care							-
7 Physical Therapy							,
8 Occupational Therapy							- 1
9 Speech Pathology							
10 Medical Social Services							1
11 Home Health Aide							1
12 Supplies (see instructions)							1
13 Drugs							1
14 DME							1
HHA NONREIMBURSABLE SERVICES							
15 Home Dialysis Aide Services							1
16 Respiratory Therapy							1
17 Private Duty Nursing							1
18 Clinic							1
19 Health Promotion Activities							1
20 Day Care Program							2
21 Home Delivered Meals Program							2
22 Homemaker Service							2
23 All Others							2
24 Total (sum of lines 1-23)							2
25 Cost To Be Allocated (per Worksheet H-1, Part I)							2
26 Unit Cost Multiplier							2

ALLOC	ATION OF GENERAL SERVICE TO HHA COST CENTERS								PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART I	
	HHA COST CENTER (omit cents)	From Wkst. H-1 Part I,	HHA TRIAL BALANCE	RELATE BLDGS. &	ED COSTS MOVABLE	EMPLOYEE BENEFITS	SUBTOTAL	ADMINIS- TRATIVE &	MAIN- TENANCE &	OPERATION	LAUNDRY & LINEN	
		col. 6, line	(1)	FIXTURES	EQUIPMENT 2	DEPARTMENT	(cols. 0-4) 4A	GENERAL 5	REPAIRS 6	OF PLANT	SERVICE 8	4
1	Administrative and General	5	U	1	2	4	4A	3	0	/	8	+
2	Skilled Nursing Care	6										2
3	Physical Therapy	7										3
4	Occupational Therapy	8		<u> </u>				1				4
- 5	Speech Pathology	9										5
- 6	Medical Social Services	10										6
7	Home Health Aide	11										7
8	Supplies	12										8
	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
	Health Promotion Activities	19										15
16	Day Care Program	20										16
	Home Delivered Meals Program	21										17
	Homemaker Service	22	<u> </u>				<u> </u>					18
	All Others	23										19
	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1, line 20, minus column 26, line 1, rounde											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.

01-22					rok	IVI CIVIS-233	02-10					4090 (Cont.)
	ATION OF GENERAL SERVICE TO HHA COST CENTERS									PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART I (CONT.)	
	HHA COST CENTER (omit cents)	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	NON- PHYSICIAN ANES- THETISTS	
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
	Health Promotion Activities												15
16	Day Care Program												16
	Home Delivered Meals Program												17
	Homemaker Service												18
	All Others												19
	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1, dir line 20, minus column 26, line 1, rounded												21

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

ALLOC	ATION OF GENERAL SERVICE TO HHA COST CENTERS			PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-2, PART I					
	HHA COST CENTER (omit cents)	NURSING PROGRAM 20	INTERNS & SALARY AND FRINGES 21	RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL (sum of cols. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	SUBTOTAL (cols. 23 ± 24) 26	ALLOCATED HHA A&G (see Part II) 27	TOTAL HHA COSTS 28	
1	Administrative and General										1
	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
	Homemaker Service										18
	All Others										19
	Totals (sum of lines 1-19) (2)										20
21	Unit Cost Multiplier: column 26, line 1, dir line 20, minus column 26, line 1, rounded		mn 26,								21

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

07-13		1 (SIGNI CIVIS-2332-	10					Cont.)
	ATION OF GENERAL SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	
	TO HHA COST CENTERS						FROM	PART II	
STATIS	TICAL BASIS					HHA CCN:	ТО		
1									
			ITAL						
			ED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
	HHA COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
		(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	l
		1	2	4	4A	5	6	7	
1	Administrative and General								1
2	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
	Drugs								9
10									10
	Home Dialysis Aide Services								11
	Respiratory Therapy								12
	Private Duty Nursing								13
	Clinic								14
15									15
	Day Care Program								16
	Home Delivered Meals Program								17
	Homemaker Service						Į		18
	All Others						Į		19
	Totals (sum of lines 1-19)								20
	Total cost to be allocated								21
22	Unit Cost Multiplier								22

	(Cont.)				JICIVI CIVIS-2332-	10					07-13
COSTS	ATION OF GENERAL SERVICE TO HHA COST CENTERS TICAL BASIS							PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART II (CONT.)	
	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
	Occupational Therapy										4
5	Speech Pathology										5
	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
	All Others										19
20	Totals (sum of lines 1-19)										20
21											21
22	Unit Cost Multiplier										22

01-22	1 (JICIVI CIVID-2332	10		Innaran ar-	I non von	1070 ((Cont.
ALLOCATION OF GENERAL SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	
COSTS TO HHA COST CENTERS						FROM	PART II (CONT.)	
STATISTICAL BASIS					HHA CCN:	ТО	_	
		1	NON-	1			DADA	1
			NUN- PHYSICIAN		DITERNIC	& RESIDENTS	PARA- MEDICAL	
	SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
HILL COST SENTER								
HHA COST CENTER	SERVICE	GENERAL	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	
	(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
	SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	4
	17	18	19	20	21	22	23	ļ.,
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								(
7 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Home Dialysis Aide Services								1.
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

1070 (Cont.)			1 01011 01115 2552 10				01 21
APPORTIONMENT OF I	PATIENT SERVIC	E COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET H-3,	
					FROM	Parts I & II	
				HHA CCN:	TO		
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX				

PAR	TI-COMPU	TATION O	THE AGGE	REGATE PI	ROGRAM	COST

Cost Per Visit Computation								Program Vis	its		Cost	of Services		
				Total				Par	t B		Pa	rt B		
	From,	Facility	Shared	HHA		Average		Not			Not		Total	
	Wkst.	Costs	Ancillary	Costs		Cost		Subject to	Subject to		Subject to	Subject to	Program	
	H-2,	(from	Costs	(sum of		Per Visit		Deductibles	Deductibles		Deductibles	Deductibles	Cost	
	Part I,	Wkst. H-2,	(from	col. 1	Total	(col. 3		&	&		&	&	(sum of	
Patient Services	col. 28,	Part I)	Part II)	+ col. 2)	Visits	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	cols. 9-10)	
	line	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Care	2													
2 Physical Therapy	3													
3 Occupational Therapy	4												1	
4 Speech Pathology	5													
5 Medical Social Services	6													
6 Home Health Aide	7													
7 Total (sum of lines 1 through	6)									·				

	Limitation Cost Computation			Program Visits		
				Par	rt B	
				Not Subject to	Subject to	
				Deductibles	Deductibles	
	Patient Services	CBSA NO. (1)	Part A	& Coinsurance	& Coinsurance	
		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 through 13)					14

Supplies	and Drugs Cost							Program 0	Covered Charg	es	Cost of Se	ervices		
Computa	ations						Par	t B		Par	rt B			
			Facility	Shared					Not Subject		1	Not Subject		
		From	Costs	Ancillary		Total			to	Subject to		to	Subject to	
		Wkst. H-2	(from	Costs	Total	Charges	Ratio		Deductibles	Deductibles		Deductibles	Deductibles	
		Part I,	Wkst. H-2,	(from	HHA Costs	(from HHA	(col. 3		&	&		&	&	
	Other Patient Services	col. 28,	Part I)	Part II)	(cols. 1 + 2)	Records)	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	
		line	1	2	3	4	5	6	7	8	9	10	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,	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		col. 9, line:	1	3	3	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

12-22				FORM CMS-2552-	10		4090	(Cont.)
CALCU SETTLE		REIMBURSEMENT			PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-4, Parts I & II	
Check a	pplicable box:	[] Title V	[] Title XVIII	[] Title XIX		I.	I.	
PART I	- COMPUTATION	OF THE LESSER OF	F REASONABLE COST	T OR CUSTOMARY CHARGES				
						P	art B	
					Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description				1	2	3	
		Part A & Part B Serv						
1		services (see instructi	ons)					1
2	Total charges							2
	Customary Charges							
3	charge basis (from	your records)	liable for payment for se					3
4			om patients liable for pa le in accordance with 42	ayment for services on a 2 CFR 413.13(b)				4
5	Ratio of line 3 to li	ne 4 (not to exceed 1.0	000000)					5
6	Total customary ch	arges (see instructions	s)					6
7	Excess of total cus	tomary charges over to	otal reasonable cost (con	nplete only if line 6 exceeds line 1)				7
8	Excess of reasonab	le cost over customar	y charges (complete only	y if line 1 exceeds line 6)				8
9	Primary payer amo	unts						9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	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	Allowable bad debts (from your records)			27
27.01	Adjusted reimbursable bad debts (see instructions)			27.01
28	Allowable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (see instructions)			29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
30.99	Demonstration payment adjustment amount before sequestration			30.99
31	Subtotal (see instructions)			31
31.01	Sequestration adjustment (see instructions)			31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)			31.75
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			35

4090 (Cont.)	FORM (CMS-	-2552-10				12-22
	SIS OF PAYMENTS TO HOSPITAL- HHAS FOR SERVICES				PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-5	
RENDE	RED TO PROGRAM BENEFICIARIES				HHA CCN:	то		
				P	art A		Part B	
	Description			mm/dd/yyyy	Amount 2	mm/dd/yyyy	Amount 4	1
1	Total interim payments paid to provider			1	-	J	·	1
2	Interim payments payable on individual bills eith	her submitted or						2
	to be submitted to the intermediary for services of cost reporting period. If none, write "NONE" of							
3	List separately each retroactive lump sum	Program	.01					3.01
	adjustment amount based on subsequent revision	to to	.02					3.02
	of the interim rate for the cost reporting period.	Provider	.03					3.03
	Also show date of each payment. If none, write		.04					3.04
	"NONE" or enter a zero.(1)		.05					3.05
		Provider	.50					3.50
		to	.51					3.51
		Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum		00					2.00
4	of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3	00)	.99					3.99
4	(transfer to Wkst. H-4, Part II, column as approp							4
	(transfer to wast. 11-4, 1 art 11, column as approp	mate, mie 32)						1
	TO BE COMPLETED BY INTERMEDIARY							
- 5	List separately each tentative settlement paymen	Program	.01		1			5.01
	after desk review. Also show date of each	to	.02					5.02
	payment. If none, write "NONE" or enter	Provider	.03					5.03
	a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		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)	Ü						
	based on the cost report (see instructions)	to	.01					
		Provider						6.01
		Provider	.02					
		to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY							7
,	(see instructions)							1 ′
8	Name of Contractor	Contractor Number			NPR Date: Month, Da	ny, 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.

ANALY	SIS OF RENAL I	DIALYSIS DEPARTMENT COSTS			PROVIDER CCN:	PERIOD: FROM	WORKSHEET I-1	
Chaols or	plicable box:	Renal Dialysis Department	[] Home Program Dial	zeie		ТО		
Спеск ар	рисанс вох.	Kenai Biarysis Bepartment	[] Home Hogram Dian	TOTAL			FTEs per	T
				COSTS	BASIS	STATISTICS	2080 Hours	
				1	2	3	4	1
1	Registered Nurse	s		-	Hours of Service	-		1
2	Licensed Practica				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
	Subtotal (sum of							9
10	Employee Benefi	ts			Salary			10
		Costs-Bldgs. & Fixtures			Square Feet			11
		Costs-Mov. Equip.			Percentage of Time			12
13	Machine Costs &	Repairs			Percentage of Time			13
14	Supplies	•			Requisitions			14
14.01	Pediatric Medica	l Supplies			Requisitions			14.01
15	Drugs				Requisitions			15
16	Other				Accumulated Cost			16
17	Subtotal (sum of	lines 9-16)*						17
18	Capital Related C	Costs-Bldgs. & Fixtures			Square Feet			18
19	Capital Related C	Costs-Mov. Equip.			Percentage of Time			19
20	Employee Benefi	ts Department			Salary			20
21	Administrative ar	nd General			Accumulated Cost			21
22	Maint./Repairs-O	peration-Housekeeping			Square Feet			22
23	Medical Education	on Program Costs						23
24	Central Services	& Supplies		•	Requisitions			24
25	Pharmacy				Requisitions			25
	Other Allocated 0				Accumulated Cost			26
27	Subtotal (sum of	lines 17-26)*						27
28	Laboratory (see is	nstructions)		_	Charges			28
		apy (see instructions)			Charges			29
	Other (see instruc				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 24, less the sum of columns 21 and 22, for line 74 or line 94, as appropriate.

