Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 41, Form CMS-2540-10

Centers for Medicare and Medicaid Services (CMS)

Transmittal 6 **Date: September 2014**

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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Cost Reporting Periods Ending on or After September 30, 2014.

This transmittal updates Chapter 41, Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Reports, Form CMS-2540-10 to clarify and correct existing instructions. The effective dates vary.

Revisions include:

- Worksheet S-2, Part I, removed line 40.
- Worksheet D-1, Part II, clarified instruction for line 2.
- Worksheet H-4, Part II, clarified instructions for line 31.
- Worksheet I-3, Part II, clarified instructions for line 15.
- Worksheet J-3, clarified instruction for lines 17.01 and 20.
- Addition of Edits 1091S, 1010D, 2000E and 2005E.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after

September 30, 2014.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

Pub 15-2-41

CHAPTER 41

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT FORM CMS-2540-10

Section

SKILLED NURSING FACILITY AND SKILLED NURSING
FACILITY HEALTH CARE COMPLEX COST REPORT
FORM CMS-2540-10

Section

MED-ED	-	Medical Education
MSA	-	Metropolitan Statistical Area
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NF	-	Nursing Facility
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
PBP	-	Provider-Based Physician
PEP	-	Partial Episode Payment
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SNF	-	Skilled Nursing Facility
WKST	-	Worksheet

4101 RECOMMENDED SEQUENCE FOR COMPLETING A SNF COST REPORT

4101.1 Recommended Sequence for Completing a SNF or SNF Health Care Complex - Full Cost Report.

Part I - Departmental Cost Adjustments and Cost Allocation

Step No.	Worksheet	
1	S-2	Read §4104. Complete entire worksheet.
2	S-3	Read §4105. Complete all worksheets.
3	S-7	Read §4109. Complete entire worksheet.
4	A	Read §4113. Complete columns 1 through 3, lines 1 through 100.
5	A-6	Read §4114. Complete, if applicable.
6	A	Read §4113. Complete columns 4 and 5, lines 1 through 100.
7	A-7	Read §4115. Complete entire worksheet.
8	A-8-1	Read §4117. Complete entire worksheet.
9		
10	A-8	Read §4116. Complete entire worksheet.
11	A	Read §4113. Complete columns 6 and 7, lines 1 through 100.
12	B (Parts I & II), B-1, and B-2	Read §4120 and §4121. Complete all worksheets entirely.

Part II - Departmental Cost Distribution and Cost Apportionment

Step No.	Worksheet	
1	C	Read §4123. Complete entire worksheet.
2	D	Read §4124. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for *the* SNF and *the* nursing facility (NF).
3	D-1	Read §4125. A separate worksheet must be completed for each applicable health care program for *the* SNF and *the* NF.

4102. SEQUENCE OF ASSEMBLY

All providers using Form CMS-2540-10 must adhere to the sequence *of worksheets set forth below in filing their annual cost report*. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

Worksheet	Part	Full Cost Report
S	I ,II &III	X
S-2	I & II	X
S-3	I, II, III, & IV	X
S-4		X
S-5		X
S-6		X
S-7		X
S-8		X
A		X
A-6		X
A-7		X
A-8		X
A-8-1		X
A-8-2		X
B	I	X
B	II	X
B-1		X

Worksheet	Part	Full Cost Report
B-2		X
C		X
D		X
D-1		X
E	I	X
E	II	X
E-1		X
G		X
G-1		X
G-2		X
G-3		X
H Through H-5		X
I Through I-5		X
J-I Through J-4		X
K Through K-6		X

4103. WORKSHEET S - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly.

4103.1 Part I – Cost Report Status.--This section is to be completed by the provider and contractor as indicated on the worksheet.

Lines 1 through 3--The provider must check the appropriate box to indicate on line 1 or 2, column 1, whether this cost report is being filed electronically or manually. For electronic filing, indicate on line 1, column 2 the date and on line 1, column 3 the time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3, column 1 the number of times the cost report has been amended.

Line 4, Column 1--The contractor must enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 5, Column 1--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 6, Column 1--Enter the 5 position Contractor Number.

Lines 7 and 8, Column 1--If this is an initial cost report, enter "Y" for yes in the box on line 7. If this is a final cost report, enter "Y" for yes in the box on line 8. If neither, leave both lines 7 and 8 blank. An initial report is the very first cost report for a particular provider *CMS certification number (*CCN*)*. A final cost report is a terminating cost report for a particular provider CCN.

Line 9, Column 1--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.

Line 10, Column 1--If this is a reopened cost report (response to line 4, column 1 is "4"), enter the number of times the cost report has been reopened.

Line 11, Column 1--Enter the software vendor code for the software used by the contractor to process this cost report. Use the format "X99", where X is the alpha character representing a specific cost report transmittal and 99 is the two digit software vendor code.

4103.2 Part II - Certification.--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

4103.3 Part III - Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the program. Transfer settlement amounts as follows:

	From			
Skilled Nursing Facility Component	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX
Skilled Nursing Facility Line 1	Wkst. E, Part II, Line 33	Wkst. E, Part I, Line 15	Wkst. E, Part I, Line 29	Wkst. E, Part II, Line 33
Nursing Facility Line 2	Wkst. E, Part II Line 33	N/A	N/A	Wkst. E, Part II, Line 33
ICF/MR Line 3	N/A	N/A	N/A	Wkst. E, Part II, Line 33
SNF-Based Home Health Agency Line 4	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34	Wkst. H-4, Part II, Col. 1 Line 34	Wkst. H-4, Part II, Col. 2 Line 34	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34
SNF-Based RHC Line 5	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based FQHC Line 6	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based CMHC Line 7	Wkst. J-3, Col. 1, Line 20	N/A	Wkst. J-3, Col. 1, Line 20	Wkst J-3, Col. 1, Line 20

4104. WORKSHEET S-2 - PART I SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider.

Lines 1 and 2.--Enter the address of the skilled nursing facility.

Line 3.--Indicate your county in column 1. Enter in column 2 the Core Based Statistical Area (CBSA) code. Enter in column 3, a “U” or “R” designating urban or rural.

Lines 4 through 12.--On the appropriate lines and columns indicated, enter the names, provider identification numbers, and certification dates of the skilled nursing facility (SNF) and its various components, if any. For each health care program, indicate the payment system applicable to the SNF and its various components by entering "p" (prospective payment system), "o" (indicating cost reimbursement), or "n" (for not applicable) respectively.

Line 4.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR section 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1819 of the Social Security Act. Skilled Nursing Facility cost reports, reimbursed under title XVIII must use the Prospective Payment System.

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1919 of the Social Security Act.

Line 6.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR *440.155* that has been issued a separate identification number indicating that it meets the requirements of §1905 of the Social Security Act.

Line 7.--This is a SNF based HHA that has been issued a *CCN* and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one SNF based HHA, subscript this line and report the required information for each HHA.

Lines 8 & 9.--This is a SNF-based RHC/FQHC that meets the requirements of §1861(aa) of the Act.

Line 10.--This is a SNF-based community mental health center that has been issued a separate identification number. See § 1861(ff) of the Social Security Act.

Line 11.--This is any other SNF-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 12.--This is a SNF-based Hospice that meets the requirements of §1861(dd) of the Social Security Act.

Line 13.--For any component type not identified on lines 4 through 12, enter the required information in the appropriate column. Subscript this line accordingly to accommodate multiple *SNF-based* CORFs (lines 13.00-13.09), OPTs (lines 13.10-13.19), OOTs (lines 13.20-13.29) and OSPs (lines 13.30-13.39).

Line 14.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations which generally cover a consecutive 12-month period of operations. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. The ONLY provision for an extension of the cost report due date is identified in 42 CFR 413.24(f) (2) (ii).

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 5 months following the effective date or termination of your agreement or change of ownership.

Line 15.--Enter in column 1, a number from the list below which indicates the type of ownership or auspices under which the SNF is conducted.

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other *
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other *
7 = Governmental, Federal
8 = Governmental, City-County
9 = Governmental, County
10 = Governmental, State
11 = Governmental, Hospital District
12 = Governmental, City
13 = Governmental, Other *

* Where an "other" item is selected, please specify in column 2.

Lines 16 through 18.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Line 19.--If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for No.

Line 19.01.--If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for No.

Lines 20 through 23.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-1, Chapter 1, regarding depreciation).

Lines 20, 21, and 22.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 23.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 25 through 28.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 29 through 36.--Indicate for each component the type of service that qualifies for the exception.

Line 37.--Indicate whether the provider is licensed in a State that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 38.--Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and SNF's to cover the cost of being sued for malpractice.

Line 39.-- A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The Occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 40.-- *Removed and reserved.*

Line 41.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 42.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence – often providers will manage their own funds or purchase a policy referred to as captive insurance, *that provides* providers *with* excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 43.--Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes, or "N" for no, in column 1

EXHIBIT 1

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____
NUMBER _____
FYE _____

PREPARED BY _____
DATE PREPARED _____
SNF INPATIENT _____ SNF Part B _____
Subprovider_____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

4105. WORKSHEET S-3 - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In accordance with 42 CFR 413.20(a), and 42 CFR 413.24(a), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to *the* SNF, *the* NF, *the* ICF/MR, *and SNF based* HHA*s*, CMHC*s*, OLTC*s* and hospice*s*. The data to be maintained, depending on the services provided by the component, include the number of beds, the number of bed days available, the number of inpatient days/visits, the number of discharges, the average length of stay, the number of admissions, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period.

Column 2.--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

NOTE: An institution or institutional complex may only change the bed size of its SNF and/or its NF up to two times per cost reporting *period*. The two changes *must* occur as follows; once on the first day of the beginning of its cost reporting *period*; and again on the first day of a single cost reporting quarter within that same cost reporting *period*, in order to effect one of the combinations set forth in §2337.2.

Columns 3 through 6.--Enter the number of inpatient days/visits for all classes of patients for each component by program.

Column 7.--Enter the total number of inpatient days for each component. The total in column 7 must equal the sum of columns 3 through 6.

Columns 8 through 11.--Enter the number of discharges, including deaths, for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

Column 12.--Enter the total number of discharges (including deaths) for all classes of patients for each component.

Columns 13 through 16.--The average length of stay is calculated as follows:

a. Column 13, lines 1, 2 & 7	Column 3 divided by column 8
b. Column 14, lines 1 & 7	Column 4 divided by column 9
c. Column 15, lines 1, 2, 3, & 7	Column 5 divided by column 10
d. Column 16, lines 1, 2, 3, 5 & 7	Column 7 divided by column 12
e. Column 16, line 8	Column 7 (line 8 minus line 4) divided by column 12

EXCEPTION: Where the skilled nursing facility is located in a State that *licenses* the provider as an SNF regardless of the level of care given for Titles V and XIX patients combine the statistics on lines 1 and 2.

Columns 17 through 21.--Enter the number of admissions (from your records) for each component by program.

Columns 22 and 23.--The average number of employees (full-time equivalent) for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first *week of a* payroll *for* the beginning of each quarter and divide the sum by *160 (*four times the number of hours in the standard work *week)*. When semiannual data are used, add the total number of hours worked by all employees on the first *week of a* payroll *period for* the first and seventh months of the period, and divide th*e* sum by *80 (*two times the number of hours in the standard work *week)*. Enter the average number of paid employees in column 22 and the average number of non-paid worker's in column 23 for each component, a*s* applicable.

4105.1 Part II - SNF Wage Index Information.--*This part provides for the collection of skilled nursing facility and nursing facility data to develop a SNF wage index in accordance with the Social Security Act Amendments of 1994 (P.L. 103-432).* In order to collect the data necessary to develop a SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 100.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 100.

Line 3.--Enter the total physician and physician assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--If you are a member of a chain or other related organization, as defined in CMS Pub. 15-1, §2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 5.--Enter the sum of lines 2 through 4.

Line 6.--Subtract line 5 from line 1 and enter the result.

Line 7.--Enter the total of Worksheet A, column 1, line 33. This amount represents other long term care.

Line 8.--Enter the total of Worksheet A, column 1, line 70. If this line is subscripted to accommodate more than one HHA, also enter the total of the subscripted lines.

Line 9.--Enter the amount from Worksheet A, column 1, line 73.

Line 10.--Enter the amount from Worksheet A, column 1, line 83.

Line 11.--Enter the amount from Worksheet A, column 1, lines 14, 72, 74, 84, and lines 90 through 95.

Line 12.--Enter the sum of lines 7 through 11.

Line 13.--Line 6 minus line 12 and enter the result.

Line 14.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v) (5) of the Act and 42 CFR 413.106. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract management services, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

In addition, if you have no contracted labor as defined above or management contract services; enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

Line 15.--Enter from your records the amount paid under contract for physician services for Part A only related directly to the SNF and/or NF. This includes Part A physician services from the home office allocation and/or from related organizations.

Line 16.--Enter the salaries and wage related costs (as defined on lines 17 and 18 below) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the SNF and/or NF, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries excluded on line 4. This figure is based on recognized methods of allocating an individual's home office salary to the SNF and/or NF. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the SNF and/or NF, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: All wage-related costs, including amounts related to excluded areas and physician services should be included on lines 17 and 18.

Line 17.--Enter the total core wage related costs as described in Part IV. Only the total cost of the wage related costs that are considered fringe benefits may be directly charged to each cost center provided the costs are reported in column 2 and not column 1 of Worksheet A. For purposes of determining the wage related costs for the wage index, a facility must use generally accepted accounting principles (GAAP). Continue to use Medicare payment principles on all other areas to determine allowable fringe benefits.

Line 18.--Enter the total of all wage related costs that are considered an exception to the core list. A detailed list of each additional wage related core must be shown in Part IV. In order for a wage related cost to be considered an exception, it must meet the following tests:

a. The costs are not listed on Part IV,

b. The cost is reasonable and prudent,

c. The individual wage related cost exceeds 1 percent of total salaries after the direct excluded salaries are removed,

d. The wage related cost is a fringe benefit and has not been furnished for the convenience of the provider, and

e. The wage related costs that are fringe benefits, where required, have been reported as wages to Internal Revenue Service, (e.g., the unrecovered cost of employee meals, education costs, auto allowances).

Wage related cost exceptions are not to include those wage related costs that are required to be reported to the Internal Revenue Service, since they are considered as salary or wages, i.e., loan forgiveness, sick pay accruals. Include these costs in total salaries reported on line 1 of this worksheet. The total wage related costs listed on this line must agree with the total of all other wage related costs listed in Part IV.

Line 19.--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on line 12.

Line 20.-- Enter the total wage-related costs applicable to Part A Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 21.-- Enter the total wage-related costs applicable to Part B Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 22.--Enter the total adjusted wage related costs, line 17 plus line 18, minus lines 19 through 21.