ALLOC	ATION OF RENAL DEPARTMENT COSTS T	TO TREATMENT	MODALITIES								PROVIDER CCN:	PERIOD:	WORKSHEET I-2	
												FROM	-	
61 1												TO		
	pplicable box: [] Renal Dialysis Department	artment [] F	Iome Program Dia	lysis				T	T			T	T	
	TIENT SERVICES	G + Prm		DIDECO	D	EL MY OVER			pent, marc	n or mn in	ar inmom . r		mom.r	
COMPC	OSITE PAYMENT RATE		AL AND	DIRECT		EMPLOYEE) EDICAL	PEDIATRIC	ROUTINE	SUBTOTAL		TOTAL	
			D COSTS	CARE S		BENEFITS	PRIVAG	MEDICAL	MEDICAL	ANCILLARY	(sum of	OVERVE A	(col. 9 +	
		BUILDING	EQUIPMENT 2	RNs	OTHER	DEPARTMENT	DRUGS	SUPPLIES	SUPPLIES 7.01	SERVICES	cols. 1-8)	OVERHEAD	col. 10)	_
	Total Renal Department Costs	1	2	3	4	5	6	/	7.01	8	9	10	11	
1	MAINTENANCE													1
	Hemodialysis													2
	AKI-Hemodialysis													2.01
	Hemodialysis-Pediatric													2.01
3	Intermittent Peritoneal													3
	AKI-Intermittent Peritoneal													3.01
	IPD-Pediatric													3.01
3.02	TRAINING													3.02
	Hemodialysis													4
	Hemodialysis-Pediatric													4.01
	Intermittent Peritoneal													4.01
	IPD-Pediatric													5.01
	CAPD													
	CAPD-Pediatric													6.01
	CCPD CCPD													6.01
	CCPD-Pediatric													7.01
7.01														7.01
	HOME Hemodialysis													
														8
	Hemodialysis-Pediatric Intermittent Peritoneal													8.01
														9.01
	IPD-Pediatric CAPD													9.01
10	CAPD-Pediatric													
	CCPD													10.01
	CCPD-Pediatric													11.01
11.01	OTHER BILLABLE SERVICES													11.01
12														12
	Inpatient Dialysis Method II Home Patient	1										+	+	12
														13
	ESAs (included in Renal Department) ARANESP (see instructions)													14
	Other													
														16 17
	Total (sum of lines 2 through 16)													
	Medical Educational Program Costs													18
19	Total Renal Costs (line 17 plus line 18)													19

	TAND INDIRECT RENAL DIALYSIS COST ALLOCATION - TICAL BASIS									PROVIDER CCN:	PERIOD: FROM	WORKSHEET I-3	
											ТО	_	
Check a	pplicable box: [] Renal Dialysis Department []	Home Program Di							_				
	COMPOSITE PAYMENT SERVICES	RELATE	AL AND D COSTS EQUIPMENT (% OF TIME)	DIRECT CARE S RNs (HOURS)	PATIENT GALARY OTHERS (HOURS)	EMPLOYEE BENEFITS DEPARTMENT (SALARY)	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	PEDIATRIC MEDICAL SUPPLIES (REQUIST.)	ROUTINE ANCILLARY SERVICES (CHARGES)	SUB- TOTAL	OVERHEAD (ACCUM. COST)	
	Total Renal Department Costs		_			-		,	,,,,,	-	The second second		1
	MAINTENANCE												<u> </u>
2	Hemodialysis												2
	AKI-Hemodialysis												2.01
	Hemodialysis-Pediatric												2.02
													3
	AKI- Intermittent Peritoneal												3.01
	IPD-Pediatric												3.02
3.02	TRAINING												3.02
4	Hemodialysis												4
	Hemodialysis-Pediatric	1											4.01
	Intermittent Peritoneal												5
	IPD-Pediatric												5.01
6	CAPD												6
-	CAPD-Pediatric												6.01
7	CCDP	1											7
7.01	CCPD-Pediatric												7.01
	HOME												
- 8	Hemodialysis												8
	Hemodialysis-Pediatric												8.01
9	Intermittent Peritoneal												9
9.01	IPD-Pediatric												9.01
	CAPD												10
	CAPD-Pediatric												10.01
	CCDP												11
11.01	CCPD-Pediatric												11.01
	OTHER BILLABLE SERVICES												
12	Inpatient Dialysis Treatments												12
	Method II Home Patient												13
	ESAs												14
15	ARANESP (see instructions)												15
16	Other												16
17	Total Statistical Basis												17
18	Unit Cost Multiplier (line 1 ÷ line 17)												18

4090	(Cont.)				rok	M CM3-23	32-10								03-23
	JTATION OF AVERAGE COST PER TREATMENT UTPATIENT RENAL DIALYSIS									PROVIDER O	CCN:	PERIOD: FROM TO		WORKSHEET	' I-4
Check a	applicable box: [] Renal Dialysis Department	[] Home Program	n Dialysis							J					
		Number	Total Cost (from	Average Cost of Treatments	Number	Number	Number	Total Program Expenses	Total	Total	Total	Average Payment Rate		Average Payment Rate	
		of Total Treatments	Wkst. I-2, col. 11)	(col. 2 ÷ col. 1)	of Program Treatments	of Program Treatments 4.01	of Program Treatments 4.02	(see instructions)	Program Payment	Program Payment 6.01	Program Payment 6.02	(col. 6 ÷ col. 4)	(col. 6.01 ÷ col. 4.01)	(col. 6.02 ÷ col. 4.02) 7.02	
1	Maintenance - Hemodialysis	1		,		4.01	4.02	3	0	0.01	0.02	,	7.01	7.02	1
1.01	Maintenance - AKI Hemodialysis														1.01
2	Maintenance - Peritoneal Dialysis														2
2.01	Maintenance - AKI Peritoneal Dialysis														2.01
3	Training - Hemodialysis														3
4	Training - Peritoneal Dialysis														4
5	Training - CAPD														5
6	Training - CCPD														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis														8
9	Home Program - CAPD	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
10	Home Program - CCPD														10
11	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instructions)														11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)														12

12-22	FOF	RM CMS-2552-10)		409	90 (Cont.)
CALCU	JLATION OF REIMBURSABLE		PROVIDER CCN:	PERIOD:	WORKSHEET I-5	
BAD D	EBTS - TITLE XVIII - PART B			FROM		
				TO		
	B 1.0					
	Description					
1	Total expenses related to care of program beneficiaries (see instructions)					1
				1 .	1	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)			1	2	2
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)					2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)					2.01
2.03	Total payment due (see instructions)					2.02
2.04	Outlier payments					2.03
2.01	Outlier payments					2.01
3	Deductibles billed to Medicare (Part B) patients (see instructions)					3
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)					3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)					3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)					3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)					4
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)					4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)					4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)					4.03
5	Bad debts for deductibles and coinsurance, net of bad debt recoveries					5
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of	bad debt recoveries for				5.01
	services rendered on or after 1/1/2011 but before 1/1/2012					
5.02	1 ,	bad debt recoveries for				5.02
	services rendered on or after 1/1/2012 but before 1/1/2013					
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of	bad debt recoveries for				5.03
	services rendered on or after 1/1/2013 but before 1/1/2014					
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries	s for				5.04
	services rendered on or after 1/1/2014					5.05
5.05	(5.05
6						7
	Allowable bad debts for dual eligible beneficiaries (see instructions) Net deductibles and coinsurance billed to Medicare (Part B) patients (see instru					8
9	1, 7,	uctions)				9
10	8 1 7 \					10
11	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, lin	ue 33)				11
	Remindusable dad debts (see instituctions) (transfer to worksheet E, 1 art B, in	ie 33)				- 11
DADT	II. CALCULATION OF FACILITY OPECIFIC COMPOSITE COST DED	CENTA CE				
	II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PER	CENTAGE			- T	12
13	Total allowable expenses (see instructions) Total composite costs (from Wkst. I-4, col. 2, line 11)					12
14						13
14	Facility specific composite cost percentage (fine 13 divided by fine 12)					14
DART	HI ECDD DAVMENTS INFORMATION ONLY					
	III - ESRD PAYMENTS - INFORMATION ONLY				ı	15
	Low volume payment amount (see instructions) TDAPA					16
	TPNIES					17
	CRA TPNIES					18
	HDPA					19
	PPA					20
20						20

	ATION OF GENERAL SERVICE COSTS TO JNITY MENTAL HEALTH CENTERS			PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART I					
								COMPONENT CCN:	то	-	
PART I	ALLOCATION OF GENERAL SERVICE CO	STS TO COMMUNITY	MENTAL HEALTH	CENTER COST CENT	ΓERS				•	•	
COM	MPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.)		ED COSTS MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
1	Administrative and General	U	1	2	4	4A	5	6	/	8	-
	Skilled Nursing Care			-			-				2
	Physical Therapy										2
	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
12	Family Counseling										12
	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
	Durable Medical Equipment-Sold										20
	All Others										21
	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.

01-22				FO	RM CMS-25	52-10					4090 ((Cont.
ALLOCATION OF GENERAL SERVICE COSTS COMMUNITY MENTAL HEALTH CENTERS											WORKSHEET J-1, PART I (CONT.)	
									COMPONENT CCN:			
PART I - ALLOCATION OF GENERAL SERVIC	E COSTS TO CON	AMUNITY MENT	TAL HEALTH CE	NTER COST CEN	TERS	1	1		_	1		т —
COMPONENT COST CENTER (omit cents)	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	_
1 Administrative and General	,	10	11	12	13	14	13	10	17	10	17	\vdash
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												9
10 Group Therapy												10
11 Individualized Activity Therapies												1
12 Family Counseling												12
13 Diagnostic Services												1.3
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												1.5
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)

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

TU/U	(Cont.)			1	Oldivi Civib-2552	2-10					01-22
ALLOC	CATION OF GENERAL SERVICE COSTS TO							PROVIDER CCN:	PERIOD:	WORKSHEET J-1,	
COMM	UNITY MENTAL HEALTH CENTERS								FROM	PART I	
								COMPONENT CCN:	TO		
PART I	- ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMUNIT	Y MENTAL HEALTH	CENTER COST CENT	ΓERS						
							INTERN &				
					PARA-		RESIDENT		ALLOCATED		
CO	MPONENT COST CENTER		INTERNS &	RESIDENTS	MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
	(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
		PROGRAM	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	
		20	21	22	23	24	25	26	27	28	
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
	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	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	WORKSHEET J-1, PART II	
COMMONTT MENTAL HEALTH CENTERS							COMPONENT CCN:		- TAKI II	
PART II - ALLOCATION OF GENERAL SERVICE C	OSTS TO COMMUN	JITV MENTAL HEALT	H CENTER COST CEN	TERS - STATISTICAL F	PASIS					
TART II - ALEOCATION OF GENERAL SERVICE C	OSTS TO COMMON		PITAL	IERS - STATISTICAL I	ASIS					T
			ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
		BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN	
CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	SERVICE	
(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	
(omit cents)		FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	
	0	1	2	4	4A	5	6	7	8 8	1
1 Administrative and General	Ů	·		· ·			v	,	· ·	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

Rev. 4

1070	(Cont.)				101	CIVI CIVID 255	2 10						0) 1.
	CATION OF GENERAL SERVICE COSTS TO IUNITY MENTAL HEALTH CENTERS									PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART II (CONT.)	
COMM	IUNII I MENTAL HEALTH CENTERS									COMPONENT CCN:		- FART II (CONT.)	
										COMPONENT CCN:	10	=	
PARTI	II - ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMI	INITY MENTA	I HEALTH CEN	TER COST CENT	EDS - STATISTIC	'AI BASIS				!	-	
TAKTI	II-ALLOCATION OF GENERAL SERVICE CO	DSTS TO COMMI	I MENTA	I	MAIN-	LKS-STATISTIC	AL DAGIS				1	NON-	Т
					TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
		HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
	CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
	(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
	(onit cens)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
		9	10	11	12	13	14	15	16	17	18	19	1
1	Administrative and General								_	·			1
2	Skilled Nursing Care											1	2
3	Physical Therapy											1	3
4	Occupational Therapy											1	4
5	Speech Pathology												5
6	Medical Social Services											1	6
7	Respiratory Therapy											1	7
- 8	Psychiatric/Psychological Services											1	8
9	Individual Therapy											1	9
	Group Therapy												10
	Individualized Activity Therapies												11
	Family Counseling												12
	Diagnostic Services												13
	Approved Patient Training & Education												14
	Prosthetic and Orthotic Devices												15
	Drugs and Biologicals												16
	Medical Supplies												17
	Medical Appliances												18
	Durable Medical Equipment-Rented												19
	Durable Medical Equipment-Sold												20
	All Others												21
	Totals (sum of lines 1-21)	 											22
	Total Cost to be Allocated Linit Cost Multiplier (see instructions)	ļ										4	23
-24				•							1		2/

	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART II (CONT.)	(Colling)
								COMPONENT CCN.	10	-	
PART I	I - ALLOCATION OF GENERAL SERVICE C	OSTS TO COMMUNITY	MENTAL HEALTH CE	ENTER COST CENTER	RS - STATISTICAL BASI	IS			<u>.</u>	-1	
	CORF COST CENTER (omit cents)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & SALARY & FRINGES (ASSIGNED TIME) 21	PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	24	25	26	27	28	
1	Administrative and General	20	21	22	23	24	23	20	21	26	1
	Skilled Nursing Care										2
	Physical Therapy										3
	Occupational Therapy										4
	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)										22
	Total Cost to be Allocated		ļ								23
2.4	Unit Cost Multiplian (see instructions)	1									2.4

4090	Cont.)			ГС	JRM CM3-2332.	-10					01-22
COMPU	TATION OF COMMUNITY MENTAL HE	ALTH CENTER PROV	TDER COSTS					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET J-2, PART I	
PART I	- APPORTIONMENT OF CMHC COST CE	ENTERS									
		(From		Ratio of		Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Pt. I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
		col. 28)	Charges	(col. 1 ÷ col. 2)	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	
		1	2	3	4	5	6	7	8	9	1
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
	Individualized Activity Therapy										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
	Medical Appliances										18
	All Others (1)										19
20	Totals (sum of lines 1 through19)	•									20

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

											()
COMP	UTATION OF COMMUNITY MENTAL HEALTH CENTER PROVI	DER COSTS						PROVIDER CCN:	PERIOD:	WORKSHEET J-2,	
									FROM	PART II	
								COMPONENT CCN:	TO		
									-		
PART	II - APPORTIONMENT OF COST OF CMHC PROVIDER SERVICE	S FURNISHED BY	SHARED HOSP	ITAL DEPARTMEN	TS						
		(From				Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Ratio of	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Pt. I,	Component	Costs to	Component	costs (col. 3	Component	costs (col. 3	Component	costs (col. 3	
		col. 29)	Charges	Charges (1)	Charges (2)	x col. 4)	Charges (2)	x col. 6)	Charges (2)	x col. 8)	
		1	2	3	4	5	6	7	8	9	1
21	Respiratory Therapy										21
22	Physical Therapy										22
23	Occupational Therapy										23
24	Speech Pathology										24
25	Medical Supplies Charged to Patients										25
26	Implantable Devices Charged to Patients										26
27	Drugs Charged to Patients										27
28	Total (sum of lines 21-28)										28
29	Total component costs. Add the amount from Pt. I, line 20,										29
	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.

4090 ((Cont.) FORM	FORM CMS-2552-10								
	LATION OF REIMBURSEMENT SETTLEMENT COMMUNITY IL HEALTH CENTER PROVIDER SERVICES	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-3						
Check applicable box:	[] Title V le [] Title VIII [] Title XIX			'						
00.11	1 ()			PROGRAM COST						
1	Cost of component services (from Wkst. J-2, Pt. II, line 29)				1					
2	PPS payments received excluding outliers				2					
3	Outlier payments				3					
	Primary payer payments				4					
	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	n a charge			8					
	basis had such payment been made in accordance with 42 CFR 413.13(e)									
	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9							
	Total customary charges (see instructions)				10					
	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									
	Total reasonable cost (from line 5)				13					
	Part B deductible billed to program patients				14					
	Net cost (line 13 minus line 14)				15					
	Excess of reasonable cost over customary charges (from line 12)				16					
	Subtotal (line 15 minus line 16)				17					
	80 percent of costs (80% of line 17) (see instructions)				18					
	Actual coinsurance billed to program patients (from provider records)				19					
	Net cost less actual billed coinsurance (line 17 minus line 19)				20					
	Allowable bad debts (from provider records) (see instructions)				21					
	Adjusted reimbursable bad debts (see instructions)				22					
	Allowable bad debts for dual eligible beneficiaries (see instructions)				23					
	Net reimbursable amount (see instructions)				24					
	Other adjustments (see instructions) (specify)				25					
	Pioneer ACO demonstration payment adjustment (see instructions)				25.50					
	Demonstration payment adjustment amount before sequestration				25.99					
	()				26					
	Sequestration adjustment (see instructions)				26.01					
26.02	Demonstration payment adjustment amount after sequestration				26.02					

28 Tentative settlement (for contractor use only)

29 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)
30 Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)

11-16]	FORM CMS-2552	-10			4090) (Cont.)	
	TO HOSPITAL-BASED COMMUNITY MENTAI ENDERED TO PROGRAM BENEFICIARIES	. HEALTH	PROVIDER (CCN:	PERIOD: FROM	WORKSHEET J-4		
			COMPONEN	T CCN:	то			
Check	1		1	_	<u>I</u>	<u>I</u>		
applicable	[] Title XVIII							
boxes:								
					Pa	art B		
DESCRIPTION					1	2		
					mm/dd/yyyy	Amount		
1 Total interim payment	ts paid to providers						1	
2 Interim payments pay	able on individual bills, either						2	
	omitted to the intermediary, for							
	he cost reporting periods. If							
none, write "NONE", 3 List separately each re			ı	.01			3.01	
lump sum adjustment			Program	.02			3.02	
based on subsequent i			to	.02			3.03	
the interim rate for th			Provider	.03			3.04	
cost reporting period.			Tiovidei	.05			3.05	
date of each payment.				.50			3.50	
If none, write "NONE			Provider	.51			3.51	
or enter zero (1).	- ,		to	.52			3.52	
			Program .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 payment	ts (sum of lines 1, 2, and 3.99)						4	
(transfer to Workshee	et J-3, line 27)							
	D BY INTERMEDIARY		т_		Ī	ī		
5 List separately each to			Program	.01			5.01	
settlement payment af			to	.02			5.02	
Also show date of each			Provider Provider	.03			5.03	
If none, write "NONE or enter zero (1).	ž ₉ ''		to	.50			5.50 5.51	
or enter zero (1).			Program	.52			5.52	
Subtotal (sum of lines	5.01-5.40 minus		Tiogram	.32			3.32	
sum of lines 5.50-5.98				.99			5.99	
6 Determine net settlem			Program	.,,,			3.77	
(balance due) based o			to					
report (see instruction			Provider	.01			6.01	
	, . ,		Provider	1				
			to					
			Program	.02			6.02	
7 Total Medicare liabili	ty			-			7	
(see instructions)								
8 Name of Contractor		Contractor Number		NPR I	Date (Month, Day, Year)		8	
					R Date (Month, Day, Year)			

⁽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.

ANALY	SIS OF HOSPITAL-BASED EE COSTS								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET K	
cos	T CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER 5	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9)	
-	GENERAL SERVICE COST CENTERS	1	2	3	4	3	0	/	0	9	10	_
1	Capital Related Costs-Bldg and Fixt.											1
	Capital Related Costs-Movable Equip.											2
	Plant Operation and Maintenance											3
	Transportation - Staff											4
	Volunteer Service Coordination											5
	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
	Inpatient - Respite Care			i				i				8
	VISITING SERVICES											
9	Physician Services											9
	Nursing Care											10
	Nursing Care-Continuous Home Care											11
12	Physical Therapy											12
	Occupational Therapy											13
	Speech/ Language Pathology											14
	Medical Social Services											15
	Spiritual Counseling											16
	Dietary Counseling											17
	Counseling - Other											18
	Home Health Aide and Homemaker											19
	HH Aide & Homemaker - Cont. Home Care											20
	Other											21
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
	Analgesics											23
	Sedatives / Hypnotics											25
	Other - Specify											25
	Durable Medical Equipment/Oxygen											26
	Patient Transportation											27
	Imaging Services											28
	Labs and Diagnostics											29
30	Medical Supplies			1	1			1	1			30
	Outpatient Services (including E/R Dept.)											31
	Radiation Therapy											32
	Chemotherapy			i								33
	Other											34
	HOSPICE NONREIMBURSABLE SERVICE											
35	Bereavement Program Costs											35
	Volunteer Program Costs											36
	Fundraising											37
	Other Program Costs											38
	Total (sum of lines 1 thru 38)		Ì	1				1				39

HOSPICE COMPENSATION ANALYS SALARIES AND WAGES	IS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-1	
SALARIES AND WAGES								COMPONENT CCN:		-	
								COMPONENT CCN:	10	-	
				MEDICAL							
COST CENTER DESCRIPTIONS		ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)		TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
` ,	ľ	1	2	3	4	5	6	7	8	9	
GENERAL SERVICE COST C	ENTERS										
 Capital Related Costs-Bldg and 	Fixt.										1
2 Capital Related Costs-Movable	Equip.										2
3 Plant Operation and Maintenand	ce										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	e 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 Homem	aker										19
20 HH Aide & Homemaker - Cont	. Home Care										20
21 Other											21
OTHER HOSPICE SERVICE	COSTS										
22 Drugs, Biological and Infusion											22
23 Analgesics	17										23
24 Sedatives / Hypnotics											24
25 Other - Specify											25
26 Durable Medical Equipment/Ox	vgen										26
27 Patient Transportation	70										27
28 Imaging Services											28
29 Labs and Diagnostics											29
30 Medical Supplies											30
31 Outpatient Services (including I	E/R Dept.)										31
32 Radiation Therapy	1 /										32
33 Chemotherapy											33
34 Other											34
HOSPICE NONREIMBURSA	BLE 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