Column 2.--Enter on each line, as appropriate, the **salary** portion of any reclassification made on Worksheet A-6.

Column 3.--Enter the result of column 1 plus or minus column 2.

Column 4.--Enter on each line the number of **paid** hours corresponding to the amount reported in column 3.

NOTE: The hours must reflect any change reported in column 2. On call hours are not included in the total paid hours. Overtime hours are calculated as one hour when an employee is paid time and a half.

Column 5.--Enter on line 1 through line 16 the average hourly wage resulting from dividing column 3 by column 4.

4105.2 Part III - Overhead Cost - Direct Salaries.--This part provides for the collection of SNF and/or NF wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. This form is completed by all SNFs and/or NFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1.--Enter the direct wages and salaries paid on lines 1 through 13, from Worksheet A, column 1, respectively.

Column 2.--Enter on the line, as appropriate, the salary portion of any reclassification made on Worksheet A-6.

Column 3.--Enter the result of column 1 plus or minus column 2.

Column 4.--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5.--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

4105.3 Part IV--Wage Related Costs.--The SNF must provide the contractor with a complete list of all core wage related costs included in Part II (section 4105.1), lines 17 and 19 through 21. This worksheet provides for the identification of such costs.

The provider must determine whether each wage related cost "other than core", reported on line 25, exceeds one (1) percent of the total adjusted salaries net of exclud*ed* salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, "Wage Related Costs Core"
- If any of the additional wage related cost applies to the excluded areas of the SNF, the cost associated with the excluded areas has been removed prior to *applying* the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, column 3, line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles, a SNF shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from you accounting books and/or records.

4105.4 Part V - Direct Care Expenditures--Section 6104(1) of Public Law 111-148 amended section 1888(f) of the Social Security Act ("Reporting of Direct Care Expenditures"), to require Skilled Nursing Facilities (SNF) to separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

Effective for cost reporting periods beginning on or after January 1, 2012, this part provides for the collection of SNF and/or Nursing Facilities (NF) direct care expenditures. Complete this form for employees who are full-time and part-time, directly hired, and acquired under contract. Do not include employees in areas excluded from SNF PPS via Worksheet S-3, Part II, Lines *7* through 1*1*. This exclusion applies to directly-hired and contract*ed* employees who provide*d* either direct or indirect patient care services in SNF PPS excluded areas. *D*o not include employees whose services are excluded from the SNF PPS, such as physician Part B, and *nursing and allied health*. This form is completed by *the* SNFs and/or *the* NFs.

Column1.--Enter the total of paid wages and salaries for the specified category of SNF/NF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on lines 1 through 3 and 5 through 13. Do not include fringe benefits or wage-related costs as defined in *CMS Pub. 15-2*, Part II, Section 4105.1.

Enter the amount paid (include only those costs attributable to services rendered in the SNF/NF), rounded to the nearest dollar, for contracted direct patient care services on lines 14 through 16 and 18 through 26.

Column 2.--Enter the appropriate portion of fringe benefits corresponding to paid wages and salaries reported in column 1, lines 1 through 3, and 5 through 13.

Column 3.--Enter the result of column 1 plus column 2.

Column 4.--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5.--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

Line 4.--Enter the sum of the amounts of lines 1 through 3.

Line 17.--Enter the sum of the amounts of lines 14 through 16.

*For Medicare cost reporting purposes, n*ursing personnel working in the following cost centers must be included in the appropriate nursing subcategory. These cost centers reflect where the majority of nursing employees are assigned in SNFs and are selected to ensure consistent reporting among SNFs. The wages and hours for nursing personnel working in other areas of the SNF or nurses who are performing solely administrative functions, should not be included.

COST CENTER DESCRIPTIONS

Lines for 2540-10	**Cost Centers**
09	Nursing Administration
30	Skilled Nursing Facility
31	Nursing Facility
47	Electrocardiology

NOTE: Subscripted cost centers that would normally fall into one of these cost centers should be included.

Definitions

Paid Salaries, Paid Hours and Wage Related Costs:

- **Paid Salaries** – Include the total of paid wages and salaries for the specified category of SNF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses.

- **Paid Hours** – Include the total paid hours for the specified category of SNF employees. Paid hours include regular hours, overtime hours, paid holiday, vacation, sick, and other paid-time-off hours, and hours associated with severance pay. Do not include non-paid lunch periods and on-call hours in the total paid hours. Overtime hours must be calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The hours reported for salaried employees who are paid a fixed rate must be recorded based on 40 hours per week or the number of hours in the *SNF*'s standard workweek.

- **Wage Related Costs** –Include wage related costs applicable to the specific category of SNF employees as reported in Part II, (section 4105.1), lines 18 and 20 through 22.

Nursing Occupations

- **Registered Nurses (RNs) -** Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required.

- **Licensed Practical Nurses (LPNs) -** Care for ill, injured, convalescent, or disabled persons. *LPNs monitor patients' health, administer basic nursing care, including changing bandages and inserting catheters, discuss health care with patients and listen to their concerns, report patients' status to RNs and physicians and maintain medical records.* LPNs may work under the supervision of a registered nurse. *M*ore experienced LPNs *may* supervise nursing assistants and aides. Licensing is required after the completion of a State-approved practical nursing program.

- ***Certified*** **Nursing Assistants/Aides -** Provide basic patient care under direction of nursing staff. Perform duties, such as *taking vital signs,* feed*ing*, bath*ing*, dress*ing*, groom*ing*, mov*ing* patients, or chang*ing* linens.

Other Medical Staff

Non-nursing employees (directly hired and under contract) that provide direct patient care. Do not include employees in excluded areas or that function solely in administrative or leadership roles that do not provide any direct patient care themselves. This category must not include occupations such as physician Part B services and the services of Advance Practice Nurses (APNs) such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists that are billable under a Part B fee schedule.

Line 35.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visits from lines 23, 25, 27, 29, 31 and 33.

Line 36.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 37.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visit charges from lines 24, 26, 28, 30, 32, 34 and 36.

Line 38.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 39.--Enter in columns 2 and 4 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

NOTE: Lines 38 and 39 are mutually exclusive.

Line 40.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5.--Enter on lines 23 through 40, respectively, the sum total of amounts from columns 1 through 4.

4107 WORKSHEET S-5 – SKILLED NURSING FACILITY-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20 *and* 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally Qualified Health Clinics (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 2.--Enter the full address of the RHC/FQHC.

Line 3.--For FQHC only, enter your appropriate designation (U=urban or R=rural). See *CMS Pub.* 100-04, Chapter 9, §20.6.2, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 through 9.--In column 1, enter the applicable grant award *amount*. In column 2, enter the date(s) awarded.

Line 10.--If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 11.

Line 11.--Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the facility provides other than RHC or FQHC services (e.g. laboratory or physician services), subscript line 11 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that the facility is available to provide other than RHC/FQHC services.

NOTE: Line 11 must still be completed even if the facility answers NO to the question on line 10.

Line 12.--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no.

Line 13.--Is this a consolidated cost report? Enter in column 1 "yes" or "no" for consolidated report. If column 1 = yes, then enter in column 2 the number of reports

Line 14.--If line 13 is yes, enter the provider's name and CCN number filing the consolidated cost report. (See *CMS Pub.* 100-04, Chapter 9, §30.8)

4108. WORKSHEET S-6 - S*NF*-BASED COMMUNITY MENTAL HEALTH CENTER*S AND OTHER OUTPATIENT REHABILITATION PROVIDER*

In accordance with 42 CFR 413.20 *and* 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to *SNF*-based community mental health center*s* (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), or outpatient rehabilitation facilities (ORFs) which generally furnish outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). If you have more than one *of these SNF*-based components complete a separate worksheet for each component.

Additionally, only CMHCs are required to complete the corresponding Worksheet J series. However, all CMHCs, CORFs, ORFs, OPTs, OOTs, and OSPs must complete the Worksheet A accordingly for the purpose of overhead allocation.

Lines 1 through 19.--These lines provide statistical data related to the human resources of the *SNF*-based component. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on lines 18 and 19.

Enter the number of hours in your normal work week in the space provided above line 1.

Report in column 1 the full time equivalent (FTE) employees on the *SNF*-based component's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the *SNF*-based component.

Staff FTEs are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, round to two decimal places, e.g., round .4452 to .45. Contract FTEs are computed for column 2 as follows: sum of all hours for which contracted and consultant staff worked divided by 2080 hours, and round to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the paid hours from the numerator in the calculations.

4109. WORKSHEET S-7 PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES STATISTICAL DATA

In accordance with 42 CFR 413.*2*0 *and* 42 CFR 413.24 you are required to maintain statistical records for proper determination of costs payable under the Medicare program. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Use this form to report the Medicare days of the provider by Resource Utilization Group (RUG).

Column Descriptions

Column 1.--The M3PI revenue code designations are already entered in this column.

Column 2.-- The only data required to be reported are the days associated with each RUG. These days should be reported in column 2. The calculation of the total payment for each RUG is not required. All payment data is reported as a total amount paid under the PPS payment system on Worksheet E, Part I, line 4, and is generated from the PS&R or your records. The total days on line 100 must agree with the amount on Worksheet S-3, Part I, column 4, line 1.

Lines 101 through 106.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Enter in column 1 the direct patient care expenses and related expenses for each category. Enter in column 2 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. For each line, indicate in column 3 whether the increased *PPS* payments received reflects increases associated with direct patient care and related expenses by responding “Y” for yes. Indicate “N” for no if there was no increase in spending in any of these areas. If column 2 is zero, enter N/A in column 3. If the increased spending is in an area not previously identified in areas one through four, identify on the “Other (Specify)” line(s), the cost center(s) description and the corresponding information as indicated above.

4110 WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

4110.1 Part I - Enrollment Days Based on Level of Care.

Lines 1 through 4.--Enter on lines 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Line 1.--**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

Line 2.--**Routine Home Care Day -** A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 3.--**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

Line 4.--**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4.--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5.--Enter in column 5 only the days applicable to the four types of care for all other non Medicare or non Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2, and 5). The amount entered in column 6 line 5 represents the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 5 reflects the actual total number of days provided by the *SNF-based* hospice.

4110.2 Part II --Census Data

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line equals the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two *cost* reporting periods, the stay is counted once in each *cost* reporting period. The patient, who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a *cost* reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects *the* Medicare hospice benefit, count the patient once for each pay*er* source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the *cost* reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one *cost* reporting period.

Line 7.--Enter the total Title XVIII unduplicated continuous care hours billable to Medicare. When computing the unduplicated continuous care hours, count only one hour regardless of the number of services or therapies provided simultaneously within that hour.

Line 8.--Enter the average length of stay for the *cost* reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then re-elects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29)	164 days
Patient (A, B & C)	
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	57 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9.--Enter the unduplicated census count of the *SNF-based* hospice for all patients initially admitted and filing an election statement with the hospice within a *cost* reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 100-02, Chapter 9, §10). *A beneficiary* who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the *cost* reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the *cost* reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

4113. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 100).

Do not include on this worksheet items not claimed in the cost report but you wish to claim and contest because they conflict with the regulations, manuals, or instructions. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part I, Part A, line 16, Part B, line 30; Worksheet H-4, Part II, line 35; Worksheet J-3, line 21; or Worksheet I-3, line 29).

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, you may do so by adding additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding on Worksheets B, B-1, H-1 Parts I & II, H-2-Parts I & II, J-1, and K-5.

Submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels used by health care providers on the Medicare cost report. Form CMS-2540-10 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The five digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4195, table 5**.**

Columns 1, 2, and 3.--The expenses listed in these columns must be in accordance with your accounting books and records. List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. Detail the expense between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3. Record any needed reclassification and/or adjustments in columns 4 and 6, as appropriate.

Column 4.--Enter any reclassification among the cost center expenses in column 3 which are needed to effect proper cost allocation.

Worksheet A-6 reflects the reclassification affecting the cost center expenses. This worksheet need not be completed by all providers but must be completed only to the extent that the reclassification are needed and appropriate in the particular provider's circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 4 must equal zero on line 100.

Column 5.--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 100.

Column 6.--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 100 must equal Worksheet A-8, column 2, line 100.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6 (increases or decreases) and extend the net balances to column 7. Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0.

Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. For example, the categories "Ancillary Cost Centers" and "Outpatient Cost Centers" appear on Worksheet D using the same line numbers as on Worksheet A.

NOTE: The category titles do not have line numbers. Only cost centers, data items, and totals have line numbers.

Lines 1 and 2.--These cost centers include depreciation, leases, and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care. Do not include in these cost centers, costs incurred for the repair or maintenance of equipment or facilities, amounts included in rentals or lease payments for repair and/or maintenance agreements, interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care, general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets, or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Many providers incur costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. 42 CFR 413.17 and CMS Pub. 15-1, Chapter 10, require that the reimbursable cost of the provider include the costs for these items at the cost to the supplying organization (unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010 is applicable).

The rationale behind this policy is that when you are dealing with a related organization, you are essentially dealing with yourself. Therefore, your costs are considered equal to the cost to the related organization.

If you include on the cost report costs incurred by a related organization, the nature of the costs (i.e., capital-related or operating costs) do not change. Treat capital-related costs incurred by a related organization as your capital-related costs.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplying related organization, your allowable cost may not exceed the market price. Unless the services, facilities, or supplies are otherwise considered capital-related cost, no part of the market price is considered capital-related cost. Also, if the exception in 42 CFR 413.17(d) and CMS Pub.15-1, §1010 applies, no part of the cost to you of the services, facilities, or supplies is considered capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related.

If the supplying organization is not related to you within the meaning of 42 CFR 413.17, no part of the charge to you may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless:

- The capital-related equipment is leased or rented by you;
- The capital-related equipment is located on your premises or is located offsite and is on real estate owned, leased, or rented by you; and
- The capital-related portion of the charge is separately specified in the charge to you.

Under certain circumstances, costs associated with minor equipment may be considered capital-related costs. CMS Pub. 15-1, §106 discusses methods for writing off the cost of minor equipment. Three methods are presented in that section. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expenses under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Line 9.--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services (including the salary cost of nurses who render direct service in more than one patient care area) are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, respiratory therapists, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 12.--This cost center includes the direct cost of the medical records cost center including the medical records library. The general library and the medical library must not be included in this cost center. Report them in the administrative and general cost center.

Line 14.--Use this line to record the cost of nursing and allied health activities *as described in 42 CFR 413.85(d)*.

Lines 16 through 29.--These lines are reserved for future use.

Lines 30 through 33.--These lines are for the inpatient routine service cost centers.

Line 33.--This cost center accumulates the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is 25 days or more. The beds in this unit are not certified for titles V, XVIII, or XIX.

Lines 34 through 39.--These lines are reserved for future use.

Lines 40 through 52.--These lines are for the ancillary cost centers.

Line 51.--The support surfaces which are classified as ancillary are those listed under the durable medical equipment regional DME MAC *Group* 2 and *Group* 3 support surfaces categories. For example, support surfaces which qualify under *Group* 2 *include powered air flotation beds, powered pressure reducing air mattresses and non-powered advanced pressure reducing mattresses*. An example of *a* support surface which qualif*ies* under *Group* 3 is *an* air fluidized bed.

NOTE: Items listed in the DME MAC's *Group* 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine *supplies* in all cases.

Lines 53 through 59.--These lines are reserved for future use.

Lines 60 through 63.--These lines are for outpatient cost centers.

Lines 64 through 69.--These lines are reserved for future use.

Lines 70 through 74.--These lines are for other reimbursable cost centers.

Lines 70.--This line is to accumulate costs which are specific to HHA services.

Line 71.--Enter on this line the ambulance cost where the ambulance is owned and operated by the facility.

Line 72.--This cost center accumulates the direct costs for *SNF-based* outpatient rehabilitation providers (CORFs, OPTs, OOTs or OSPs). If you have multiple components, subscript this line accordingly. Use lines 72.00-72.09 for CORFs, 72.10-72.19 for OPTs, 72.20-72.29 for OOTs and 72.30-72.39 for OSPs.

Line 73.--This cost center accumulates the direct costs attributable to a *SNF-based* CMHC. Direct costs normally include such cost categories as are listed on the applicable Worksheet J-1, Part I, lines 1 through 21.

Lines 75 through 79.-- These lines are reserved for future use.

Lines 80 through 84.--These lines are for special purpose cost centers.

Line 80.--This cost center includes the costs of malpractice insurance premiums and self insurance fund contributions. Also, include the cost if you pay uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a governmental provider. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 81.--After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 82.--Only include utilization review costs of the SNF. Either reclassify or adjust all costs depending on the scope of the review. If the scope of the review covers all patients, reclassify all allowable costs in column 4 to administrative and general expenses (line 4). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to administrative and general expenses all allowable costs other than physician compensation and (2) deduct, in column 6, the compensation paid to the physicians for their personal services on the utilization review committee. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 83.--This cost center accumulates the direct costs attributable to a *SNF-based* hospice.

Lines 85 through 88.--These lines are reserved for future use.

Lines 90 through 95.--Use these lines to record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers than those shown, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-1, §2328)

Line 92.--Establish a nonreimbursable cost center to accumulate the cost incurred by the provider for services related to the physicians' private practice. Examples of such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

This nonreimbursable cost center does not include costs applicable to services which benefit the general population or for direct patient services rendered by SNF-based physicians.

4114. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. Submit copies of any workpapers used to compute reclassification affected on this worksheet.

COMPLETE WORKSHEET A-6 ONLY TO THE EXTENT THAT EXPENSES HAVE BEEN INCLUDED IN COST CENTERS THAT DIFFER FROM THE RESULT THAT IS OBTAINED USING THE INSTRUCTIONS FOR THIS SECTION.

Examples of reclassifications that may be needed are:

1. Capital-related costs that are not included in one of the capital-related cost centers on Worksheet A, column 3. Examples include insurance on buildings and fixtures and movable equipment, rent on buildings and fixtures and movable equipment, interest on funds borrowed to purchase buildings and fixtures and movable equipment, personal property taxes, and real property taxes. Interest on funds borrowed for operating expenses is not included in capital related costs. It must be allocated with administrative and general expenses.

2. Employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workmen's compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits and pensions) included in the administrative and general cost center.

3. Insurance expense included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

4. Interest expense included on Worksheet A, column 3, line 81 and applicable to funds borrowed for administrative and general purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment.

5. Rent expenses included in the administrative and general cost center and applicable to the rental of buildings and fixtures and to movable equipment from other than related organizations. (See the instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.)

6. Any taxes (real property taxes and/or personal property taxes) included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

7. Utilization review costs. Administrative costs related to utilization review and the costs of professional personnel other than physicians are allowable costs and are apportioned among all users of the SNF, irrespective of whether utilization review covers the entire patient population. Reclassify these costs from Worksheet A, column 3, line 82 to administrative and general costs.

This reclassification includes the costs of physician services in utilization review only if a valid allocation between Medicare and the other programs is not supported by documentation. Otherwise, the costs of physician services in utilization review reported are in accordance with the instructions for Worksheet A-8 relating to utilization review.

Make the appropriate adjustment for physician compensation on Worksheet A-8. For further explanations concerning utilization review in SNFs, see CMS Pub. 15-1, §2126.2.

8. Any dietary cost included in the dietary cost center and applicable to any other cost centers, e.g., gift, flower, coffee shop, and canteen.

9. Any direct expense included in the central service and supply cost center and directly applicable to other cost centers, e.g., intravenous therapy, oxygen (inhalation) therapy.

10. Any direct expenses included in the laboratory cost center and directly applicable to other cost centers, e.g., electrocardiology.

11. Any direct expenses included in the radiology cost center and directly applicable to other cost centers, e.g., electrocardiology.

12. When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating your overhead and if you incur related direct costs applicable to all patients, Medicare and non-Medicare (e.g., aides who assist a physical therapist by providing support and/or administrative services related to physical therapy), such related costs are reclassified on Worksheet A-6 from the ancillary service cost center and *are* allocated as part of administrative and general expense.

However, when you purchase therapy services that include performing administrative functions such as completion of medical records, training, etc. as discussed in CMS Pub 15-1, §1412.5, the bundled charge for therapies provided under arrangements includes the provision of these services. Therefore for cost reporting purposes, these related services are NOT reclassified to A&G.

13. Rental expense on movable equipment which was charged directly to the appropriate cost center or cost centers must be reclassified on this worksheet to the capital-related movable equipment cost center unless the provider has identified and charged all depreciation on movable equipment to the appropriate cost centers.

14. Malpractice insurance cost to administrative and general cost.

4115. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. This worksheet is completed only once for the entire SNF complex.

The analysis of changes in capital asset balances during the cost reporting period must be completed by all SNFs and SNF health care complexes. Do not reduce the amount entered by any accumulated depreciation reserves.

Columns 1 and 6.--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider, noncertified health care unit, or nonhealth care unit) in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other approved basis of all capital assets sold, traded, or transferred to another provider, a noncertified health care unit, or nonhealth care unit or retired or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

Column 7.--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

4116. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care (specifically not reimbursable under the program) or amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustment in support of those *items* listed on Worksheet A, column 6. These adjustments, which are required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any workpapers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you *can*not *change* the basis *t*o revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost, and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or which result in costs incurred for reasons other than patient care and, thus, require adjustments.

The types of adjustments entered on this worksheet are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

Lines 1.--Enter the investment income to be applied against interest expense. (See CMS Pub. 15-1, §202.2.)

Line 5.--For patient telephones, either make an adjustment on this line or establish a nonreimbursable cost center. When line 5 is used, base the adjustment on cost. Revenue cannot be used. (See CMS Pub. 15-1, §2328.)

Line 8.--Enter the adjustment amount from Worksheet A-8-2, column 18. Amounts paid to SNF-based physicians for general SNF services rendered are not included in these adjustments. (See CMS Pub. 15-1, §§2108 - 2108.11.)

Line 9.--Enter allowable home office costs which have been allocated to the SNF and which are not already included in your cost report. Use additional lines to the extent that various SNF cost centers are affected. (See CMS Pub. 15-1, §§2150 - 2153.)

Line 11.--Obtain the amount from your records.

Line 12.--Obtain the amount from Part I, column 6 of Worksheet A-8-1. Note that Worksheet A-8-1 represents the detail of the various cost centers on Worksheet A, which must be adjusted.

Line 13.--An adjustment is required for nonallowable patient personal laundry.

Line 14.--Enter the amount received from the sale of meals to employees. This income offsets the dietary expense.

Line 15.--Enter the cost of meals provided for non-employees. This amount offsets the allowable dietary costs.

Line 20.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must offset the allowable administrative and general costs. (See CMS Pub. 15-1,§2110.2.)

Line 21.--Enter the interest expense imposed by the contractor on Medicare overpayments to you. Also, enter the interest expense on borrowing made to repay Medicare overpayments to you. (See CMS Pub 15-1, Chapter 2.)

Line 22.-- If the utilization review covers only Medicare patients, the costs of the physician services are removed from the utilization review costs and are shown as a direct reimbursement item of Worksheet E, Part I, line 10.

If the utilization review extends to beneficiaries under titles V or XIX, then providing that there is sufficient documentation of physician activities, the costs of physician review services for the utilization review are a direct reimbursement item for each title under which reimbursement is claimed.

If the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician services cost among all the patients using the SNF. Accomplish this apportionment by including the cost of the physician services in administrative and general costs.

The reference on this form in column 4 has been changed to line 82.

Line 23 and 24.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on line 23 and/or line 24. (See CMS Pub. 15-1, Chapter 1.)

Line 25.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the lines to indicate the nature of the required adjustments.

NOTE: An example of an adjustment entered on these lines is the grossing up of costs in accordance with provisions of CMS Pub. 15-1, §2314, and is explained below.

If you furnish ancillary services to health care program patients under arrangements with others but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the costs of the health care program portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the health care program portion results in excessive assignment of indirect costs to the health care programs. Since services were also arranged for the non-health care program patients, allocate part of the overhead costs to those groups.

In the foregoing situation, no indirect costs may be allocated to the cost center unless the contractor determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly.

Line 100.--Enter the sum of lines 1 through 99. TRANSFER THE AMOUNTS IN COLUMN 2 TO WORKSHEET A, COLUMN 6.

4117. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includible in the allowable cost of the provider at the cost to the related organization (except for the exceptions outlined in 42 CFR 413.17(d).) This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the SNF by organizations related to the provider. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-1, Chapter 10.)

Complete this worksheet if you answered yes to question 18 or 43 on Worksheet S-2, Part I, and there are costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-1, Chapter 10. If there are no costs included on Worksheet A which resulted from transactions with related organizations, DO NOT complete Worksheet A-8-1.

Part I.--Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includible in the allowable cost of the provider at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere.

Part II.--Use this part to show the interrelationship of the provider to organizations furnishing services, facilities, or supplies to the provider. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the provider, a common ownership of the provider, or control over the provider as defined in CMS Pub. 15-1, Chapter 10, must be shown in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1.--Enter the appropriate symbol which describes the interrelationship of the provider to the related organization.

Column 2.--If the symbols A, D, E, F, or G are entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 4.--Enter the name of the related corporation, partnership, or other organization.

Column 5.--If the individual indicated in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry, and linen service).

4118. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d) you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population. 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred by you. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-1, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines below the cost center using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). The identity of the physician must be made available to your contractor upon audit.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish to a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassification on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed by the Part B carrier in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5.--Enter the amount of the total remuneration included in column 3, for each cost center, which is applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

NOTE: 42 CFR 415.60(b) requires that physician compensation be allocated between physician services to patients, to the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is eliminated on Worksheet A-8.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments. *(See CMS Pub. 15-1,* §*2182)*

Column 7.--Enter for each line of data the physician's hours which are allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--Enter for each line of data five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward (up to five percent of the computed limit (column 9)) to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.

Enter for each line of data the actual amounts of these expenses paid by you.

Column 13.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 12 and dividing that amount by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians) services to your patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by you.

Column 15.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 14 and dividing the result by the amount in column 3.

Column 16.--Enter for each line of data the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero.

Column 18.--The adjustment for each cost center entered represents the provider-based physician elimination from costs entered on Worksheet A-8, column 2, line 8 and on Worksheet A, column 6 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line Descriptions

Total Line.--Total the amounts in columns 3 through 5, 7 through 9, and 12 through 18.

4120. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

In accordance with 42 CFR 413.24(a), cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting. Cost data based on such basis of accounting are acceptable subject to appropriate treatment of capital expenditures. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. The various cost finding methods recognized are outlined in 42 CFR 413.24(d). Worksheets B, Part I and B-1 have been designed to accommodate the step-down method of cost finding. These worksheets may have to be modified to accommodate other methods of cost finding which have been approved *by the contractor* for use by the SNF.

Worksheet B, Part I provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, ancillary service cost centers, inpatient routine service cost centers, outpatient service cost centers, special purpose and other reimbursable cost centers, and non-reimbursable cost centers. The total direct expenses are obtained from Worksheet A, column 7.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I.

To facilitate the allocation process, the general format*s* of Worksheets B, Part I and B-1 are identical. Each general service cost center has the same line number as its respective column number across the top. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers of each ancillary, routine, other reimbursable, and non-reimbursable cost centers are identical on the two worksheets. The cost centers and line numbers are consistent with Worksheet A. Note that lines 80, 81 and 82 from Worksheet A are not *used* on Worksheets B and B-1.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated.

A change in order of allocation and/or allocation statistics is appropriate for the current *cost reporting period* if received by the contractor, in writing, within 90 days prior to the end of the *cost reporting period*. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. *The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.* If a change in statistics is *requested*, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider *must use* the previously approved methodology. *(See CMS Pub. 15-1, §2313)*

Most cost centers are allocated on different statistical bases. However, for those cost centers for which the basis is the same (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that have been closed.

When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

If the amount of any cost center on Worksheet A, column 7 has a credit balance, this must be shown as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to such cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is to be allocated, such general service cost center must not be allocated. Rather, enter the credit balance in parentheses on line 99 as well as on the first line of the column and on line 100. This enables column 18, line 100, to cross foot to columns 0 and 3A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 18, do not carry forward such credit balance to Worksheet C.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base (including accumulated cost for allocating administrative and general expenses) over which the expenses are to be allocated (e.g., for column 1, Capital Related - Buildings and Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken).

Such statistical base including accumulated cost for allocating administrative and general expenses does not include any statistics related to services furnished under arrangements except where:

- Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or

- The contractor determines that you are able to and do gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, §2314.)

For all cost centers (below the first line) to which the capital related cost is allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line.

Enter on line 102 of Worksheet B-1 the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1 (in the case of Capital Related - Buildings and Fixtures, this amount is on Worksheet B, Part I, column 1, line 1).

Divide the amount entered on line 102 by the total statistics entered in the same column on the first line. Enter the resulting unit cost multiplier on line 103. The unit cost multiplier must be rounded to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §4100.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 100) of all of the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B, Part I, and B-1 before proceeding to the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, such general service cost center must not be allocated. However, the statistic must be displayed departmentally. No unit cost multiplier is calculated for lines 103 and 105 on Worksheet B-1.