	E COMPENSATION ANALYSIS EMPLOYEE							PROVIDER CCN:	PERIOD:	WORKSHEET K-2	
BENEF.	TS (PAYROLL RELATED)							GOV MONIENT GOV	FROM	-	
								COMPONENT CCN:	10	-	
				MEDICAL							
COS	T CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
	(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	()	1	2	3	4	5	6	7	8	9	1
	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
	Occupational Therapy										13
14	1 17										14
15											15
16											16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker										19
	HH Aide & Homemaker - Cont. Home Care										20
	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services					t				†	28
	Labs and Diagnostics					t				†	29
	Medical Supplies					t				+	30
31	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy					 				1	32
	Chemotherapy										33
	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										34
25	Bereavement Program Costs										35
36						 				+	36
	Fundraising					 				+	37
	č					-				+	38
	Other Program Costs Total (sum of lines 1 thru 38)					-				+	38
	for the amount in column 0 to Wket K, column 2										39

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

	E COMPENSATION ANALYSIS ACTED SERVICES/PURCHASED SERVICES							PROVIDER CCN: HOSPICE CCN:	PERIOD: FROMTO	WORKSHEET K-3	<u> </u>
								HOSFICE CCIV.			
COS	T 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
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
4	Transportation - Staff										4
	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
	Inpatient - General Care										7
- 8	Inpatient - Respite Care										8
	VISITING SERVICES										
	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services										15
	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
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy										32
33	Chemotherapy	1								1	33
	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
	Volunteer Program Costs										36
	Fundraising										37
38	Other Program Costs										38
	Total (sum of lines 1 thru 38)										39
- 37	(or inies i una 50)							1		1	

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

40-635

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

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

	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS							PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART I	
PARTI	- ALLOCATION OF GENERAL SERVICE COSTS	S TO HOSPICE C	OST CENTERS								
	HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7, line	HOSPICE TRIAL BALANCE (1)		PITAL ED COSTS MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT	
	Administrative and General	6	U	1	2	4	4A	3	0	/	1
- 1	Inpatient - General Care	7									2
2	Inpatient - General Care	8									3
	Physician Services	9									4
	Nursing Care	10									5
	Nursing Care-Continuous Home Care	11									6
	Physical Therapy	12							+	+	7
	Occupational Therapy	13							+	+	8
	Speech/ Language Pathology	14									9
	Medical Social Services	15									10
	Spiritual Counseling	16									11
	Dietary Counseling	17							+	+	12
	Counseling - Other	18							+	+	13
	Home Health Aide and Homemaker	19							+	+	14
	HH Aide & Homemaker - Cont. Home Care	20							+	+	15
	Other	21									16
	Drugs, Biological and Infusion Therapy	22									17
	Analgesics	23									18
	Sedatives / Hypnotics	24									19
	Other - Specify	25									20
	Durable Medical Equipment/Oxygen	26									21
22	Patient Transportation	27									22
23	Imaging Services	28									23
24	Labs and Diagnostics	29									24
	Medical Supplies	30									25
26	Outpatient Services (including E/R Dept.)	31									26
	Radiation Therapy	32									27
28	Chemotherapy	33									28
	Other	34									29
30	Bereavement Program Costs	35									30
31	Volunteer Program Costs	36									31
32	Fundraising	37									32
33	Other Program Costs	38									33
3.4	Totals (sum of lines 1-33) (2)										3.4

35 Unit Cost Multiplier (see instructions)

⁽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.

	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS				200				PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-5, PART I (Cont.)	(001111)
									HOSPICE CCN:	то	_	
PART I	- ALLOCATION OF GENERAL SERVICE COS	TS TO HOSPICE CO	OST CENTERS									
												1
	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	
		8	9	10	11	12	13	14	15	16	17	1
1	Administrative and General											1
2	Inpatient - General Care											2
	Inpatient - Respite Care											3
	Physician Services											4
	Nursing Care											5
	Nursing Care-Continuous Home Care											6
	Physical Therapy											7
	Occupational Therapy											8
	Speech/ Language Pathology											9
	Medical Social Services											10
	Spiritual Counseling											11
	Dietary Counseling											12
	Counseling - Other											13
	Home Health Aide and Homemaker											14
	HH Aide & Homemaker - Cont. Home Care											15
	Other											16
	Drugs, Biological and Infusion Therapy											17
	Analgesics											18
	Sedatives / Hypnotics											19
	Other - Specify											20
	Durable Medical Equipment/Oxygen											21
	Patient Transportation											22
	Imaging Services											23
	Labs and Diagnostics											24
	Medical Supplies											25
	Outpatient Services (including E/R Dept.)											26
	Radiation Therapy											27
	Chemotherapy											28
	Other											29
	Bereavement Program Costs											30
	Volunteer Program Costs											31
	Fundraising											32
	Other Program Costs											33
3.4	Totale (sum of lines 1-33) (2)		1			·						3.4

35 Unit Cost Multiplier (see instructions)

⁽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.

.0,0,	(001111)				I OILLII OI	10 2002 10							
	ATION OF GENERAL SERVICE									PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
COSTS	TO HOSPICE COST CENTERS										FROM	PART I (Cont.)	
										HOSPICE CCN:	ТО	_	
DADTI	- ALLOCATION OF GENERAL SERVICE COS	TS TO HOSDICE	COST CENITEDS	2									
TAKTI	- ALLOCATION OF GENERAL SERVICE COS	15 TO HOSFIEL	COST CENTER	,				I	INTERN &	I	I	Т	Т
			NON-				PARA-		RESIDENT		ALLOCATED	TOTAL	
	HOSPICE COST CENTER	OTHER	PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL		COST & POST		HOSPICE	HOSPICE	
	(omit cents)	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	SUBTOTAL	STEPDOWN	SUBTOTAL	A&G (see	COSTS	
	(onit cens)	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)	ADJUST.	(cols. 24 ± 25)	Part II)	(cols. 26 ± 27)	
		,8	19	20	21	22	23	24	25	26	27	28	1
1	Administrative and General										_,		1
	Inpatient - General Care												2
3	Inpatient - Respite Care												3
	Physician Services												4
	Nursing Care												5
	Nursing Care-Continuous Home Care												6
	Physical Therapy											-	7
	Occupational Therapy												8
	Speech/ Language Pathology												9
10	Medical Social Services												10
	Spiritual Counseling												11
	Dietary Counseling												12
	Counseling - Other												13
	Home Health Aide and Homemaker												14
	HH Aide & Homemaker - Cont. Home Care												15
	Other												
	Drugs, Biological and Infusion Therapy												16
	Analgesics												18
19	Sedatives / Hypnotics											-	19
	Other - Specify												20
	Durable Medical Equipment/Oxygen												21
22	Patient Transportation												22
23	Imaging Services												23
24	Labs and Diagnostics												24
25	Medical Supplies												25
	Outpatient Services (including E/R Dept.)												26
	Radiation Therapy												27
28	Chemotherapy	i										1	28
	Other											1	29
30	Bereavement Program Costs											1	
31	Volunteer Program Costs											1	30
	Fundraising	i										1	32
33	Other Program Costs											1	33
34	Totals (sum of lines 1-33) (2)												34

35 Unit Cost Multiplier (see instructions)

⁽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.

	ATION OF GENERAL SERVICE COSTS TO E COST CENTERS STATISTICAL BASIS		PROVIDER CCN:	FROM PART II					
						HOSPICE CCN:	ТО		
							<u> </u>		
PART II	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STA						_		
			ITAL						
		RELATI		EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
F	HOSPICE COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
		(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	4
		1	2	4	5A	5	6	7	
	Administrative and General								1
	Inpatient - General Care								2
	Inpatient - Respite Care								3
	Physician Services								4
	Nursing Care								5
	Nursing Care-Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biological and Infusion Therapy								17
18	Analgesics								18
	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (including E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
	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
26	Unit Cost Multiplior (see instructions)				1	1	1	1	26

	ATION OF GENERAL SERVICE COSTS TO DE COST CENTERS STATISTICAL BASIS							PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART II	
DADTI	I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE C	COST CENTEDS S	TATISTICAL DAS	ric						<u>↓</u>	
TAKT	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	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)	
1	Administrative and General										1
	Inpatient - General Care										2
3	Inpatient - Respite Care										3
	Physician Services										4
	Nursing Care										5
	Nursing Care-Continuous Home Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech/ Language Pathology									1	9
10	Medical Social Services									1	10
11	Spiritual Counseling										11
12	Dietary Counseling										12
13	Counseling - Other									1	13
14	Home Health Aide and Homemaker									1	14
15	HH Aide & Homemaker - Cont. Home Care										15
16	Other										16
17	Drugs, Biological and Infusion Therapy									1	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									1	32
33	Other Program Costs									1	33
	Totals (sum of lines 1-33) (2)									1	34
35	Total cost to be allocated									1	35
36	Unit Cost Multiplier (see instructions)									1	36

	ATION OF GENERAL SERVICE COSTS TO E COST CENTERS STATISTICAL BASIS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROMTO	WORKSHEET K-5, PART II	
PART I	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS	T			•	1	-		
				NON-		n men i a	a promprima	PARA-	
		COCIAI	OTHER	PHYSICIAN	NUMBERIC		& RESIDENTS	MEDICAL	
	HOSPICE COST CENTER	SOCIAL SERVICE	OTHER GENERAL	ANES- THETISTS	NURSING SCHOOL	SALARY & FRINGES	PROGRAM COSTS	EDUCATION (SPECIFY)	
	HOSPICE COST CENTER	(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(SPECIFY) (ASSIGNED	
		SPENT)	(SPECIFY)	TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	
		17	18	19	20	21	22	23	4
	Administrative and General	17	10	17	20	2.1	22	23	+
	Inpatient - General Care								1 2
	Inpatient - Respite Care							-	2
	Physician Services							1	Δ
5	Nursing Care							1	5
6	Nursing Care-Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	67 6 17								17
	Analgesics								18
	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (including E/R Dept.)								26
	Radiation Therapy								27
	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1-33) (2)								34
	Total cost to be allocated								35
36	Unit Cost Multiplier (see instructions)	I	I					1	36

APPOR	TIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
				FROM	PART III	
			HOSPICE CCN:	ТО		
PART I	II - COMPUTATION OF TOTAL HOSPICE SHARED COSTS		•	•		
				Total	Hospice	
		Wkst. C,		Hospice	Shared	
		Part I,	Cost to	Charges	Ancillary	
		col. 9,	Charge	(Provider	Costs	
	COST CENTER	line	Ratio	Records)	(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

40-644 Rev. 3

12-22		1 ORIVI CIVID-2332-10			4070 (Cont.)		
CALCU	JLATION OF HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-6		
			HOSPICE CCN:	TO			
			1			1	
	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.

Rev. 18 40-645

	(Cont.	·	1 Oldvi	CIVID 2332 I				12 22
CALCU	JLATIO1	N OF CAPITAL PAYMENT			PROVIDER CCN:	PERIOD:	WORKSHEET L	
					GOL MONTENIA GOL	FROM		
					COMPONENT CCN:	то		
Check	Т	[] Title V	[] Hospital	[] PPS				
	1.	Title XVIII, Part A	PARHM Demonstration	Cost Met	had			
applicabl	ie	Title XIX	[] CHART Model	[] Cost Met	iiod			
DART I	I - EIII I	Y PROSPECTIVE METHOD	[] CHART Woder					
TAKTI		AL FEDERAL AMOUNT						
	_	DRG other than outlier						1
1.01		4 BPCI Capital DRG other than ou	tlier					1.01
2		DRG outlier payments	illici					2
2.01		4 BPCI Capital DRG outlier payme	ents					2.01
3		1 1 1	days in the cost reporting period (see in	structions)				3
4		er of interns & residents (see instru-	1 01 1	su uctions)				4
- 5	_	et medical education percentage (se						5
6		et medical education adjustment (se	/					6
7	_		Medicare Part A patient days (Workshe	et F Part Δ line 30)	(see instructions)			7
- 8		tage of Medicaid patient days to tot		et E, Turt II iiie 50)	(see instructions)			8
9		f lines 7 and 8	ar days (see histractions)					9
10		able disproportionate share percenta	age (see instructions)					10
11		portionate share adjustment (see in						11
12		prospective capital payments (see in	· · · · · · · · · · · · · · · · · · ·					12
		MENT UNDER REASONABLE C	· · · · · · · · · · · · · · · · · · ·					
1		m inpatient routine capital cost (see						1
2		m inpatient ancillary capital cost (s						2
3		npatient program capital cost (line 1						3
4		l cost payment factor (see instruction	* /					4
5		npatient program capital cost (line 3						5
PART I		PUTATION OF EXCEPTION PA						
1	-	m inpatient capital costs (see instru						1
2		<u> </u>	dinary circumstances (see instructions)					2
3		ogram inpatient capital costs (line 1						3
4	Applic	able exception percentage (see inst	ructions)					4
5	Capita	l cost for comparison to payments (I	line 3 x line 4)					5
6	Percen	tage adjustment for extraordinary ci	ircumstances (see instructions)					6
7	Adjust	ment to capital minimum payment l	evel for extraordinary circumstances (lin	e 2 x line 6)				7
8	Capita	l minimum payment level (line 5 plu	us line 7)					8
9	Curren	t year capital payments (from Part I	, line 12 as applicable)					9
10	Curren	t year comparison of capital minim	um payment level to capital payments (li	ne 8 less line 9)				10
11	Carryo	ver of accumulated capital minimur	n payment level over capital payment					11
	(from)	prior year Worksheet L, Part III, lin	ne 14)					
12	Net co	mparison of capital minimum paym	ent level to capital payments (line 10 plu	ıs line 11)				12
13	Curren	t year exception payment (if line 12	is positive, enter the amount on this line	e)				13
14	Carryo	ver of accumulated capital minimur	n payment level over capital payment					14
	for the	following period (if line 12 is nega	tive, enter the amount on this line)					
15	Curren	t year allowable operating and capi	ital payment (see instructions)					15
16	Curren	t year operating and capital costs (s	see instructions)					16
17	Curren	t year exception offset amount (see	instructions)					17

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		ITAL D COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	GENERAL SERVICE COST CENTERS	U	1	2	2A	4	3	6	/	_
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department									4
	Administrative and General									5
	Maintenance and Repairs									6
	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
	Pharmacy									15
16	Medical Records & Medical Records Library									16
17	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Ed. Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider									42
	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I	
LATICA	OKDIVAKI CIRCOMSTANCES							TO	- I AKI I	
		EXTRA-	CAP	ITAL				10		Т
		ORDINARY		D COSTS						
		CAPITAL	KEERTE	D CODID	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION	
	Cost Center Descriptions	COSTS	FIXTURES	EQUIPMENT	cols. 0-2)	DEPARTMENT	GENERAL	REPAIRS	OF PLANT	
		0	1 IXTORES	2	2A	4	5	6	7	-
	ANCILLARY SERVICE COST CENTERS	U	1	2	ZA	4	3	0	/	_
50	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Diagnostic Radiology-Therapeutic									55
	Radioisotope Radioisotope					-				50
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catherization									59
	Laboratory									60
	PBP Clinical Laboratory Service-Program Only									
										61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									60
	Occupational Therapy									6'
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									7
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									7.
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
91	Emergency									9
	Observation Beds									92
93	Other Outpatient (specify)									93
	Partial Hospitalization Program									93.9

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I	
-		EXTRA- ORDINARY		ITAL D COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	7	_
	Home Program Dialysis									94
	Ambulance Services								+	95
	Durable Medical Equipment-Rented								+	96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)						 	1	†	99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									102
	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition									108
	Pancreas Acquisition									109
110	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
117	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 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
	Cross Foot Adjustments									200
201	Negative Cost Centers									201
202	Total (sum of line 118 and lines 190 through 201)									202
203	Total Statistical Basis									203
204	Unit Cost Multiplier									204

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	Ü		10		12			10	10	1,	
Capital Related Costs-Buildings and Fixtures											1
Capital Related Costs-Movable Equipment											2
4 Employee Benefits Department	1										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 Program											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											
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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	Ü		10		.2	13		13	10		
	Operating Room										1	50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic			ĺ	Ì						1	55
	Radioisotope			ĺ	Ì						1	56
	Computed Tomography (CT) Scan										1	57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catherization											59
60	Laboratory											60
	PBP Clinical Laboratory Service-Program Only											61
	Whole Blood & Packed Red Blood Cells										1	62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
70	Electroencephalography											70
	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											72
73	Drugs Charged to Patients											73
74	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
77	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient (specify)											93
93.99	Partial Hospitalization Program											93.99

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
,	Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	OTHER REIMBURSABLE COST CENTERS	Ü		10	11	12	15	11	13	10	17	
	Home Program Dialysis											94
	Ambulance Services											95
	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. tchng. prgm.)											100
101	Home Health Agency											101
	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
	Gift, Flower, Coffee Shop, & Canteen											190
	Research											191
	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
	Cross Foot Adjustments											200
	Negative Cost Centers											201
202	Total (sum of line 118 and lines 190 through 201)											202
	Total Statistical Basis											203
204	Unit Cost Multiplier											204

12-22				FORM CM3-2	.552-10				4090	(Cont.)
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
Cost Center Descriptions	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS	10	.,	20	2.	22	23	2.	23	20	
Capital Related Costs-Buildings and Fixtures										1
Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										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 Program										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										
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									.	4(
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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I (Cont.)	
									TO		
	Cost Center Descriptions	OTHER GENERAL	NONPHYSICIAN	NURSING	INTERNS & RESIDENTS SALARY AND	INTERNS & RESIDENTS PROGRAM	PARA- MEDICAL EDUCATION	GUDTOTAL	INTERN & RESIDENT COST & POST STEPDOWN	TOTAL	
		SERVICE	ANESTHETISTS	PROGRAM 20	FRINGES	COSTS 22	(SPECIFY) 23	SUBTOTAL	ADJUSTMENTS 25	TOTAL	4
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	-
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catherization										59
60	Laboratory										60
61	PBP Clinical Laboratory Service-Program Only										61
	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
68	Speech Pathology										68
	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
78	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
90											90
	Emergency										91
	Observation Beds Other Outpatient (specify)										92 93
	Partial Hospitalization Program										93.99
95.99	raruai nospitalization Program										93.99

	ATION OF ALLOWABLE COSTS FOR							PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I (Cont.)	
EATRA	ORDINARY CIRCUMSTANCES								TO	PART I (Cont.)	
	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	1
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
	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
	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
102	Opioid Treatment Program										102
	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
	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
	Physicians' Private Offices										192
193	Nonpaid Workers										193
	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
201	Negative Cost Centers										201
	Total (sum of line 118 and lines 190 through 201)										202
203	Total Statistical Basis										203
204	Unit Cost Multiplier										204

4090 ((Cont.)	г	JKW CW3-2332	-10					12-22
	JTATION OF PROGRAM INPATIENT ROUTINE SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART II	
Check applicable box:	[] Title V e [] Title XVIII, Part A [] Title XIX								
	Cost Center Description	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)	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6)	-
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)						<u> </u>		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
	Nursery								43
	Total (sum of lines 30-199)								200

⁽A) Worksheet A line numbers

				I OIGNI CIVID-2332-	10				T070 ((Cont.
			E				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
AL COSTS I	FOR EXTRAORDINART CIRC	UMSTANCES					COMPONENT CCN:		- FART III	
	_									
	[] Hospital									
e										
			Title XIX			T	1	1	-	
						T + 1 Cl	D C CC			
0 .0 .	B 111							T .: .		
Cost Cente	er Description									
					Part 1, col. 20)					4
ANCILLA	DV SEDVICE COST CENTEDS				1		3	4	3	d .
										50
									 	51
										52
									 	53
										54
										55 56
										57
									1	58
Cardiac Ca	atherization									59
Laboratory	y									60
		nly								61
										62
										63
										64
										65
										66
									ļ	67
									<u>_</u>	68
										70
										71
									 	72
										74
									 	75
									+	76
							+		 	77
1	ANCILLA Operating Recovery Labor Roo Anesthesi Radiology Radiology Radiology Computed Magnetic Cardiac C Laborator Pabr Clini Whole Bl Blood Sto Intravenou Respirator Physical T Occupatic Speech P: Electrocan Electrocan Medical S Implantab Drugs Ch Renal Dia ASC (Nio) Other Anc	UTATION OF PROGRAM INPATIENT AND AL COSTS FOR EXTRAORDINARY CIRCULARY COSTS FOR EXTRAORDINARY CIRCULARY COSTS FOR EXTRAORDINARY CIRCULARY SERVICE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTERS OPERATION OF THE COST CENTER OF THE COST CE	UTATION OF PROGRAM INPATIENT ANCILLARY SERVIC AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital [] Hospital [] Hospital [] Hospital ANCILLARY SERVICE COST CENTERS Operating Room Recovery Room Labor Room and Delivery Room Anesthesiology Radiology-Diagnostic Radiology-Diagnostic Radiology-Therapeutic Radioisotope Computed Tomography (CT) Scan Magnetic Resonance Imaging (MRI) Cardiac Catherization Laboratory PBP Clinical Laboratory Service-Program Only Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Occupational Therapy Speech Pathology Electrocardiology Electroc	UTATION OF PROGRAM INPATIENT ANCILLARY SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	UTATION OF PROGRAM INPATIENT ANCILLARY SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital	UTATION OF PROGRAM INPATIENT ANCILLARY SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	UTATION OF PROGRAM INPATIENT ANCILLARY SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital [] Title V [] Title VIII, Part A [] Title XVIII, Part A [] Title XIX Capital Cost for Extraordinary Circumstances Total Charges (from West, 1-1, (from West, 1-2, (from Wes	UTATION OF PROGRAM INPATIENT ANCILLARY SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	PROVIDER CCN. PRODE PROVIDER CCN. PROVIDER CCN. PRODE PROVIDER CCN. PRODE PROVIDER CCN. PROVIDER CCN. PRODE PROVIDER CCN. PROVIDER CCN	URATION OF PECKRAM INVATIENT ANCILLARY SERVICE COMPONENT CCN FROM PERIOD P