Use lines 104 and 105 of Worksheet B-1 in conjunction with the allocation of capital-related cost on Worksheet B, Part II. Complete line 104 for all columns after Worksheets B, Part I, and B-1 have been completed and the amount of direct and indirect capital-related cost has been determined on Worksheet B, Part II. Line 105 for all columns is the unit cost multiplier used in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier after the amounts to be entered on line 104 have been determined by dividing the capital-related cost recorded on line 104 by the total statistics entered in the same column on the first line. Round the unit cost multiplier to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 16 the sum of the costs in columns 3A through 15 for lines 30 through 95.

When an adjustment is required to expenses after cost allocation, show the amount applicable to each cost center in column 17 of Worksheet B, Part I. A corresponding adjustment to Worksheet B, Part II, may be applicable for capital-related cost adjustments. You must submit a supporting worksheet showing the computation of the adjustment in addition to completing Worksheet B-2.

Some examples of adjustments which may be required to expenses after cost allocation are (1) the allocation of available costs between the certified portion and the noncertified portion of a distinct part provider and (2) costs attributable to unoccupied beds of a SNF with *a* restrictive admission policy. (See CMS Pub. 15-1, §§2342 - 2344.3.)

After the adjustments have been made on Worksheet B, Part I, column 17, adjust the amounts in column 16 by the amounts in column 17 and extend the new balances to column 18 for each line. The total costs entered in columns 18, line 100, must equal the total costs entered in column 0, line 100.

Transfer the totals in column 18, lines 40 through 52 (ancillary service cost centers), lines 60 through 63 (outpatient service cost centers), and line 71, to Worksheet C, column 1, lines 40 through 71 respectively.

4123. WORKSHEET C - RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Column 1.--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 18. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 18. However, report the charges applicable to such cost centers with a credit balance in column 2 of the applicable line on Worksheet C.

Column 2.--Enter on each cost center line the total gross patient charges including charity care for that cost center. Include in the applicable cost centers items reimbursed on a fee schedule *d*o not include Medicare charges applicable to items *that are excluded from SNF PPS and paid on a fee schedule* in the Medicare charges reported on Worksheet D. However, include your standard customary charges for these items in total charges on Worksheet C.

Column 3.--Divide the cost for each cost center in column 1 by the total charges for the cost center in column 2 to determine the ratio of total cost to total charges. Enter the resultant department ratios in this column. Round ratios to 6 decimal places, e.g., .102589241 is rounded to .102589.

4124. WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST

A separate copy of this worksheet must be completed for each situation applicable under titles V, XVIII, and XIX.

4124.1 Part I - Calculation of Ancillary and Outpatient Cost.--This worksheet provides for the apportionment of cost applicable to inpatient and outpatient services reimbursable under titles V, XVIII, and XIX for SNFs, NFs, ICF/MR and Other in accordance with 42 CFR 413.53(b).

NOTE: For titles V and XIX, use columns 1, 2, and 4.

Column 1.--Enter the ratio of cost to charges developed for each cost center from Worksheet C, column 3.

Columns 2 and 3.--Enter from your records or the PS&R, the program SNF charges for *each* cost center.

For title XVIII, Part B, transfer the charges (less any professional component charges included therein) from column 3, line 100, plus Part II, line 2 *to* Worksheet E, Part I, line 20.

Provide a reconciliation showing how the elimination of any professional component charges was accomplished.

Columns 4 & 5.--Multiply the indicated program charges in column 2 by the ratio in column 1 to determine the program expenses. Transfer column 4, sum of lines 40 th*r*ough 52, to Worksheet E, Part I, line 1. Title XVIII outpatient, Part B expenses will be transferred from column 5, line 100, to Worksheet E, Part I, line 17.

Line 48.--Enter only the program charges for medical supplies charged to patients that are not paid on a fee schedule.

Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32.

EXCEPTION: When the SNF is located in a State that *licenses* the provider as an SNF regardless of the level of care given for Titles V and XIX patients enter the general inpatient routine service costs from lines 30 and 31.

Line 6.--Enter the total charges for general inpatient routine services for the SNF, the NF, or the ICF/MR as applicable. These charges should agree with the amounts on Worksheet G-2, column 1, lines 1, 2, and 3. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., .102589241 is rounded to .102589) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

Line 8.--Enter the private room charges from your records.

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations (line 8) by the total number of days of care furnished in private room accommodations (line 2).

Line 10.--Enter the semi-private room charges from your records.

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations (line 10) by the total number of days of care furnished in semi-private room accommodations (line 1 – line 2).

Line 12.--Subtract the average per diem charge for all semi-private accommodations (line 11) from the average per diem charge for all private room accommodations (line 9) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential (line 12) by the inpatient general routine cost/charge ratio (line 7) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential (line 13) by the private room accommodation days (line 2) to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment (line 14) from the general inpatient routine service cost (line 5) to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) shown on line 1.

Line 17.--Determine the routine service cost by multiplying the program inpatient days (including the private room days) shown on line 3 by the amount on line 16.

Line 18.--Determine the medically necessary private room cost applicable to the program by multiplying line 4 by the amount on line 13.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 21 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 22 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on line 24 from the amount on line 23.

Line 26.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Enter the per diem limitation applicable to the respective title.

Line 27.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your contractor and is entered in the space provided in the line description.

Line 28.--This line is not applicable for title XVIII, but may be used for title V and or title XIX. Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part II, line 4.

4125.2 Part II - Calculation of Inpatient Nursing & Allied Health Cost for PPS Pass Through.

Line 1.--Enter the total SNF inpatient days from Worksheet S-3, Part I, column 7, line 1.

Line 2.--Enter the SNF program inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3.--Enter the program Nursing & Allied Health cost from Worksheet B, Part I, column 14, line 30 for SNF. Do not complete for titles V or XIX.

Line 4.--Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5.--Calculate the Nursing & Allied Health pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part I, line 2, for title XVIII.

4130. WORKSHEET E – *Parts I and II*

Worksheet E is used to calculate reimbursement settlement. Use the applicable part of Worksheet E as follows:

Part I - *Calculation of Reimbursement Settlement Title XVIII*

Part II - *Calculation of* Reimbursement Settlement for Title V and Title XIX

4130.1 Part I – *Calculation of* Reimbursement *Settlement for Title XVIII*.--Use this part to calculate reimbursement settlement under *SNF* PPS for program services. *F*ree-standing SNF*s are* reimbursed *by* Medicare under *SNF* PPS for cost reporting periods beginning *on or* after July 1, 1998.

Part A *- Inpatient Service PPS Provider Computation of Reimbursement*

Line 1.--Enter the prospective payment amount from your PS&R.

Line 2.--Enter the sum of title XVIII Nursing & Allied Health costs, from Worksheet D, Part III, column 5, line 100 and Worksheet D-1, Part II, line 5.

Line 3.--Enter the sum of lines 1 and 2.

Line 4.--Enter the amounts paid or payable by workmen's compensation and other primary payers where program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered to be non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program days and charges. In this situation, no primary payer payment is entered on line 4.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 4 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 4.

Line 5.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 6.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 7.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 6.

Line 8. --Calculate this line as follows: ((line 6 - line 7) times.7) PLUS the amount on line 7. For cost reporting periods that begin on or after October 1, 2012, as amended by section 3201(b) of the Middle Class Tax Extension and Job Creation Act of 2012, calculate this line as follows: [((line 6 - line 7) times 65 percent) + (line 7 times 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [((line 6 - line 7) times 65 percent) + (line 7 times 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 6 times 65 percent.

Line 9.--Enter the amount of recovery of reimbursable bad debts. This amount is for statistical purposes only, and does not enter into any reimbursement calculation.

Line 10.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF.

Line 11.--Enter the sum of line 3, plus line 8 and 10 for title XVIII, plus or minus the sum of lines 4, and line 5.

Line 12.--Enter interim payments from Worksheet E-1, column 2, line 4.

NOTE: Include amounts received from PPS (for inpatient routine services) as well as amounts received from ancillary services.

Line 13.--Your contractor will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 14.--Enter OTHER adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 14.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 11 plus or minus lines 14 through 14.98)]. *If the sum of line 11 plus or minus lines 14 through 14.98 is less than zero, do not calculate the sequestration adjustment.*

Line 15.--Enter the sum of the amount on line 11 minus lines 12, 13 and 14.99, plus or minus line 14 and its subscripts not previously identified. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part III, column 2, line 1.

Line 16.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a worksheet showing the details and computations for this line.

Part B Line Descriptions.--

Use this part to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line 17.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 5, line 100.

Line 18.-- Enter the vaccine cost from Worksheet D, Part II, line 3.

Line 19.-- Enter the sum of the amounts on lines 17 and 18.

Line 20.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 100, plus Worksheet D, Part II, Line 2.

Line 21.-- Enter the lesser of line 19 or 20.

Line 22.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 22.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 22 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 22.

Line 23.--Enter the Part B deductible and coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to you. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to you. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 24.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 24.01.--For cost reporting periods that begin on or after October 1, 2012, enter the gross reimbursable bad debts for dually eligible beneficiaries. This amount must also be included in the amount on line 24.

Line 24.02.--For cost reporting periods that begin prior to October 1, 2012, enter the amount from line 24. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: [((line 24 - line 24.01) times 65 percent) + (line 24.01 times 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [((line 24 - line 24.01) times 65 percent) + (line 24.01 times 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 24 times 65 percent.

Line 25-- Enter the sum of the amounts on lines 21, and 24.02, minus the amounts on lines 22, and 23.

Line 26.--Enter interim payment from Worksheet E-1, column 4, line 4.

Line 27.--Your contractor will enter the Part B tentative adjustments from Worksheet E-1, column 4.

Line 28.--Enter OTHER adjustments

Line 28.99.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 25 plus or minus lines 28 through 28.98)]. *If the sum of line 25 plus or minus lines 28 through 28.98 is less than zero, do not calculate the sequestration adjustment.*

4130.2 Part II – Calculation of Reimbursement Settlement for Title V and Title XIX Only.--Use Worksheet E, Part II, to calculate reimbursement settlement for titles V, and XIX services furnished by SNFs, NFs, and ICF/MRs reimbursed under cost principles.

Mark in the appropriate box at the top of each page of Worksheet E, Part II, to indicate the program and the provider component for which it is used.

Line Descriptions

Line 1.--Enter the cost of ancillary services furnished to inpatients for titles V, and XIX. Transfer these amounts from Worksheet D, Part I, column 4, lines 40 through 52.

Line 2.--Enter Nursing & Allied Health costs for title V or title XIX from Worksheet D-1, part II, line 5 accordingly.

Line 3. -- For titles V and XIX, enter the cost of outpatient services. Obtain the amount from Worksheet D, Part I, column 4, lines 60 through 71.

Line 4.--Enter the inpatient operating costs from Worksheet D-1, line 28.

Line 5.--Enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF, from the provider records.

Line 7.--Enter the applicable charge differential between semi-private and less than semi-private accommodations. The amount of the differential is the difference between the customary charge for semi-private accommodations and the customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations provided were not medically necessary.

Line 8.--Enter the amount on line 6 minus the amount on line 7.

Line 9.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges, but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 9.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and applicable deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer

payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductibles and coinsurance. In all situations for services rendered on or after November 13, 1989, the primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 10.--Enter the amount on line 8 minus the amount on line 9.

Lines 11 through 15.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 10.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §§2570 - 2577.

If the charges on Worksheet C do include such professional component, eliminate the amount of the professional component from the charges to be entered on lines 11 and 13. Submit a schedule showing these computations with the cost report.

Line 11.--For titles V or XIX only; enter the total charges for inpatient ancillary services from Worksheet D, Part I, column 2, lines 40 through 52 net of professional component.

Line 12.--For titles V and XIX only, enter the total charges for outpatient services from Worksheet D, Part I, column 2, lines 60 through 71 net of professional component.

Line 13.--Enter the program inpatient routine service charges from your records for the applicable component.

The amount on this line includes covered late charges which have been billed to the program where the patient’s medical condition is the cause of the extended stay. In addition, these charges include the charges for semi-private accommodations of inpatients which workmen’s compensation and other primary payers paid. Adjust these charges on line 13 in determining final settlement.

Line 14.--If the amount entered on line 12 has not been adjusted to take into consideration the differential between semi-private room charges and charges for less than semi-private accommodations. Enter the amount from line 7.

Line 15.--Enter the sum of lines 11 through 13 minus line 14.

Lines 16 through 19.--These lines provide for the reduction of program charges when the provider does not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 16 through 18 but instead enter on line 19 the amount from line 15. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 19 exceed the actual charge on line 15.

Computation of Reimbursement Settlement

Line 20.--Enter the lesser of reasonable cost (line 8 before the application of the primary payer amount) or customary charges (line 19), minus the primary payer amount on line 9.

Line 21.--Enter the deductibles billed to title V and title XIX beneficiaries.

Line 22.--Enter the amount on line 20 minus the amount on line 21.

Line 23.--Enter the coinsurance billed to beneficiaries. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 24.--Enter the amount on line 22 minus the amount on line 23.

Line 25.--Enter program reimbursable bad debts net of bad debt recoveries for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services.

Line 26.--Enter the sum of the amounts on lines 24 and 25.

Line 27.--If your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit *are* required to be refunded to the beneficiary. Enter any amounts which are not refunded either because they are less than $5.00 collected from a beneficiary or because the provider is unable to locate the beneficiary. (See CMS Pub. 15-1, §2577.)

Line 28.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination *from the program* or a decrease in program utilization. (See CMS Pub. 15-1, §§136 - 136.16.)

Line 29.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Include any portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §1919(b)(5) of the Social Security Act. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility-based program.

Line 30.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss from the disposition of depreciable assets. (See CMS Pub. 15-1, §§132-132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in est

Line 31.--Enter the sum of the amounts on line 26, plus or minus lines 29 and 30, minus lines 27 and 28.

Line 32.--Enter the Title V or Title XIX interim payment from your records.

Line 33.--Enter a negative amount in parentheses ( ). Transfer titles V and XIX SNF amounts on this line to Worksheet S, Part III, line 1, columns 1 or 4, as applicable. Transfer titles V and XIX NF amounts to Worksheet S, Part III, line 2, columns 1 or 4, respectively. Transfer title XIX ICF/MR amounts to Worksheet S, Part III, line 3, column 4.

4131. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Complete an analysis of payments to providers for services furnished for each component of the health care complex which has a separate provider number. Worksheet E-1 is used by the SNF when the provider has received Medicare interim payments made by the contractor. It must not be completed for purposes of reporting interim payments for titles V or XIX.

The following components use one of the indicated worksheets instead of Worksheet E-1:

- SNF-based HHAs use Worksheet H-5;
- SNF-based RHC/FQHCs use Worksheet I-5; and
- SNF-based CMHC's use Worksheet J-4.