⁽A) Worksheet A line numbers

			1014.10						· ·
ATION OF	PROGRAM INPATI	ENT ANCILLARY SERVICE				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
COSTS FO	OR EXTRAORDINAL	RY CIRCUMSTANCES					FROM	PART III (CONT.)	
						COMPONENT CCN:	ТО	, , ,	
	[] Hospital	[] Title V					•	•	
		[] Title XVIII, Part A							
		[] Title XIX							
				Capital Cost for					
				Extraordinary				Program	
				Circumstances	Total Charges	Ratio of Cost		Extraordinary	
Cost Center I	Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
				1	2	3	4	5	1
OUTPATIE	NT SERVICE COST	CENTERS							
Rural Health	n Clinic (RHC)								88
Federally Qu	ualified Health Center	(FQHC)							89
Clinic									90
									91
									92
									93
									93.99
		T CENTERS							
									94
									95
			·						96
		·-	·						97
		·-	·						98
Total (sum o	of lines 50 through 199	9)							200
	Cost Center Cost	ATION OF PROGRAM INPATI COSTS FOR EXTRAORDINAL [] Hospital Cost Center Description DUTPATIENT SERVICE COST Rural Health Clinic (RHC) Federally Qualified Health Center Clinic Emergency Deservation Beds Other Outpatient (specify) Partial Hospitalization Program DTHER REIMBURSABLE COST Home Program Dialysis Ambulance Services Durable Medical Equipment-Rent Durable Medical Equipment-Sold Other Reimbursable (specify)	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital [] Title V [] Title XVIII, Part A [] Title XIX Cost Center Description DUTPATIENT SERVICE COST CENTERS Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC) Clinic Emergency Dobservation Beds Dther Outpatient (specify) Partial Hospitalization Program DTHER REIMBURSABLE COST CENTERS Home Program Dialysis Ambulance Services Durable Medical Equipment-Rented Durable Medical Equipment-Rented Durable Medical Equipment-Sold	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital [] Title V [] Title XVIII, Part A [] Title XIX Cost Center Description DUTPATIENT SERVICE COST CENTERS Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC) Clinic Emergency Observation Beds Other Outpatient (specify) Partial Hospitalization Program DTHER REIMBURSABLE COST CENTERS Home Program Dialysis Ambulance Services Durable Medical Equipment-Rented Durable Medical Equipment-Sold Durable Medical Equipment-Sold Durable Medical Equipment-Sold Durable Medical Equipment-Sold Durable Medical Equipment-Sold Durable Medical Equipment-Sold	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital	ATION OF PROGRAM INPATIENT ANCILLARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital	ATION OF PROGRAM INPATIENT ANCIL LARY SERVICE COSTS FOR EXTRAORDINARY CIRCUMSTANCES [] Hospital [] Title V [] Title XVIII, Part A [] Title XIX Cost Center Description [] Title XIX Capital Cost for Extraordinary Circumstances (from Wast, L.) (from

⁽A) Worksheet A line numbers

ANALY	SIS OF HOSPITAL-BASED RHC/FQHC COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET M-1	`
							FROM		
						COMPONENT CCN:	ТО		
Cl1	pplicable box: [] Hospital-based RHC [] Hospital-based FQHC								
Спеск а	pplicable box: Hospital-based RHC Hospital-based PQHC	T	T	I		RECLASSIFIED	1	NET EXPENSES	т —
						TRIAL		FOR	
		COMPEN-		TOTAL	RECLASS-	BALANCE		ALLOCATION	
			OTHER COSTS				ADJUGTMENTS		
		SATION	OTHER COSTS 2	(col. 1 + col. 2) 3	IFICATIONS	(col. 3 + col. 4)	ADJUSTMENTS	(col. 5 + col. 6)	4
	FACILITY HEALTH CARE STAFF COSTS	I	2	3	4	5	6	/	_
	Physician Physician								4
2	Physician Assistant								1
	•								
3	Nurse Practitioner								+ -
4	Visiting Nurse								4
5	Other Nurse								- 3
6	Clinical Psychologist								
- 7	Clinical Social Worker								- /
- 8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								,
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								4
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services								22
	(sum of lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27									27
28	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

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

	ATION OF OVERHEAD PTIAL-BASED RHC/FOHC SE	PVICES			PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-2	
10 1105	THAL-BASED KHCH QHE SEI	CVICES			COMPONENT CCN:	то	 	
Check ap	pplicable box: [] Hospi	tal-based RHC []	Hospital-based FQHC			<u> </u>		
VISITS A	AND PRODUCTIVITY		•					
			Number			Minimum	Greater of	
			of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
			Personnel	Visits	Standard (1)	x col. 3)	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 through	3)						4
5	Visiting Nurse							5
6	Clinical Psychologist							6
7	Clinical Social Worker							7
7.01	Medical Nutrition Therapist (FQ)	HC only)						7.01
7.02	Diabetes Self Management Train	ing (FQHC only)						7.02
8	Total FTEs and Visits (sum of lir	es 4 through 7)						8
9	Physician Services Under Agreer	nents						9
DETERN	MINATION OF ALLOWABLE O	OST APPLICABLE TO	HOSPITAL-BASED F	RHC/FQHC SERVI	ICES			
10	Total costs of health care services	(from Worksheet M-1,	column 7, line 22)					10
11	Total nonreimbursable costs (from	n Worksheet M-1, colun	nn 7, line 28)					11
12	Cost of all services (excluding ov	erhead) (sum of lines 10	and 11)					12
13	Ratio of hospital-based RHC/FQ							13
14	Total hospital-based RHC/FQHC	overhead (from Worksl	neet M-1, column 7, line	: 31)				14
15	Parent provider overhead allocate	ed to facility (see instruc	tions)					15
16	Total overhead (sum of lines 14 a	nd 15)						16
17	Allowable Direct GME overhead	(see instructions)	•	•	•			17
		•	•	•	•			18
19	Overhead applicable to hospital-	ased RHC/FQHC service	es (line 13 x line 18)					19
20	Total allowable cost of hospital-b	ased RHC/FOHC service	es (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 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

03-23		I OKWI CIV	13-2332-10		4030(Com.)
	ON OF REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET M-3	
SETTLEMEN	T FOR HOSPITAL-BASED RHC/FQHC SER	VICES		FROM	_	
			COMPONENT CCN:	TO		
Check	[] Hospital-based RHC	[] Title V				
applicable	[] Hospital-based FQHC	[] Title XVIII				
boxes:		[] Title XI				
DETERMINA'	TION OF RATE FOR HOSPITAL-BASED R	HC/FQHC SERVICES				
1 Total	allowable cost of hospital-based RHC/FQHC	services (from Worksheet M-2, line 20)	1			1
2 Cost	of injections/infusions and their administration	(from Worksheet M-4, line 15)				2
3 Total	allowable cost excluding injections/infusions (line 1 minus line 2)				3
4 Total	visits (from Worksheet M-2, column 5, line 8)					4
5 Physi	cians visits under agreement (from Worksheet	M-2, column 5, line 9)				5
6 Total	adjusted visits (line 4 plus line 5)	_	·			6
7 Adju	sted cost per visit (line 3 divided by line 6)	_	·			7
	-					

			Calculation of Limit (1)		1
		Payment Limit	Payment Limit	Payment Limit	
		Period 1	Period 2	Period 3	
		1	2	3	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6, or your contractor)				8
	Rate for Program covered visits (see instructions)				9
	LATION OF SETTLEMENT				
	Program covered visits excluding mental health services (from contractor records)				10
11	6 (1 1)				11
12	Program covered visits for mental health services (from contractor records)				12
13					13
14					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 (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)				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 injections/infusions (see instructions)				20
21	Program cost of injections/infusions and their administration (from Worksheet M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)				22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				25.50
25.99	Demonstration payment adjustment amount before sequestration				25.99
26	Net reimbursable amount (see instructions)				26
26.01	Sequestration adjustment (see instructions)				26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments				27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program line 26 minus lines 26.01, 26.02, 27, and 28				29
30	Protested amounts (nonallowable cost report items) in accordance with CMS				30
	Pub. 15-2, chapter 1, section 115.2				

⁽¹⁾ Lines 8 through 14: Fiscal year providers use columns 1 and 2 (and column 3, if applicable). Calendar year providers with one rate in effect for the entire cost reporting period use column 2 only.

Rev. 19 40-661

	TATION OF HOSPITAL-BASED RHC/FQHC VAC	CINE	COST		PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-4	
					COMPONENT CCN:			
Check applicab boxes:	[] Hospital-based RHC [] Hospital-based FQHC] Title V] Title XVIII] Title XI			<u> </u>		
			•	PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES 2	COVID-19 VACCINES 2.01	MONOCLONAL ANTIBODY PRODUCTS 2.02	
1	Health care staff cost (from Worksheet M-1, column	7, line	10)		_			1
2	Ratio of injection/infusion staff time to total							2
	health care staff time							
3	Injection/infusion health care staff cost (line 1 x line 2	.)						3
4	Injections/infusions and related medical supplies costs	3						4
	(from your records)							
5	Direct cost of injections/infusions (line 3 plus line 4)							5
6	Total direct cost of the hospital-based RHC/FQHC (fr	om						6
	Worksheet M-1, column 7, line 22)							
7	Total overhead (from Worksheet M-2, line 19)							7
8	Ratio of injection/infusion direct cost to total direct							8
	cost (line 5 divided by line 6)							
9	Overhead cost - injection/infusion (line 7 x line 8)							9
10	Total injection/infusion costs and their							10
	administration costs (sum of lines 5 and 9)							
11	Total number of injections/infusions							11
- 12	(from your records)							10
12	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered							12
13	to Program beneficiaries							13
13.01	Number of COVID-19 vaccine injections/infusions							13.01
13.01	administered to MA enrollees							13.01
14	Program cost of injections/infusions and their adminis	tratio	n					14
• •	costs (line 12 times the sum of lines 13 and 13.01, as a							
		FF	/		COST OF			
					INJECTIONS /			
					INFUSIONS AND			
					ADMINISTRATION			
				1	2	1		
15	Total cost of injections/infusions and their							15
	administration costs (sum of columns 1, 2, 2.01, and 2	2.02, li	ine 10)					
	(transfer this amount to Worksheet M-3, line 2)							
16	Total Program cost of injections/infusions and their							16
	administration costs (sum of columns 1, 2, 2.01, and 2	2.02, li	ine 14)					
	(transfer this amount to Worksheet M-3, line 21)							

40-662 Rev. 19

11-16	FORM (CMS-2552-10		409	0 (Cont.)
ANALY	SIS OF PAYMENTS TO HOSPITAL-BASED	PROVIDER C		WORKSHEET M-5	
RHC/FQ	HC FOR SERVICES RENDERED		FROM		
TO PRO	GRAM BENEFICIARIES	COMPONENT	CCN: TO		
Charles	pplicable box: [] Hospital-based RHC [] Hospital-based FQHO				
Спеск а	pplicable box: [] Hospital-based RHC [] Hospital-based PQHC			Part B	
	DESCRIPTION		1	2	
			mm/di	d/ivy Amount	
1	Total interim payments paid to hospital-based RHC/FQHC				1
2	Interim payments payable on individual bills, either				2
	submitted or to be submitted to the intermediary, for				
	services rendered in the cost reporting periods. If				
	none, write "NONE", or enter zero.				
3	List separately each retroactive	_	.01		3.01
	lump sum adjustment amount	Program	.02		3.02
	based on subsequent revision of	to	.03		3.03
	the interim rate for the	Provider	.04		3.04
	cost reporting period. Also show		.05		3.05
	date of each payment.		.50		3.50
	If none, write "NONE",	Provider	.51		3.51
	or enter zero (1).	to	.52		3.52
		Program	.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 Worksheet M-3, line 27)				4
	TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative	Program	.01		5.01
	settlement payment after desk review.	to	.02		5.02
	Also show date of each payment.	Provider	.03		5.03
	If none, write "NONE,"	Provider	.50		5.50
	or enter zero (1).	to	.51		5.51
		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	Program			
	(balance due) based on the cost	to			
	report (see instructions). (1)	Provider	.01		6.01
		Provider			
		to			
		Program	.02		6.02
7	Total Medicare liability (see instructions)	•			7
8	Name of Contractor		Contractor Number	NPR Date	8
				(Month/Day/Year)	1
					1

⁽¹⁾ On lines 3, 5, and 6, where an amount is due component 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.

	SSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES OSPITAL-BASED FQHC	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET N-1					
COS	T CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
GENER	AL SERVICE COST CENTERS	1	2	3	4	3	0	/	
	Cap Rel Costs-Bldg and Fix								1
	Cap Rel Costs-Myble Equip								2
	Employee Benefits					1			3
	Administrative and General								4
	Plant Operation and Maintenance								5
	Janitorial								6
7	Medical Records								7
- 8	Subtotal - Administrative Overhead								8
9	Pharmacy								9
10	Medical Supplies								10
11	Transportation								11
	Other General Service								12
13	Subtotal - Total Overhead								13
	CARE COST CENTERS								
23	Physician								23
	Physician Services Under Agreement								24
25	Physician Assistant								25
	Nurse Practitioner								26
	Visiting Registered Nurse								27
	Visiting Licensed Practical Nurse								28
29	Certified Nurse Midwife								29
	Clinical Psychologist								30
	Clinical Social Worker								31
	Laboratory Technician								32
	Reg Dietician/Cert DSMT/MNT Educator								33
	Physical Therapist								34
	Occupational Therapist								35
	Other Allied Health Personnel								36
37	Subtotal - Direct Patient Care Services								37

RECLASSIFICATI FOR HOSPITAL-B	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES BASED FQHC					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET N-1	
	R DESCRIPTIONS it cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	_
	PASS THROUGH COSTS								
	occal Vaccines & Med Supplies								47
	Vaccines & Med Supplies								48
	9 Vaccine & Med Supplies								48.10
	nal Antibody Products								48.11
	Reimbursable Pass through Costs								49
OTHER FQHC SEI									
	Excluded Services								60
	c & Screening Lab Tests								61
62 Radiology									62
63 Prosthetic									63
64 Durable N	Medical Equipment								64
65 Ambulanc									65
66 Telehealth									66
	arged to Patients								67
	Care Management								68
69 Other									69
	Other FQHC Services								70
NONREIMBURSA	ABLE COST CENTERS								
77 Retail Pha									77
78 Other Nor									78
	Non-Reimbursable Costs								79
100 TOTAL (s	sum of lines 13, 37, 49, 70, and 79)								100

1050 (2011)	1 011.1 01.15 2002 10		01 23
CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT	PROVIDER CCN:	PERIOD:	WORKSHEET N-2
		FROM:	
	COMPONENT CCN:	TO:	

									Total Visits		Title XVIII Visits		Title XVIII Costs		
		From Wkst. N-1, col. 7,	Direct Cost by Practitioner from Wkst. N-1	Total Medical & Mental Health Visits by Practitioner	Other Direct Care Costs & Pharmacy Costs (see	General Service Cost (see	Total Costs by Practitioner	Average Cost Per Visit by Practitioner	Medical Visits by Practitioner	Mental Health Visits by Practitioner	Medical Visits by Practitioner	Mental Health Visits by Practitioner	Medical Cost by Practitioner	Mental Health Cost by Practitioner	
	Positions	line:	1 1	2	instructions)	instructions)	5	6	7	8	Q	10	11	12	4
1	Physician	23		2		· ·	,	0		0	,	10	11	12	
2	Physician Services Under Agreement	24													
3	Physician Assistant	25													
4	Nurse Practitioner	26													_
5	Visiting Registered Nurse	27													5
6	Visiting Licensed Practical Nurse	28													6
7	Certified Nurse Midwife	29													7
8	Clinical Psychologist	30													8
	Clinical Social Worker	31													9
10	Reg Dietician/Cert DSMT/MNT Educator	33													10
11	Totals														11
12	Unit Cost Multiplier														12
13	Total Cost Per Visit														13

TATION OF HOSPITAL-BASED FQHC VACCINE COST		PROVIDER CCN:	PERIOD:	WORKSHEET N-3	
			FROM:		
		COMPONENT CCN:	TO:		
	VACCINES	VACCINES	VACCINES	PRODUCTS	
	1	2	2.01	2.02	
Health care staff cost (from Worksheet N-1, column 7, sum of					1
lines 23, and 25 through 36)					
Ratio of injection/infusion staff time to total					2
health care staff time					
Injection/infusion health care staff cost (line 1 x line 2)					3
Injections/infusions and related medical supplies cost (from Worksheet N-1,					4
					5
					6
					7
					8
•					
					9
Total cost of injections/infusions and their					10
					11
					12
					13
					13.01
v					
					14
					15
(Sum of Columns 1, 2, 2.01, and 2.02, line 10)					
Total Medicare cost of injections/infusions and their	+				16
	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36) Ratio of injection/infusion staff time to total health care staff time	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36) Ratio of injection/infusion staff time to total health care staff time Injection/infusion health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, 48.10, and 48.11, respectively) Direct cost of injections/infusions (line 3 + line 4) Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8) Total administrative overhead (from Worksheet N-1, column 7, line 8) Ratio of injections/infusion direct cost to total direct cost (line 5 / line 6) Overhead cost - injections/infusions (line 7 x line 8) Total cost of injections/infusions (from your records) Cost per injections/infusions (from your records) Cost per injections/infusions administered to Medicare beneficiaries Number of COVID-19 vaccine injections/infusions administration costs furnished to Medicare/MA beneficiaries (line 12 times the sum of lines 13 and 13.01, as applicable) Total cost of injections/infusions and their administration costs furnished to Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14)	PNEUMOCOCCAL VACCINES 1 2 2 1 2 2 2 2 2 2	PNEUMOCOCCAL VACCINES PNEUMOCOCCAL VACCINES PNEUMOCOCCAL VACCINES PNEUMOCOCCAL VACCINES PNEUMOCOCCAL VACCINES 1 2 2.01 Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36) Ratio of injection/infusion staff time to total health care staff cost (line 1 x line 2) Injections/infusions and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, 48, 10, and 48.11, respectively) Direct cost of injections/infusions (line 3 + line 4) Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8) Total administrative overhead (from Worksheet N-1, column 7, line 8) Total cost of injections/infusions (line 7 x line 8) Total cost of injections/infusions and their administration (sum of lines 5 and 9) Total number of injections/infusions administered to Medicare beneficiaries Number of injections/infusions administered to Medicare beneficiaries Number of injections/infusions administered to Medicare beneficiaries Number of injections/infusions administration costs (sum of COVID-19 vaccine injections/infusions administration costs furnished to Medicare/MA beneficiaries (jine 12 times the sum of lines 13 and 13.01, as applicable) Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10)	PREUMOCOCCAL INFLUENZA COVID-19 MONOCLONAL ANTIBODY PRODUCTS VACCINES VACCINES VACCINES VACCINES VACCINES VACCINES PRODUCTS VACCINES VACC

CALCU	LATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET N-4	
		COMPONENT CCN:	FROM: TO:	—	
		COMPONENT CCN:	10:		
			J		
1	FQHC PPS Amount (see instructions)				1
2	Medicare cost of injections/infusions and administration (From Worksheet N-3, line 16)				2
3	Medicare advantage supplemental payments (for information only)				3
4	Total (sum of lines 1 through 2)			4	
5	Primary payer payments			5	
6	Total amount payable for program beneficiaries (line 4 minus line 5)				6
7	Coinsurance billed to program beneficiaries				7
8	Net Medicare reimbursement excluding bad debts (line 6 minus line 7)				8
9	Allowable bad debts (see instructions)				9
10	Adjusted reimbursable bad debts (see instructions)				10
11	Allowable bad debts for dual eligible beneficiaries (see instructions)				11
12	Subtotal (line 8 plus line 10)				12
13	Other adjustments (specify) (see instructions)				13
13.99	Demonstration payment adjustment amount before sequestration				13.99
14	Amount due hospital-based FQHC prior to the sequestration adjustment (see instructions)				14
15	Sequestration adjustment (see instructions)				15
15.25	Sequestration for non-claims based amounts (see instructions)				15.25
16	Amount due hospital-based FQHC after sequestration adjustment (see instructions)				16
16.01	Demonstration payment adjustment amount after sequestration				16.01
17	Interim payments (from Worksheet N-5, col. 2, line 4)				17
18	Tentative settlement (for contractor use only)				18
19	Balance due hospital-based FQHC/program (line 16 minus lines 16.01, 17 and 18)	·-			19
20	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chap	•		20	

40-668 Rev. 17

ANALY	SIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERI	ED PRO	/IDER CCN:	PERIOD: FROM:	WORKSHEET N-5	<u> </u>
		COM	PONENT CCN:	TO:		
				1	Part B	
				mm/dd/yyyy	Amount	
	Description			1	2	
1	Total interim payments paid to hospital-based FQHC					1
2	Interim payments payable on individual bills, either submitted or to be submitted to for services rendered in the cost reporting period. If none, write "NONE" or enter a					2
3	List separately each retroactive		.01			3.01
	lump sum adjustment amount based		.02			3.02
	on subsequent revision of the	Program to	.03			3.03
	interim rate for the cost reporting period.	Provider	.04			3.04
	Also show date of each payment.		.05			3.05
	If none, write "NONE" or enter a zero. (1)		.50			3.5
			.51			3.51
		Provider to	.52			3.52
		Program	.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01 through 3.49 minus sum of lines 3.50 through 3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)					4
	(transfer to Wkst. N-4, line 17)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement	Program to	.01			5.01
	payment after desk review. Also show	Provider	.02			5.02
	date of each payment.		.03			5.03
	If none, write "NONE" or enter a zero. (1)		.50			5.5
		Provider to	.51			5.51
		Program	.52			5.52
	Subtotal (sum of lines 5.01 through 5.49 minus sum of lines 5.50 through 5.98)		.99			5.99
6	Determine net settlement amount (balance	Program to p	rovider .01			6.01
	due) based on the cost report (1)	Provider to p	rogram .02			6.02
7	Total Medicare program liability (see instructions)					7

Rev. 15 40-669

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

ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
GENED	AL SERVICE COST CENTERS	1	2	3	4	5	6	7	
	Cap Rel Costs-Bldg & Fixt*								1
	Cap Rel Costs-Myble Equip*								2
	Employee Benefits Department*								3
	Administrative & General *								4
	Plant Operation and Maintenance*								5
	Laundry & Linen Service*								6
	Housekeeping*								7
	Dietary*								8
9	Nursing Administration*								9
10	Routine Medical Supplies*								10
11	Medical Records*								11
12	Staff Transportation*								12
13	Volunteer Service Coordination*								13
14	Pharmacy*								14
	Physician Administrative Services*								15
	Other General Service*								16
17	Patient/Residential Care Services								17
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care-Contracted**								25
	Physician Services**								26
	Nurse Practitioner**								27
28	Registered Nurse**								28
	LPN/LVN**								29
	Physical Therapy**								30
	Occupational Therapy**								31
32	Speech/ Language Pathology**								32
	Medical Social Services**								33
	Spiritual Counseling**								34 35
	Dietary Counseling**								35
	Counseling - Other**								36
	Hospice Aide and Homemaker Services**								37
	Durable Medical Equipment/Oxygen**								38
39	Patient Transportation**								39