The column headings designate two categories of payments:

Columns l and 2 - Inpatient Part A
Columns 3 and 4 - Part B

You should complete lines 1 through 4. Your contractor will complete lines 5 through 9. All amounts reported on this worksheet must be for services, the cost of which is included in this cost report.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from your interim payments due to an offset against overpayments to you, applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines l, 2, and 3.99). Transfer the total amount from column 2 Worksheet E, Part I, line 12 for inpatient Part A, and from column 4 to Worksheet E, Part I, Line 27 for Part B.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when 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.

Line 7.--The sum of lines 4, 5.99, and 6, column 2, for inpatient Part A must equal Worksheet E, Part I, line 11 *plus or minus line 14 and all subscripts of line 14*. For Part B, the amount in column 4 must equal Worksheet E, Part I, line 2*5 plus or minus line 28 and all subscript of line 28*.

Line 8.--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

4140. FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from your accounting books and records.

Complete all worksheets in the "G" series. Complete Worksheets G and G-1 if you maintain fund-type accounting records, complete separate amounts for General, Specific Purpose, Endowment and Plant funds on Worksheets G and G-1. If you do not maintain fund-type accounting records, complete the general fund column only. Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report. Worksheets G, G-1, G-2 and G-3 must be consistent with financial statements prepared by Certified Public Accountants or Public Accountants.

4140.1 Worksheet G - Balance Sheet--If the lines on the Worksheet G are not sufficient, use lines 5 (Other receivables), 9 (Other current assets), 41 (Other current liabilities), and 47 (Other long term liabilities), as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation or subscript the appropriate lines.

Enter accumulated depreciation as a negative amount.

Column 1.--General Fund--Use only this fund column when you do not maintain fund-type accounting records. This fund is similar to a general ledger account and records all assets and liabilities of the entity

Column 2.--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Column 3.--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Column 4.--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1.--Cash on Hand and in Banks--The amounts on this line represents the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2.--Temporary Investments--The amounts on this line represent current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3.--Notes Receivable--The amounts on this line represent current unpaid amounts evidenced by certificates of indebtedness.

Line 4.--Accounts Receivable--Include on this line all unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items if they are not included elsewhere.

Line 6.--Less: Allowance for Uncollectable Notes and Accounts--These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers. Enter this amount as a negative.

Line 7.--Inventory--Enter the costs of unused supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the provider. The Skilled Nursing Facility inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8.--Prepaid Expenses--Enter the costs incurred which are properly chargeable to a future accounting period.

Line 9.--Other Current Assets --These balances include other current assets not included in other asset categories.

Line 10.--Due from Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are represented in columns 1 through 4, respectively. Amounts reported in each column should be the amount due from other funds in their respective columns on Worksheet G, line 41 (Due to Other Funds).

Line 12.--Land--This balance reflects the cost of land used in operations. Included here is the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature. Unlike building and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated.

The cost of land includes (1) the cash purchase price, (2) closing costs such as title and attorney's fees, (3) real estate broker's commission, and (4) accrued property taxes and other liens on the land assumed by the purchaser.

Land 13.--Land Improvements--Amounts on this line include structural additions made to land, such as driveways, parking lots, sidewalks; as well as the cost of shrubbery, fences and walls, landscaping, on-site sewer and water lines, and underground sprinklers. The cost of land improvements includes all expenditures necessary to make the improvements ready for their intended use.

Line 15.--Buildings--This line includes the cost of all buildings and subsequent additions used in operations (including purchase price, closing costs, (attorney fees, title insurance, etc.), and real estate broker commission). Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings, and interest paid for construction financing.

Line 17.--Leasehold Improvements--All expenditures for the improvement of a leasehold used in SNF operations are included on this line.

Line 19.--Fixed Equipment--Include the cost of building equipment that has the following general characteristics:

1. Affixed to the building, not subject to transfer or removal.
2. A life of more than one year, but less than that of the building to which it is affixed.
3. Used in SNF operations.

Fixed equipment includes such items as boilers, generators, engines, pumps, and refrigeration machinery, wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc.

Line 21.--Automobiles and Trucks--Enter the cost of automobiles and trucks used in SNF operations.

Line 23.--Major movable Equipment--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in SNF operations.

Line 25.--Minor Equipment-Depreciable--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in SNF operations.

Line 26.--Minor Equipment-Nondepreciable--Costs of equipment included on this line has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various departments of the hospital.
2. Relatively small size.
3. Subject to storeroom control.
4. Fairly large number in use.
5. Generally a useful life of usually approximately three years or less.
6. Used in SNF operations.

Minor equipment includes items *such* as, but not limited to*:* wastebaskets, bed pans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Lines 14, 16, 18, 20, 22, and 24.--Less Accumulated Depreciation--These balances, respectively, include the depreciation accumulated on the related assets used in operations. Enter this amount as a negative.

Line 29.--Investments--This field contains the cost of investments purchased with SNF funds and the fair market value (at date of donation) of securities donated to the SNF.

Line 30.--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 31.--Due from Owners/Officers--Report the amount loaned to the SNF by owners and/or officers.

Line 32.--Other Assets--This is the amount of assets not reported on line 9 (other current assets) or any other line 1 through 31. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 33.--Total Other Assets--Sum of lines 29 through 32.

Line 34.--Total Assets--Sum of lines 11, 28 and 33.

Line 35.--Accounts Payable--This amount reflects the amounts due trade creditors and others for supplies and services purchased.

Line 36.--Salaries, Wages and Fees Payable--This amount reflects the actual or estimated liabilities of the SNF for salaries and wages/fees payable.

Line 37.--Payroll Taxes Payable--This amount reflects the actual or estimated liabilities of the SNF for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the SNF and other payroll deductions, such as hospitalization insurance premiums.

Line 38.--Notes and Loans Payable (Short-Term)--The amounts on this line represent current amounts owing as evidenced by certificates of indebtedness coming due in the next 12 months.

Line 39.--Deferred Income--Deferred income is received or accrued income which is applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities. These amounts also reflect the effects of any timing differences between book and tax or third-party reimbursement accounting.

Line 40.--Accelerated Payments--Accelerated payments are payments not yet due to be repaid to the contractor.

Lines 13 through 17.--Deductions--Most expenses are included in the net income reported on line 2. Any decreases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 13 through 17.

Line 18.--Total Deductions--In columns 2, 4, 6 and 8, enter the sum of lines 13 through 17, columns 1, 3, 5 and 7, respectively.

Line 19.--Fund Balance at the end of Period per Balance Sheet--Enter the result of line 11 minus line 18 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank. The amount in line 19, column 2 must agree with Worksheet G, line 52, column 1. The amount on line 19, column 4 must agree with Worksheet G, line 53, column 2. The amount on line 19, column 6 must agree with the sum of Worksheet G, column 3, lines 54 through 56. The amount on line 19, column 8 must agree with the sum of Worksheet G, column 4, lines 57 and 58.

These amounts will also be used to start next year's Worksheet G-1.

4140.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses--The worksheets require the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission. If you have more than one SNF-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each *SNF*-based facility separately.

Part I - Patient Revenues.--Enter total patient revenues associated with the appropriate cost centers on lines 1 through 4, and 6 through 13.

Line 1.--SNF--Enter revenues generated by the SNF component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2.--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 3.--ICF/MC--Enter the ICF/MC revenue from your accounting books and/or records.

Line 4.--Other Long Term Care-- Enter the revenue generated from other long term care sub providers from your accounting books and/or records. Subscript this line as necessary.

Line 5.--Total General Inpatient Routine Care--Sum of lines 1 through 4.

Line 6.--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 7.--Clinic--Enter in the appropriate column revenue from clinic services from your accounting books and/or records.

Line 8.--Home Health Agency-- Enter home health agency revenue from your accounting books and/or records. If there is more than one home health agency, include the revenues for all home health agencies on this line.

Line 9.--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 71.

Line 10.--RHC/FQHC--Enter in column 2 only, the revenue generated from RHC/FQHC.

Line 11.--CMHC--Enter in column 2 only, the revenue generated from CMHC.

Line 12.--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 13.--Other (specify).

Line 14.--Total Patient Revenues--Enter the sum of lines 5 through 13.

Column 3.--Enter the sum of columns 1 and 2, lines 1 – 14 respectively in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the *SNF* complex.

Line 1.--Operating Expenses--This amount is transferred from Worksheet A, line 100, column 3.

Lines 2 through 7.--Add (Specify)--Identify on these lines additional operating expenses not included in line 1.

Line 8.--Total Additions--Enter on line 8, column 2, the sum of lines 2 through 7, column 1.

Lines 9 through 13.--Deduct (specify)--Identify on these lines deductions from operating expenses not included in line 1.

Line 14.--Total Deductions--Enter on line 14, column 2, the sum of lines 9 through 13, column 1.

Line 15.--Total Operating Expenses--Enter in column 2, the result of line 1, column 2 plus line 8, column 2, less line 14, column 2.

4140.4 Worksheet G-3 - Statement of Revenues and Expenses--This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission.

Line 1.--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 14, column 3.

Line 2.--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Net Patient Revenues--Subtract line 2 from line 1.

Line 4.--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 15.

Line 5.--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6 through 23.--Enter on the appropriate lines 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24.--Other (Specify)--Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25.--Total Other Income--Enter the sum of lines 6 through 24.

Line 26.--Total--Enter the sum of lines 5 plus line 25.

Line 27.--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 25.

Line 30.--Total Other Expenses--Enter the sum of lines 27 through 29, including subscripts.

Line 31.--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 30.

4141. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Obtain these direct costs from your records *and enter* in columns 1, 2 and 4. All of the cost centers listed *may* not apply to all agencies.

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your contractor determines that the method is no longer valid due to changes in your operations.

Column 1.--Enter all salaries and wages (a salary is gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses (See CMS Pub. 15-1, Chapter 21)) for the HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary (and any employee-related benefits) is entered on line 5 (administrative and general-HHA) and 25 percent of the administrator's salary (and any employee-related benefits) is entered on line 6 (skilled nursing care). Enter the sum of column 1, lines 1 through 24 on line 25.

Column 2.--Enter all payroll-related employee benefits for the HHA in the appropriate cost center in this column. See CMS Pub. 15-1, §§2144 - 2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages in column 1. Therefore, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (administrative and general - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care). Enter the sum of column 2, lines 1 through 24 on line 25.

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; and

All other payroll-related benefits based on gross salaries by cost center

Line 13.--Enter the costs of vaccines exclusive of the cost of administering the vaccines. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

The cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under the outpatient prospective payment system (OPPS), but the actual cost of the pneumococcal, influenza, and hepatitis B vaccines are cost reimbursed. Additionally, the cost of administering the osteoporosis drugs is included in the skilled nursing visit while the actual cost of the osteoporosis drug is reimbursed at reasonable cost.

Enter on this line the vaccine and drug cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza, and hepatitis B vaccines as well as osteoporosis drugs.

Some of the expenses includable in this cost center are the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14.--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Line 15.--Enter the telemedicine costs.

Lines 16-24.--These lines identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 16), respiratory therapy (line 17), private duty nursing (line 18), clinic (line 19), health promotion activities (line 20), day care program (line 21), home delivered meals program (line 22), and homemaker service (line 23). The cost of all other nonreimbursable services is aggregated on line 24. Use this line throughout all applicable worksheets.

4142 WORKSHEET H-1 - COST ALLOCATION HHA GENERAL SERVICE COST

Worksheet H-1, Part I, provides for the allocation of the expenses of each HHA general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the home health agency, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-1, Part I, the same cost centers with corresponding line numbers (lines 1 through 25) are listed on both worksheets.

Worksheet H-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the home health agency general service cost centers on Worksheet H-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4120 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The column and line numbers for each general service cost center are identical on both parts. In addition, the line numbers for each general, reimbursable, and nonreimbursable cost centers are identical on the two parts of the worksheet. The cost centers and line numbers are also consistent with Worksheet H.

The statistical bases shown at the top of each column on Worksheet H-1, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

When closing the general service cost center, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change *in order of* allocation *and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, §2313)*

Transfer the amounts on Worksheet H-1, Part I, column 6 to Worksheet H-2, Part I, column 0, as follows:

From Worksheet H-1 Part I, Column 6	To Worksheet H-2, Part I, Column 0
Line 6	Line 2
7	3
8	4
9	5
10	6
11	7
12	8
13	9
14	10
15	11
16	12
17	13
18	14
19	15
20	16
21	17
22	18
23	19
24	20

4143. WORKSHEET H-2 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Use this worksheet only if you operate a certified SNF-based HHA as part of your complex. If you have more than one SNF-based HHA, complete a separate worksheet for each facility.

4143.1 Part I - Allocation of General Service Costs to HHA Cost Centers--Worksheet H-2, Part I, provides for the allocation of the expenses of each general service cost center of the SNF to those cost centers which receive the services. Worksheet H-2, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-2, Part I.

Obtain the total direct expenses (column 0, line 21) from Worksheet A, column 7, line 70. Obtain the cost center allocation (column 0, lines 1 through 20) from Worksheet H-1, Part I, column 6, lines as indicated. The amounts on line 21, columns 0 through 15 and column 17 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 15 and column 17, line 70. Complete the amounts entered on lines 1 through 20, columns 1 through 15 and column 17.

Line 22.--Enter the unit cost multiplier (column 18, line 1, divided by the sum of column 18, line 21 minus column 18, line 1, rounded to 6 decimal places. Multiply each amount in column 18, lines 2 through 20, by the unit cost multiplier, and enter the result on the corresponding line of column 19.

4143.2 Part II - Allocation of General Service Costs to HHA Cost Centers -Statistical Basis--To facilitate the allocation process, the general format of Worksheet H-2, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet H-2, Part II, is the recommended basis of allocation of the cost center indicated.

NOTE: A change *in order of* allocation *and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology.* (See CMS Pub. 15-1, §2313)

If there is a change in ownership, the new owners may request that the contractor approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313)

Lines 1 through 20.--On Worksheet H-2, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 21.--Enter the total of lines 1 through 20 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 70.

Line 22.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 70, from the same column used to enter the statistical base on Worksheet H-2, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 70).

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

4145.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10.--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payor amounts.

Lines 11 through 20.--Enter in column 1 only for lines 11 through 14 as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 15 and 16, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 17 through 19 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 17 through 19 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21.--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

Line 23.--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 25.--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 27.--Enter the reimbursable bad debts in the appropriate columns. If recoveries exceed the current year’s bad debts, line 27 will be negative.

Line 28.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27.

Line 29.--Enter the result of line 26 plus line 27.

Line 30.-- Enter any other adjustments.

Line 30.99.--Enter the sequestration adjustment amount from the PS&R.

Line 31.--Enter the sum of the amount on line *29* minus lines 30.99, plus or minus line 30 and its subscripts no*t* previously identified.