^{*} Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

^{**} See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
		SALARIES 1	OTHER 2	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL 5	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
DIRECT	PATIENT CARE SERVICE COST CENTERS (Cont.)	1	-	,	·	J	Ů	,	
	Imaging Services**								40
	Labs and Diagnostics**								41
	Medical Supplies-Non-routine**								42
	Drugs Charged to Patients**								42.50
	Outpatient Services**								43
44	Palliative Radiation Therapy**								44
	Palliative Chemotherapy**								45
46	Other Patient Care Services**								46
NONRE	EIMBURSABLE COST CENTERS								
60	Bereavement Program *								60
61	Volunteer Program *								61
	Fundraising*								62
	Hospice/Palliative Medicine Fellows*								63
	Palliative Care Program*								64
	Other Physician Services*								65
	Residential Care *								66
	Advertising*								67
	Telehealth/Telemonitoring*								68
	Thrift Store*								69
	Nursing Facility Room & Board*								70
	Other Nonreimbursable*								71
100	Total								100

^{*} Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

^{**} See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

1050 (Cont.)	1,	51011 CIVID 2552	10					05 10
	SIS OF HOSPITAL-BASED HOSPICE COSTS E CONTINUOUS HOME CARE					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-1	
						HOSPICE CCN:	то		
		1		SUBTOTAL					т —
				(col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(\text{col. } 5 \pm \text{col. } 6)$	
		1	2	3	4	5	6	7	1
DIRECT	PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38 39
39	Patient Transportation								39
40	Imaging Services								40
	Labs and Diagnostics								41
	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
	Other Patient Care Svc								46
100	Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 50

	SIS OF HOSPITAL-BASED HOSPICE COSTS E ROUTINE HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROMTO	WORKSHEET O-2	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	1
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

	SIS OF HOSPITAL-BASED HOSPICE COSTS E INPATIENT RESPITE CARE	PROVIDER CCN:	FROM						
						HOSPICE CCN:	то		
			1	SUBTOTAL					T
				(col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(col. 5 \pm col. 6)$	
		1	2	3	4	5	6	7	1
DIRECT	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
	Physical Therapy								30
31	Occupational Therapy								31
	Speech/ Language Pathology								32
33	Medical Social Services								33
	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
	Drugs Charged to Patients								42.50
43	Outpatient Services								43
	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
	Other Patient Care Svc								46
100	Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-4	
					HOSPICE CCN:	то		
			SUBTOTAL					T
			(col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
	SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(\text{col. } 5 \pm \text{col. } 6)$	
	1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
42.50 Drugs Charged to Patients								42.50
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy								45
46 Other Patient Care Svc								46
100 Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

4090 ((Cont.) FORM	CMS-2552-10			10-18
COST A	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET EX	XPENSES FOR ALLOCATION		FROM		
		HOSPICE CCN:	TO		
			GENERAL		
		HOSPICE	SERVICE		
		DIRECT	EXPENSES	TOTAL	
		EXPENSES	FROM WKST B, PART I	EXPENSES	
		(see instructions)	(see instructions)	(sum of cols. 1 + 2)	
	Descriptions	1	2	3	
	AL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt				1
2	Cap Rel Costs-Mvble Equip				2
	Employee Benefits				3
4	Administrative & General				4
5	Plant Operation and Maintenance				5
6					6
7	Housekeeping				7
8	Dietary				8
9	Nursing Administration				9
10	Routine Medical Supplies				10
11	Medical Records				11
12	Staff Transportation				12
13	Volunteer Service Coordination				13
14	Pharmacy				14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
	OF CARE				
	Hospice Continuous Home Care				50
	Hospice Routine Home Care				51
	Hospice Inpatient Respite Care				52
	Hospice General Inpatient Care				53
NONRE	IMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
62	Fundraising				62
63	Hospice/Palliative Medicine Fellows				63
64	Palliative Care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth/Telemonitoring				68
69	Thrift Store				69
70	Nursing Facility Room & Board				70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
100	Total				100

COST	ALLOCATION - HOSPITAL-BASED HOSPIC	PROVIDER CCN:		PERIOD: FROM		WORKSHEET O-6 PART I						
							HOSPICE CCN:		то			
		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	
	Descriptions	0	1	2	3	3A	4	5	6	7	8	7
GENER	AL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies											10
	Medical Records											11
	Staff Transportation											12
	Volunteer Service Coordination											13
	Pharmacy											14
	Physician Administrative Services											15
	Other General Service											16
	Patient/Residential Care Services											17
	OF CARE											
	Hospice Continuous Home Care											50
	Hospice Routine Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care											53
	EIMBURSABLE COST CENTERS											-
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center				†				+		+	99
	Total											100

COST A								PROVIDER CCN:		PERIOD: FROM		0-6
							HOSPICE CCN:	=	TO		PART I	
		NURSING ADMINIS- TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS- PORTATION	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT / RESIDENT CARE SVCS	TOTAL	
	Descriptions	9	10	11	12	13	14	15	16	17	18	-
GENER	AL SERVICE COST CENTERS	Ź	10	**	.2	15		13	10	1,	10	
	Cap Rel Costs-Bldg & Fixt											\top
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance											5
	Laundry & Linen Service											6
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies			1								10
	Medical Records											11
	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services								7			15
16	Other General Service (specify)											16
17	Patient/Residential Care Services										1	17
LEVEL	OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
	Inpatient Respite Care										Ί	52
	General Inpatient Care											53
NONRE	IMBURSABLE COST CENTERS											
	Bereavement Program											60
61	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store										4	69
	Nursing Facility Room & Board											70
	Other Nonreimbursable (specify)											71
	Negative Cost Center											99
100	Total											100

COST A	ST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS						PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM TO		WORKSHEET O-6 PART II	
		CAP REL BLDG & FIX (Square	CAP REL MVBLE EQUIP (Dollar	EMPLOYEE BENEFITS DEPARTMENT (Gross	RECONCIL-	ADMINIS- TRATIVE & GENERAL (Accum.	PLANT OP & MAINT (Square	LAUNDRY & LINEN	HOUSE- KEEPING (Square	DIETARY (In-Facil-		
	and Country Descriptions	Feet)	Value)	Salaries)	IATION	Cost)	Feet)	ity Days)	Feet)	ity Days) 8	4	
	ost Center Descriptions AL SERVICE COST CENTERS	1		3	4A	4	5	6	/	8	+-	
	Cap Rel Costs-Bldg & Fixt										- ,	
	Cap Rel Costs-Bidg & Fixt Cap Rel Costs-Myble Equip			-							2	
	Employee Benefits										3	
	Administrative & General			-							4	
	Plant Operation and Maintenance			+		+ +		-			5	
	Laundry & Linen Service			+		+ +					6	
	Housekeeping			+		+ +				-	7	
	Dietary			-		+					8	
	Nursing Administration			-		+					9	
	Routine Medical Supplies										10	
	Medical Records										11	
	Staff Transportation										12	
	Volunteer Service Coordination										13	
	Pharmacy										13	
	Physician Administrative Services										15	
	Other General Service										16	
	Patient/Residential Care Services										17	
	OF CARE										1.	
	Hospice Continuous Home Care										50	
	Hospice Routine Home Care										51	
52	Hospice Inpatient Respite Care										5.	
NONDE	Hospice General Inpatient Care IMBURSABLE COST CENTERS										٥.	
	Bereavement Program					ļ					60	
	Volunteer Program			 		 					62	
	Fundraising Hospice/Palliative Medicine Fellows			+		+					63	
	Palliative Care Program			+		+ +					64	
	Other Physician Services			+		+ +					65	
	Residential Care										66	
	Advertising										67	
	Telehealth/Telemonitoring			+		+ +					68	
	Thrift Store			+		+ +					69	
	Nursing Facility Room & Board										70	
	Other Nonreimbursable										7	
	Negative Cost Center										99	
	Cost to be allocated (per Wkst. O-6, Part I)										10	
	Unit cost multiplier			+		_		-		+	10	

	LLOCATION - HOSPITAL-BASED HOSPICE G	GENERAL SERVICE	COSTS STATISTIC		TUVI CIVIS 2002		PROVIDER CCN: HOSPICE CCN:		PERIOD: FROMTO	_	WORKSHEET O- PART II	-6
		NURSING ADMINIS- TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS- PORTATION (Mileage)	VOLUNTEER SVC COOR- DINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMIN SERVICES (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENT CARE SVCS (In-Facil- ity Days)	TOTAL	
	ost Center Descriptions	9	10	11	12	13	14	15	16	17	18	
	AL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance	⊣										5
	Laundry & Linen Service	_										6
	Housekeeping	⊣										7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies]							10
	Medical Records											11
	Staff Transportation											12
	Volunteer Service Coordination											13
	Pharmacy											14
	Physician Administrative Services											15
	Other General Service										_	16
	Patient/Residential Care Services											17
	OF CARE											
	Continuous Home Care											50
	Routine Home Care											51
	Inpatient Respite Care											52
	General Inpatient Care											53
	IMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services						ļ					65
66	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center											99
	Cost to be allocated (per Wkst. O-6, Part I)											100
101	Unit cost multiplier				l							101

APPORT	TIONMENT OF HOSPITAL-BASED HOSPICE	SHARED SERVICE	COSTS BY LEV	EL OF CARE					PROVIDER CCN:	PERIOD:	WORKSHEET O-7	
										FROM		
									HOSPICE CCN:	TO		
		Wkst. C,	Cost to	C	harges by LOC (fre	om Provider Reco	rds)		Shared Servic	e Costs by LOC		
		Pt. I, col. 9,	Charge					HCHC	HRHC	HIRC	HGIP	1
		line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
(Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	1
	ANCILLARY SERVICE COST CENTERS											
1	Physical Therapy	66										
2	Occupational Therapy	67										
3	Speech/ Language Pathology	68										1
4	Drugs, Biological and Infusion Therapy	73										4
5	Durable Medical Equipment/Oxygen	96										1
6	Labs and Diagnostics	60										- (
7	Medical Supplies	71										T '
8	Outpatient Services (including E/R Dept.)	93										5
9	Radiation Therapy	55										
10	Other	76										10
11	Totals (sum of lines 1 through 10)									Î	1	T 1

Rev. 10 40-681

4090 ((Cont.) FOR	RM CMS-2552-10				11-16
CALCU	JLATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	PR	OVIDER CCN:	PERIOD: FROM	WORKSHEET O-8	
		HC	OSPICE CCN:	то	-	
		 	TITLE XVIII	TITLE XIX		
		<u> </u>	MEDICARE	MEDICAID 2	TOTAL 3	4
HOSPIC	CE CONTINUOUS HOME CARE		1	2	3	
1	Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 11)					1
2	Total unduplicated days (Wkst. S-9, col. 4, line 10)					2
3	Total average cost per diem (line 1 divided by line 2)					3
4	Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)					4
5	Program cost (line 3 times line 4)					5
HOSPIC	CE ROUTINE HOME CARE					
6	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)					6
7	Total unduplicated days (Wkst. S-9, col. 4, line 11)					7
- 8	Total average cost per diem (line 6 divided by line 7)					8
9	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)					9
10	Program cost (line 8 times line 9)					10
HOSPIC	CE INPATIENT RESPITE CARE					
11	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)					11
12	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12
13	Total average cost per diem (line 11 divided by line 12)					13
14	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)					14
15	Program cost (line 13 times line 14)					15
HOSPIC	CE GENERAL INPATIENT CARE					
16	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)					16
17	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17
18	Total average cost per diem (line 16 divided by line 17)					18
19	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)					19
20	Program cost (line 18 times line 19)					20
TOTAL	HOSPICE CARE					
21	Total cost (sum of line 1 + line 6 + line 11 + line 16)					21
22	Total unduplicated days (Wkst. S-9, col. 4, line 14)					22
23	Average cost per diem (line 21 divided by line 22)					23