Line 32.--Enter the interim payment amount from Worksheet H-5, line 4. For titles V and XIX, enter the interim payments from your records

Line 33.--For contractor use only: Enter the amount from Worksheet H-5, line 5.99.

Line 34.--Enter the sum of the amount on line 31 minus lines 32 and 33. Transfer to Worksheet S, Part III, line 4 as applicable.

Line 35.--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

Line Descriptions

Lines 1 through 9.--Enter the costs of your health care staff.

Line 10.--Enter the sum of the amounts on lines 1 through 9.

Line 11.--Enter the cost of physician medical services furnished under agreement.

Line 12.--Enter the expenses of physician supervisory services furnished under agreement.

Line 14.--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 19.--Enter the expenses of health care costs listed on these lines.

Line 21.--Enter the sum of the amounts on lines 15 through 19.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet I-2, Part II, line 12.

Lines 23 through 26.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27.--Reserved for future use.

Line 28.--Enter the sum of the amounts on lines 23 through 26. Transfer the total amount in column 7 to Worksheet I-2, line 13.

Line 29.--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30.--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31.--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet I-2, Part II, line 16.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total facility cost.

4149. WORKSHEET I-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

4149.1 Part I - Visits and Productivity.--Worksheet I-2, Part I, summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column Descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See *CMS Pub.* 100-04, Chapter 9, §40.3 for a definition of FTEs.)

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the *cost* reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Enter a level of 4200 visits for each physician (line 1) and a level of 2100 visits for each nonphysician practitioner (lines 2 and 3), unless you received an exception to these levels. If you were granted an exception to the productivity standards, enter the number of productivity visits approved by the contractor in lines 1 through 3.

Contractors have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the contractor need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Column 4.--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5.--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

On lines 5 through 9 and 11, enter the actual number of visits for each type of position.

Line Descriptions

Line 10.--Enter the total of lines 4 through 9.

Line 11.--Enter the number of visits furnished to facility patients by physicians under agreement with you. Physician's services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

4149.2 Part II - Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Worksheet I-2, Part II, determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 12.--Enter the cost of health care services from Worksheet I-1, column 7, line 22.

Line 13.--Enter the total nonreimbursable costs from Worksheet I-1, column 7, line 28.

Line 14.--Enter the sum of lines 12 and 13 for the cost of all services (excluding overhead).

Line 15.--Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 12 (the cost of health care services) by the amount on line 14 (the cost of all services, excluding overhead).

Line 16.--Enter the total facility overhead costs incurred from Worksheet I-1, column 7, line 31.

Line 17.--Enter the overhead cost incurred by the *SNF* allocated to the RHC/FQHC. This amount is the difference between the total costs allocated to the corresponding RHC/FQHC cost center on Worksheets B, Part I column 18, line 61 or 62, minus column 14, line 61 or 62, minus column 0, line 61 or 62.

Line 18.--Enter the sum of lines 16 and 17 to determine the total overhead costs related to the RHC/FQHC.

Line 19.--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 15 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20.--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 12 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

4150. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due *to or from the program* for the *cost* reporting period.

4150.1 Part I - Determination of Rate For RHC/FQHC Services.--Part I calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter the cost of vaccines and their administration from Worksheet I-4, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet I-2, Part I, column 5, line 10.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, column 5, line 11.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.--The limits are updated every January 1, Complete columns 1, 2 and if needed 3 of lines 8 and 9, if applicable (add a column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from your contractor.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For *cost reporting* periods beginning on January 1, complete column 2 only. For cost reporting periods beginning other than January 1, amounts will be entered in columns 1 and 2.

4150.2 Part II - Calculation of Settlement.-- Part II *calculates* the total payment *amount* due *to or from the Medicare program* for covered RHC/FQHC services furnished to program beneficiaries during the *cost* reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on January 1, then only column 2 is completed. For cost reporting periods beginning other than January 1, both columns 1 and 2 must be completed.

Line Descriptions

Line 10.--Enter the number of program covered visits, excluding visits subject to the outpatient mental health services limitation from your contractor*'s* records *(PS&R)*.

Line 11.--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the *cost* reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor*'s* records *(PS&R)*.

Line 13.--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. This limit applies only to therapeutic services, not initial diagnostic services. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: for services rendered through December 31, 2009, the limitation is 62.50 percent; for services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; for services from January 1 2012, through December 31, 2012, the limitation is 75 percent; for services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and for services on and after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total program cost. Enter the sum of the amounts on lines 11 and 14, in columns 1 and 2 respectively. *For cost reporting periods beginning on or after January 1, 2011 do not complete column 1 and enter the sum of the amounts on lines 11 and 14, columns 1 and 2 in column 2.*

NOTE: Section 4104 of the Affordable Care Act (ACA) eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Providers will need to maintain this documentation in order to apply the appropriate reductions on lines 15.03 and 15.04.

Line 15.01.--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 15.02.--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 15.03.--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15, columns 1 and 2)) in column 2.

Line 15.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program non- preventive costs ((line 15 minus lines 15.03 and 17) times .80)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 15, columns 1 and 2 minus lines 15.03 and 17) times .80)) in column 2.

Line 15.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter the total program costs (line 15 times .80) for services rendered prior to January 1, 2011, in column 1, and enter total program costs (line 15.03 plus line15.04) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program costs (line 15.03 plus line15.04), in column 2.

Line 16.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 16.

Line 17.--Enter the amount credited to the RHC program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contactor from clinic bills processed during the *cost* reporting period. RHCs determine this amount from the interim payment lists provided by the contractor. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the coinsurance amount applicable to the RHC or FQHC for program patients for visits on lines 10 and 12 as recorded by the contactor from clinic bills processed during the *cost* reporting period. Informational only.

Line 19.--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 16 from the amounts on line 15.05, columns 1 and 2.

Line 20.--Enter the total reimbursable program cost of vaccines and their administration from Worksheet I-4, line 16.

Line 21.--Enter the total reimbursable program cost (line 19 plus line 20).

Line 22.--Enter the total reimbursable bad debts, net of recoveries, from your records.

Line 22.01.--Enter the total adjusted reimbursable bad debt for cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: line 22 times 88 percent. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: line 22 times 76 percent. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 22 times 65 percent.

Line 23.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 22.

Line 24.--Enter any other adjustment. Specify the adjustment in the space provided.

Line 25.--Enter the sum of line 21 plus line 22, plus or minus line 24. For cost reporting periods that begin on or after October 1, 2012, enter the sum of line 21 plus line 22.01, plus or minus line 24.

Line 25.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 25]. *If line 25 is less than zero, do not calculate the sequestration adjustment.*

Line 26.--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records). Transfer amount from Worksheet I-5, line 4.

Line 27.--Your contractor will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 28.--Enter the total amount due to/from the program, line 25 minus lines 25.01, 26 and 27. Transfer this amount to Worksheet S, Part III, columns 1, 3, or 4 as applicable, line 5 or line 6 accordingly.

Line 29.--Enter the program reimbursement effect of protested items. The reimbursement effect of non-allowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2 §115.2)

4151. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines. Use this worksheet only for vaccines rendered to patients who at the time of receiving the vaccine(s) were not inpatients or outpatients of the *SNF*. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the *SNF* and cannot be claimed by the RHC and FQHC.

Effective for services rendered on and after September 1, 2009, in accordance with CR 6633, dated August 27, 2009, the administration of influenza A (H1N1) vaccines furnished by RHC's and FQHC's is cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include *the* physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet I-1, column 7, line 22. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet I-2, line 18.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.
Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet I-3, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet I-3, Part II, line 20.

4152. WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each rural health clinic and federally qualified health center.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Transfer the total interim payments to the title XVIII Worksheet I-3, line 26.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET I-5. LINES 5 THROUGH 9
ARE FOR CONTRACTOR USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: 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.

Line 7.-- The sum of lines 4, 5.99, and 6, column 2, must equal the amount on Worksheet I-3, line 25 plus or minus line 25.01.

4153. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC

Use this worksheet only if you operate as part of your complex a certified SNF-based community mental health center (CMHC). If you have more than one SNF-based CMHC, complete a separate worksheet for each provider.

4153.1 Part I - Allocation of General Service Costs to Cost Centers for CMHC.--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, line 73. Obtain the cost center allocation (column 0, lines 1 through 21) from your records.

4153.2 Part II - Allocation of General Service Costs to Cost Centers for CMHC. -Statistical Basis.--Worksheet J-1, Parts II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, are identical.

The statistical basis shown at the top of each column on Worksheet J-1, Part II is the recommended basis of allocation of the cost center indicated.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current *cost reporting period* if received by the contractor, in writing, within 90 days prior to the end of the *cost reporting period*. The contractor has 60 days to make a decision or the change is automatically accepted. The change must *be shown to* more accurate*ly* allocat*e the* overhead cost*, or if the change is as accurate, should be changed due to simplification of maintaining the statistics*. If a change in statistics is *requested*, the provider must maintain both sets of statistics until an approval is made. *The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.* If the request is denied, the provider *must use* to the previously approved methodology. *(See CMS Pub. 15-1, §2313)*

Lines 1 through 21.--On Worksheet J-1, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22.--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 73.

Line 23.--Enter the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, line 73, columns 1 through 18 as appropriate (e.g., capital-related cost buildings and fixtures, transfer the amount from Worksheet B, Part I, column 1, line 73 to Worksheet J-1, Part II, column 1).

Line 24.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

Line 4.--Enter the amounts paid and payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5.--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6.--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, Columns 4, and 8 as appropriate, lines 22 and 30.

NOTE: Title XVIII CMHCs and providers not subject to reasonable cost reimbursement do not complete lines 7 and 8.

Lines 7 and 8.--Lines 7 and 8 provide for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e). DO NOT complete for Title XVIII.

Enter on line 7 the excess of total customary charges (line 6) over the total reasonable cost (line 5). In situations when in any column the total charges on line 6 are less than the total cost on line 5, enter zero (0) on line 7.

Enter on line 8 the excess of total reasonable cost (line 5) over total customary charges (line 6). In situations when in any column the total cost on line 5 is less than the customary charges on line 6, enter zero (0) on line 8.

Line 9.--Title XVIII providers enter the total reasonable costs from line 5. Titles V and XIX providers not reimbursed under PPS enter the lesser of line 5 or line 6.

Line 10.--Enter the Part B deductibles billed to program patients (from your records).

Line 11.--Enter the Part B coinsurance billed to program patients (from your records).

Line 12.--Enter the sum of line 9 minus lines 10 and 11.

Line 13.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 13.01.--Enter the adjusted reimbursable bad debt for cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: line 13 times 88 percent. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: line 13 times 76 percent. For cost reporting periods that begin on or after October 1, 2014, calculate this line as follows: line 13 times 65 percent.

Line 14.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount must also be included in the amount on line 13.

Line 15.--Enter the sum of lines12 and 13. For cost reporting periods that begin on or after October1, 2012 enter the sum of lines 12 and 13.01.

Line 16.--Enter the amount of other adjustments from your records.

Line 17.--Enter the amount on line 15 plus or minus line 16.

Line 17.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 17]. *If line 17 is less than zero, do not calculate the sequestration adjustment.*

Line 18.--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 19.--Your contractor will enter the tentative adjustment from Worksheet J-4, line 5.99.

Line 20.--Enter the balance due component/program (sum of lines 17 minus lines 17.01, 18 and 19) and transfer this amount to Worksheet S, Part III, columns as appropriate, line 7.

Line 21.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a worksheet showing the details and computations for this line.

4156. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED CMHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each community mental health center.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Transfer the total interim payments to the title XVIII Worksheet J-3, line 18.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 9 ARE FOR CONTRACTOR USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: 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.

Line 7.--The sum of lines 4, 5.99, and 6, column 2, must equal the amount on Worksheet J-3, line 17 *plus or minus line 17.01*.

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Line 8 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine, and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs are recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 9 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians direct patient care services.

Line 10 - Nursing Care.--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11 - Nursing Care–Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 12 - Physical Therapy.--Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. *Physical* therapy may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, and to maintain health. *Occupational t*herapy may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Speech/Language Pathology.--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. *S*peech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 15.--Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 16, 17, and 18.--Counseling.--Counseling services must be available to the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for the individual to adjust to the their approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with such counseling are accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 35.

Line 19.--Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care.

Line 20.--Home Health Aide and Homemaker-Continuous Home Care.--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 21.--Other.--Enter on this line any other visiting *services* cost*s* which cannot be appropriately identified in the services already listed.

Line 22.--Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 22 (Drugs and Biologicals) and line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of Worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 23.--Analgesics.- Enter the cost of analgesics.

Line 24.--Sedatives/Hypnotics. - Enter the cost of sedatives/hypnotics.

Line 25.--Other Specify. - Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 26.--Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management
of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 27.--Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 28.--Imaging Services.--Enter the cost of imaging services including MRU.

Line 29.--Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 30.--Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 31.--Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 32-33.--Radiation Therapy and Chemotherapy.--Radiation, chemotherapy, and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 34.--Other (Specify).--Enter any additional costs involved in providing *other hospice* services which have not been provided for in the previous lines.

Lines 35-38.--Non Reimbursable Costs.--Enter *o*n the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (I)(1) (A) of the Social Security Act, bereavement counseling is a required hospice service, but it is not reimbursable.

Line 39.--Total.--Line 39 column 10, must agree with Worksheet A, line 83, column 7.

4158. WORKSHEET K-1 – HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 55 percent of that person's time, then enter 45 percent of the administrator's salary on line 6 (A&G) and 55 percent of the administrator's salary enter on line 10 (Nursing Care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the contractor, and the contractor can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the contractor determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, Chapter 21.)

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer.

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating *operations*. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director.

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Medical Social Worker (Column 3).-- These services must be *provided* under the direction of a physician by a social worker *who meets the requirements set forth in 42 CFR 418.114(b)(3)*.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that "the cost of the nonrevenue-producing cost center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first." This is clarified in CMS Pub. 15-1, §2306.1 which further clarifies the order of allocation for step down purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current *cost reporting period* if received by the contractor in writing within 90 days prior to the end of that *cost reporting period*. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is *as* accurate, *should* be changed due to simplification of maintaining the statistics. *The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used.* If a change in statistics is *requested*, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider *must use* the previously approved methodology. (See CMS Pub. 15-1, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, Part I column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 34. This enables column 6, line 34, to cross foot to columns 0 and 5A, line 34. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, Part I, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, Part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, Part II line 39, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, Part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, Part I, column 1, line 1.

Divide the amount entered on line 39 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 40. Round the unit cost multiplier to six decimal places. Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, Part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 39) of all of the cost centers receiving the allocation on Worksheet K-4, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets K-4, Part I & II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, Part I, enter in column 7 the sum of the expenses on lines 7 through 38. The total expenses entered in column 7, line 39, must equal the total expenses entered in column 0, line 39.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2.--Allocate all expenses (e.g., interest or personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4.--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-1, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6.--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A.-- Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, Part I, column 5A, line 39 and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A for (1) any service provided under arrangements to program patients only that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, Part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, column 5A and Worksheet K-4, Part II, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

4162. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Use this worksheet only if you operate a certified SNF-based hospice as part of your complex. If you have more than one SNF-based hospice, complete a separate worksheet for each facility.

4162.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the SNF to those cost centers which receive the services. Worksheet K-5, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, Part I.

Obtain the total direct expenses (column 0, line 34) from Worksheet A, column 7, line 83. Obtain the cost center allocation (column 0, lines 1 through 33) from Worksheet K-4 part I column 7, lines as indicated. The amounts on line 34, columns 0 through 16 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 16, line 83. Calculate the amounts entered on lines 1 through 33, columns 1 through 16.

Line 35.--Enter the unit cost multiplier (column 16, line 1), divided by the sum of column 16, line 34 minus column 16, line 1, rounded to 6 decimal places. Multiply each amount in column 16, lines 2 through 33, by the unit cost multiplier, and enter the result on the corresponding line of column 17.

In column 16, Part I, enter the total of columns 4A through 15.

In column 17, Part I, for lines 2 through 33, multiply the amount in column 16 by the unit cost multiplier on line 35, column 17, and enter the result in this column. On line 34, enter the total of the amounts on lines 2 through 33. The total on line 34 equals the amount in column 16, line 1.

In column 18, Part I, enter on lines 2 through 33 the sum of columns 16 and 17. The total on line 34 equals the total in column 16, line 34.

4162.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis

NOTE: *A* change *in order of* allocation *and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology.* (See CMS Pub. 15-1, §2313.)

If there is a change in ownership, the new owners may request that the contractor approve a change of allocation basis in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313.)

Lines 1 through 33.--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 34.--Enter the total of lines 1 through 33 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 83.

Line 35.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 83.

Line 36.-- Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35 by the total statistic entered in the same column on line 34. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on line 34, Part II.

Perform the preceding procedures for each general service cost center.

4162.3 Part III- Computation of Total Hospice Shared Costs.--This worksheet provides for the shared therapy, drugs, or medical supplies from the SNF to the hospice.

Column Description

Column 1.--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, column 3, lines as indicated.

Column 2.--Where SNF departments provide services to the hospice, enter on the appropriate lines the charges from the provider's records, applicable to the SNF-based hospice.

Column 3.--Multiply the amount in column 2 by the ratios in column 1 and enter the result in column 3.

Line 9.--Sum of column 3 lines 1 through 8.

4163. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per day for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet K-5, Part I, column 18, line 34, less column 18, line 33, plus Worksheet K-5, Part III, column 3, line 9. This line reflects the true cost including shared cost and excluding any non-hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-8, line 5, col. 6.

Line 3.--Average total cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-8, line 5, column 1.

Line 5.--Average Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the average Medicare cost.

Line 6.--Unduplicated Medicaid days from Worksheet S-8, line 5, column 2.

Line 7.--Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-8, line 5, column 3.

Line 9.--Average SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10.--Unduplicated NF days from Worksheet S-8, line 5, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.--Unduplicated other days from Worksheet S-8, line 5, column 5.

Line 13.--Average other cost. Multiply the average cost from line 3 by the number of unduplicated other days on line 12 to arrive at the average other cost.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 1 - RECORD SPECIFICATIONS

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:

SNNNNNNN.YYLC, where

1. SN (SNF electronic cost report) is constant;
2. NNNNNN is the 6 digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from skilled nursing facilities with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed.

Name each cost report PI file in the following manner:

PINNNNNN.YYLC, where

1. PI (Print Image) is constant;
2. NNNNNN is the 6 digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from skilled nursing facilities with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed.

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	For Future Use	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	SNF Provider CCN	6	9	17-22	Field must have 6 numeric characters
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "3" (for FORM CMS-2540-10)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 41-502.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1 (Continued)

		Size	Usage	Loc.	Remarks
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods *ending on or after 2014273 (September, 30 2014)* Prior approval(s) *2012275 for cost reporting periods beginning on or after October 1, 2012,* 2012213 for cost reporting periods ending on or after July 31, 2012 and 2010335 for cost reporting periods beginning on or after December 1, 2010.

RECORD NAME: Type 1 Records - Record Numbers 2 – 99

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number				#2 to #6 - Reserved for future use. #7 – The time that the cost report is created. This is represented in military time as alpha numeric. Use position 21-25. Example 2:30PM is expressed as 14:30. #8 to #99 - Reserved for future use
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "2"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Sub line Number	2	9	14-15	Numeric

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-5 (Cont.)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Amount of Federal Funds:	4-9	1	11	9
Award Date (MM/DD/YYYY)	4-9	2	10	X
Does this facility operate as other than an RHC or FQHC?	10	1	1	X
Indicate number of operation(s)	10	2	2	9
Type of operation	11	0	36	X
Facility hours of operations *				
Clinic - Hours: from/to	11	1-14	4	9
Have you received an approval for an exception to the productivity standard?	12	1	1	X
Is this a consolidated cost report in accordance with CMS Pub. 100-04, Chapter 9, §30.8?	13	1	1	X
Enter the number of providers included in this report.	13	2	2	9
Provider Name	14	1	36	X
Provider Number (CCN)	14	2	6	X

* List hours of operations based on a 24 hour clock. For example 8:00 AM is 0800, 6:30 PM is 1830, and midnight is 2400.

WORKSHEET S-6

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of hours in a normal work week	0	1	6	9(3).99
Other (specify)	18-19	0	36	X
Number of full time equivalent employees on staff	1-19	1	6	9(3).99
Number of full time equivalent contract personnel	1-19	2	6	9(3).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-7

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Days (see instructions)	1-99	2	6	9

Enter in column 1 the expense for each category. Enter in column 2 the percentage of total expense for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category.

Enter in column 1 the direct patient care expenses and related expenses for each category.				
Staffing	101	1	9	9
Recruitment	102	1	9	9
Retention of employees	103	1	9	9
Training	104	1	9	9
Other (Specify)	105	0	36	X
Other (Specify)	105	1	9	9
Enter in column 2 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue.				
Staffing	101	2	6	9(3).99
Recruitment	102	2	6	9(3).99
Retention of employees	103	2	6	9(3).99
Training	104	2	6	9(3).99
Other (Specify)	105	2	6	9(3).99
Do the increased RUG payments received reflect increases associated with direct patient care and related expenses (Y/N or N/A)				
Staffing	101	3	3	X
Recruitment	102	3	3	X
Retention of employees	103	3	3	X
Training	104	3	3	X
Other (Specify	105	3	3	X
Enter total SNF revenue from Worksheet G-2, Part I, line 1, column 3.	106	2	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET H-4, PART I

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I				
Total charges for title XVIII – Part A & B services	2	1-3	11	9
Amount collected from patients	3	1-3	11	9
Amounts collectible from patients	4	1-3	11	9
Primary payer payments	9	1-3	11	9

WORKSHEET H-4, PART II

Part II				
PPS Payments	11-20	1-2	11	9
Part B deductibles billed to Medicare patients	21	2	11	9
Coinsurance billed to Medicare patients	25	2	11	9
Reimbursable bad debts	27	1 & 2	11	9
Reimbursable bad debts for dual eligible beneficiaries (see instructions)	28	1 & 2	11	9
Other adjustments (Specify)	30	0	36	X
Other adjustments (Specify)	30	1 & 2	11	-9
Sequestration amount	30.99	1 *& 2*	11	-9
Interim payments (titles V and XIX only)	32	1	11	9
Protested amounts	35	1 & 2	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET H-5

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total interim payments paid to provider	1	2 & 4	11	9
Interim payments payable	2	2 & 4	11	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1 & 3	10	X
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2 & 4	11	9
Provider to program	3.50-3.98	2 & 4	11	9
Amount of tentative payment after desk review				
Date of each tentative settlement adjustment (MM/DD/YYYY)	5.01-5.98	1 & 3	10	X
Program to provider	5.01-5.49	2 & 4	11	9
Provider to program	5.50-5.98	2 & 4	11	9
Contractor Name	8	1	36	X
Contractor Number	8	2	5	X

WORKSHEET I-1

Provider based cost	1-9, 11-13, 15-19, 23-26, 29&30	1, 2, 4, 6, & 7	11	-9

WORKSHEET I-2

Number of FTE personnel	1-3, & 5-9	1	6	9(3).99
Total visits	1-3, 5-9, & 11	2	11	9
Productivity Standards	1-3	3	4	9
Greater of columns 2 or 4	4	5	11	9
Parent provider overhead allocated to facility (see instructions)	17	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED) (CONTINUED)

Worksheet	Lines
A-8-1, Part I	1-8, 10
A-8-1, Part II	1-9
A-8-2	All
B, Parts I & II	30-33, 71, 89, 98-100
B-1	30-33, 71, 89, 98-105
B-2	All
C	71, 100
D, Part I	71, 100
D, Part II	All
D, Part III	100
D-1	All
E, Part I	All except lines 14, 28
E, Part II	All except line 29
E-1	1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01-5.03, 5.50-5.52, 6-8
G	All
G-1	1-3,10,11,18,19
G-2, Part I	1-7, 9, 14
G-2, Part II	1,8,14,15
G-3	1-23, and 25, 26, 30, 31
H	All except 24
H-1, Parts I & II	All except 24
H-2, Parts I & II	All except 20
H-3, Parts I & II	All except lines 8-13
H-4, Part I	All
H-4, Part II	All except 30
H-5	1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01-5.03, 5.50-5.52, 6-8
I-1	All
I-2	All
I-3	All, except line 24
I-4	All
I-5	1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01-5.03, 5.50-5.52, 6-8
J-1, Parts I & II	All
J-2, Parts I & II	All
J-3	All except 16
J-4	1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01-5.03, 5.50-5.52, 6-8

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED) (CONTINUED)

Worksheet	Lines
K	All
K-1	All
K-2	All
K-3	All
K-4, Parts I & II	All
K-5, Parts I & II	All
K-5, Part III & K-6	All

TABLE 3D - PERMISSIBLE PAYMENT MECHANISMS

P = Prospective payment O = Other N = Not applicable

Component	Title V	Title XVIII	Title XIX
Skilled Nursing Facility	P or O	P	P or O *or N*
Nursing Facility	P or O *or N*	N	P or O *or N*
ICF/MR	N	N	O *or N*
SNF-Based HHA	P or O *or N*	P *or N*	P or O *or N*
SNF-Based RHC	O *or N*	O *or N*	O *or N*
SNF-Based FQHC	O *or N*	O *or N*	O *or N*
SNF-Based CMHC	O *or N*	P *or N*	O *or N*
SNF-Based OLTC	N	N	N
SNF-Based Hospice	N	N	N
OTHER	N	N	N

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 - EDITS

Reject Code	*Condition*
1090S	All amounts reported on Worksheet S-3, Part I must not be less than zero.
1091S	*If Worksheet S-3, Part 1, line 1, column 4 is greater than 0 and Worksheet S-2, Part 1, line 19 is "N" then Worksheet E, Part 1, line 1, column 1 must be greater than zero and Worksheet E-1, line 1, column 2, must be greater than zero. [07/01/2013b]*
1095S	For Worksheet S-3, Part I, the sum of the inpatient days in columns 3-6 for each of lines 1, 2, 3, and 5 must be equal to or less than the total inpatient days in column 7 for each line. [12/01/2010b]

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ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 – EDITS

Reject Code	Condition
1100S	For Worksheet S-3, Part I, the sum of the discharges in columns 8-11 for each of lines 1, 2, 3, and 5 must be equal to or less than the total discharges in column 12 for each line indicated. [12/01/2010b]
1105S	The amount of total salaries reported in column 1, line 1 (Worksheet S-3, Part II) must equal Worksheet A, Column 1, line 100. [12/01/2010b]
1110S	Worksheet S-3, Part II, column 4, sum of lines 1-4, 7-11, 14-16 must be greater than zero. [12/01/2010b]
1120S	For Worksheet S-3, Part II, all values for column 5, lines 1-16, must equal or exceed $5.15. When there are no salaries reported in column three, then it is okay to have zero amounts in columns 3 and 5. [12/01/2010b]
1125S	For Worksheet S-3, Part II, sum of columns 1 and 2 for each of the lines 2-4, 7-11, 14-21, as applicable must be equal to or greater than zero. [12/01/2010b]
1130S	Worksheet S-3, Part II, sum of columns 1 & 2, line 13 must be greater than zero. [12/01/2010b]
1135S	The amount of hours reported on Worksheet S-3, Part III, column 4, lines 1-11 and 13 must be greater than zero when the corresponding lines in column 3 are greater than zero. [12/01/2010b]
1140S	The amount reported on Worksheet S-3, Part IV, line 24 must be greater than zero. [12/01/2010b]
1145S	Worksheet S-3, Part V, columns 1, *line 4 or 17* must be greater than zero. [01/01/2012b]
1150S	Worksheet S-3, Part V, if there is an amount in column 1 there must be an amount in column 4 for each respective line and vice versa. [01/01/2012b]
1160S	If Worksheet S-4 column 1, line 22 has data, then it must be five digits, including leading zeros where applicable. [07/31/2012]
1200S	Worksheet S-5, Line 13: If the response in column 1 = "Y", then column 2 must be greater than zero. If the response in column 1 = "N", then column 2 must = zero. [12/01/2010b]
1205S	If Worksheet S-5, line 10, column 1 is "Y", then column 2 must be greater than or equal to 1. There must be a subscript on line 11 equal to the number entered on line 10, column 2. If line 10, column 1 is "N", there cannot be any subscripts on line 11. [12/01/2010b]
1210S	Worksheet S-7: Column 2, sum of lines 1 through 99 must agree with Worksheet S-3, Part I, column 4, line 1. [12/01/2010b]
1000A	Worksheet A, columns 1 and 2, line 100 must be greater than zero. [12/01/2010b]
1015A	On Worksheet A, line 81 column 2 and the corresponding reclassifications and adjustments must equal zero. On lines 80 and 82, respectively, the sum of columns 1 and 2 and the corresponding reclassifications and adjustments must equal zero. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 – EDITS

Reject Code	Condition
1020A	For reclassifications reported on Worksheet A-6, the sum of all increases (columns 4 and 5) must equal the sum of all decreases (columns 8 and 9). [12/01/2010b]
1025A	For each line on Worksheet A-6, if there is an entry in columns 4 and/or, 5, there must be an entry in columns 1 and 3, and if there is an entry in columns 8 and/or 9, there must be an entry in columns 1 and 7. All entries in column 1 must be an UPPER CASE Alpha Character. All entries must be valid, for example, no salary adjustments in columns 4 and/or 8, for capital lines 1 & 2 of Worksheet A. [12/01/2010b]
1040A	For Worksheet A-8 adjustments on lines 1-7, 9-11, and 13-24, if column 2 has an entry, then columns 1 and 4 must have entries and for lines 25-99 and subscripts, if column 2 has an entry, then all four columns (0, 1, 2 and 4) for that line must have entries. [12/01/2010b]
1041A	The total Utilization Review amount shown on Worksheet E, Part I, Line 10, may not be greater than the amount on Worksheet A-8, line 22. (Absolute value of line 22) [12/01/2010b]
1045A	If Worksheet A-8-1, Part I, either of columns 4 or 5, lines 1 through 9 does not equal zero, then columns 1 and 3 of the corresponding line must be present. [12/01/2010b]
1050A	On Worksheet A-8-2, column 3 must be equal to or greater than the sum of columns 4 and 5. If column 5 is greater than zero, column 6, and column 7 must be greater than zero. Transfer only the total on line 100, column 18 to Worksheet A-8, column 2 [12/01/10b]
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [12/01/2010b]
1005B	Worksheet B, Part I, column 18, line 100 must be greater than zero. [12/01/2010b]
1010B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1 through 15, line 102), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any column, including any reconciliation column that uses accumulated cost as its basis for allocation. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

Reject Code	*Condition*
1015B	For any column that uses accumulated cost as its basis of allocation (Worksheet B-1), if there is a negative one (-1) in the accumulated cost column, then there may not be an amount in the reconciliation column for the same cost center line. [12/01/2010b]
1010C	On Worksheet C, all amounts in columns 1 and 2, respectively, line 100 must be greater than or equal to zero. [12/01/2010b]
1000D	On Worksheet D, all amounts must be greater than or equal to zero. [12/01/2010b]
1005D	The total charges on Worksheet C, column 2, lines 40-48, 50-52 and 60-71 must be greater than, or equal to the sum of Worksheet D, Part I, columns 2 and 3, lines 40-48, 50-52 and 60-71 respectively. Worksheet C, column 2, line 49 must be greater than, or equal to the sum of Worksheet D, Part I, columns 2 and 3, line 49,, plus Worksheet D, Part II, line 2. [12/01/2010b]
1010D	*If Worksheet S-3, Part I, line 1, column 4 is greater than zero then Worksheet D-1, Part1, line 6 must be greater than zero. [9/30/2014]*
1000H	Worksheet H-2 Part I: Column 0 line 21 must equal Worksheet A column 7 line 70. [12/01/2010b]
1005H	Worksheet H-2 Part I: sum of columns 0-3, 4-15, line 21 must equal the corresponding columns on Worksheet B Part I, line 70 and its subscripted lines, respectively. [12/01/2010b]
1010H	Worksheet H-2, Part II: sum of lines 1-20 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-1, line 70 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b]
1015H	Worksheet H-3, Part I, column 4, sum of lines 1 through 6, must equal total visits reported on Worksheet S-3, Part I, column 7, line 4. [12/01/2010b]
1020H	The sum of title XVIII visits, columns 6 and 7 on Worksheet H-3, Part I, must equal, the corresponding amounts on Worksheet S-4, lines 23, 25, 27, 29, 31 and 33, respectively. Also, Worksheet H-3, Part I, lines 8 through 13, columns 2 and 3, sum of all CBSA's, for each respective discipline, must equal the total visits for the same respective discipline, on lines 1 through 6, columns 6 and 7. [12/01/2010b]
1000I	If Worksheet I-1 is present, then Worksheet S-5 must be present and vice versa. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

Reject Code	*Condition*
1010I	If Worksheet S-5, line 12 equals "Y", Worksheet I-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely if Worksheet S-5, line 12 equals "N", Worksheet I-2, column 3, lines 1, 2, and 3 must contain the values 4200, 2100, and 2100. Apply this edit to both the RHC and FQHC components. [12/01/2010b]
1020I	The sum of Worksheet I-1, column 7, lines 1-9, 11-13, 15-19, 23-26, and 29-30 must equal the amount on Worksheet A, column 7, RHC/FQHC as appropriate. [12/01/2010b]
1000J	Worksheet J-1 Part I: sum of columns 0-3, and 4-15, line 22 must equal the corresponding columns on Worksheet B Part I, line 73 and its subscripted lines, respectively. [12/01/2010b]
1010J	Worksheet J-1 Part II: sum of lines 1-21 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-I, line 73 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b]
1000K	Worksheet K, column 10, line 39, must equal Worksheet A column 7 line 83 and vice versa [07/31/2012].
1010K	Worksheet K-5 Part II: sum of lines 1-33 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-I, line 83 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

Edit	Condition
2040	All calendar format dates must be edited for 10 character format, e.g., 06/22/2011 (MM/DD/YYYY).] [12/01/2010b]
2045	Administrative and general cost center code 0400-0449 may appear only on line 4 and subscripts of line 4. [12/01/2010b]
2050	All dates must be possible, e.g., no "00", no "30" or "31" of February. [12/01/2010b]
2000S	The SNF certification date (Worksheet S-2, Part I, column 3, line 4) should be on or before the cost report beginning date (Worksheet S-2, Part I, column 1, line 14). [12/01/2010b]
2005S	The length of the cost reporting period should be greater than 27 days and less than 459 days. [12/01/2010b]
2010S	Worksheet S-2, Part I, line 15 (type of control) must have a value of 1 through 13. [12/01/2010b]
2015S	The sum of column 1, lines 1-4, 7-11, 14-16, and 17-21 (Worksheet S-3, Part II) must be greater than zero. [12/01/2010b]
2115S	The amount on Worksheet S-3, Part II, column 3, line 17 minus line 19 (total wage related costs), must be greater than 7.65 percent and less than 50.0 percent of the amount in column 3, sum of lines 13 (total adjusted salaries). [12/01/2010b]
2120S	If Worksheet S-2, *P*art I, line 19 is Y for yes, then line 19.01 must be Y for yes. [12/01/2010b]
2150S	If Worksheet S-3, Part II (column 4, sum of lines 7 through 11 divided by the sum of line 1 minus the sum of lines 3 and 4) is greater than 5 percent, then Worksheet S-3, Part III, column 1, line 14 must equal the sum of the amounts on Worksheet A, column 1, lines 3 through 13, and 15. [12/01/2010b]
2155S	If Worksheet S-3, Part II (column 4, sum of lines 7 through 11 divided by the sum of line 1 minus the sum of lines 3 and 4) is equal to or greater than 15 percent, then Worksheet S-3, Part III, columns 1 and 4 for line 14 should be greater than zero. [12/01/2010b]
2160S	If Worksheet S-3, Part III, column 4, line 14 is greater than zero, then those hours should be at least 20 percent but not more than 60 percent of Worksheet S-3, Part II, column 4, line 1. [12/01/2010b]
2165S	Worksheet S-7, lines 101 through 105, for each line that includes an amount in column 1 and a percentage in column 2, a response must be included in column 3. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

Edit	*Condition*
2000A	Worksheet A-6, column 1 (reclassification code) must be alpha characters. [12/01/2010b]
2005A	For each line on Worksheet A-6, if there is an entry in column 1 and/or 3, there should be an entry in column 4 and/or 5, and if there is an entry in column 1 and/or 7, there should be an entry in column 8 and/or 9. [12/01/2010b]
2025A	For Worksheet A-8 if any one of columns 0, 1, or 4 for lines 25-99 and subscripts thereof has an entry, then all four columns for that line should have entries. [12/01/2010b]
2041A	For Worksheet A-7, line 7, the sum of columns 1 through 3, minus column 5 must be greater than zero. [12/01/2010b]
2046A	If Worksheet S-2, Part I, lines 18 or 43 are "Y", Worksheet A-8-1, Part I, columns 4 or 5, sum of lines 1-9 must be greater than zero; and Part II, column 1, any one of lines 1-10 must contain any one of alpha characters A thru G. [12/01/2010b]
2000B	At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center with costs to allocate. This edit applies to all general service cost centers required and/or listed. [12/01/2010b]
2005B	The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [12/01/2010b]
2000E	*For cost reporting periods that overlap April 1, 2013, if Worksheet E, Part I, the sum of lines 2, 6, 10, and 14 through 14.98 are greater than zero, Worksheet E, Part I, line 14.99 must equal [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 11 plus or minus lines 14 through 14.98)] [06/30/2014]*
2005E	*If Worksheet E, Part I, the sum of lines 24 and 28 through 28.98 are greater than zero, Worksheet E, Part I, line 28.99 must equal [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of (line 25 plus or minus lines 28 through 28.98)] [12/31/2013] For cost reporting periods ending on or after June 30, 2014 "DO NOT APPLY THIS EDIT"*
2000G	Total assets on Worksheet G (line 34, sum of columns 1-4) must equal total liabilities and fund balances (line 60, sum of columns 1-4). [12/01/2010b]
2010G	Net income or loss (Worksheet G-3, column 1, line 31) should not equal zero. [12/01/2010b]
2015G	Contractual allowances (Worksheet G-3, column 1, line 2) should not be negative. [07/31/2012]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet userrequirements.

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

FORM APPROVED
OMB NO. 0938-0463

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

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronic filed cost report Date:_____ Time:_____ 2. [ ] Manually submitted cost report 3. If this is an amended report enter the number of times the provider resubmitted this cost report. _____	
Contractor use only:	4. [ ] Cost Report Status [1] As Submitted: [2] Settled without audit [3] Settled with audit [4] Reopened [5] Amended	5. Date Received _____ 6. Contractor No. _____ 7. [ ] First Cost Report for this Provider CCN 8. [ ] Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. If line 4, column 1 is "4": Enter number of times reopened _____ 11. Contractor Vendor Code _____

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS)

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

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name_____ Signed_____

Title_____ Date_____

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3		
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F-Mentally Retarded					3
4	SNF - BASED HHA					4
5	SNF - BASED RHC					5
6	SNF - BASED FQHC					6
7	SNF - BASED CMHC					7
100	TOTAL					100

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART I

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	P.O. Box:			1
2	City:	State:	ZIP Code		2
3	County:	CBSA Code:	Urban / Rural:		3

SNF and SNF - Based Component Identification:

	Component	Component Name	Provider CCN	Date Certified	Payment System (P, O or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
4	S N F							4
5	Nursing Facility							5
6	I C F - Mentally Retarded							6
7	SNF-Based HHA							7
8	SNF-Based RHC							8
9	SNF-Based FQHC							9
10	SNF-Based CMHC							10
11	SNF-Based OLTC							11
12	SNF-Based HOSPICE							12
13	OTHER (specify)							13
14	Cost Reporting Period (mm/dd/yyyy) From:	To:						14
15	Type of Control (see instructions)							15

Type of Freestanding Skilled Nursing Facility		Y / N					
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						17
18	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.						18

Miscellaneous Cost Reporting Information						
19	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.					19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)					19.01

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.						
20	Straight Line					20
21	Declining Balance					21
22	Sum of the Year's Digits					22
23	Sum of line 20 through 22					23
24	If depreciation is funded, enter the balance as of the end of the period.					24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)					25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y?N)					27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM_____ TO_____	WORKSHEET S-2 PART I

	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.	Part A	Part B	Other	
29	Skilled Nursing Facility				29
30	Nursing Facility				30
31	I C F / M R				31
32	SNF-Based HHA				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
36	SNF-Based OLTC				36

		Y / N			
37	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients. (Y/N)				37
38	Are you legally required to carry malpractice insurance? (Y/N)				38
39	Is the malpractice a "claims-made" or "occurence" policy? If the policy is "claims-made," enter 1. If the policy is "occurence", enter 2.				39

		Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:				41

		Y / N					
42	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If "Y", check box, and submit supporting schedule listing cost centers and amounts.						42
43	Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?						43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.						44

If this facility is part of a chain organization, enter the name and address of the home office on the lines below.

45	Name:		Contractor Name:	Contractor Number:	45
46	Street:	P.O. Box:			46
47	City	State	ZIP Code		47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART II

General Instruction: For all column 1 responses, enter in column 1, "Y" for Yes or "N" for No
For all dates responses, use the format mm/dd/yyyy.

Completed by All Skilled Nursing Facilities

		Y/N	Date	
Provider Organization and Operation		1	2	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)			1

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

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Were costs claimed for nursing school? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)			6
7	Were costs claimed for allied health programs? (Y/N) (see instructions)			7
8	Were approvals and/or renewals obtained during the cost reporting period for nursing school and/or allied health program? (Y/N) (see instructions)			8

		Y/N	
Bad Debts		1	
9	Is the provider seeking reimbursement for bad debts? (Y/N) (see instructions)		9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		11

Bed Complement

12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		12

		Y/N Part A	Date Part A	Y/N Part B	Date Part B	
PS&R Report Data		1	2	3	4	
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid-through date of the PS&R used to prepare this cost report in cols. 2 and 4 . (see Instructions)					13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y", enter the paid-through date of the PS&R used to prepare this cost report in columns 2 and 4.					14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see instructions.					15
16	If line 13 or 14 is "Y", were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16
17	If line 13 or 14 is "Y", were adjustments made to PS&R data for Other? Describe the other adjustments:_____					17
18	Was the cost report prepared only using the provider's records? If "Y", see instructions.					18

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART I

PART I - STATISTICAL DATA

	Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Facility													1
2	Nursing Facility													2
3	ICF-Mentally Retarded													3
4	Home Health Agency													4
5	Other Long Term Care													5
6	SNF-Based CMHC													6
7	Hospice													7
8	Total (sum of lines 1-7)													8

	Component	Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2	Nursing Facility												2
3	ICF - Mentally Retarded												3
4	Home Health Agency												4
5	Other Long Term Care												5
6	SNF-Based CMHC												6
7	Hospice												7
8	Total (sum of lines 1-7)												8

SNF WAGE INDEX INFORMATION	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PARTS II & III

PART II - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
SALARIES							
1	Total salary (see instructions)						1
2	Physician salaries-Part A						2
3	Physician salaries-Part B						3
4	Home office personnel						4
5	Sum of lines 2 through 4						5
6	Revised wages (line 1 minus line 5)						6
7	Other Long Term Care						7
8	Home Health Agency						8
9	CMHC						9
10	Hospice						10
11	Other excluded areas						11
12	Subtotal excluded salary (sum of lines 7 through 11)						12
13	Total adjusted salaries (line 6 minus line 12)						13
OTHER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt						14
15	Contract Labor: Physician services-Part A						15
16	Home office salaries & wage related costs						16
WAGE RELATED COSTS							
17	Wage related costs core (see Pt. IV)						17
18	Wage related costs other (see Pt. IV)						18
19	Wage related costs (excluded units)						19
20	Physicians Part A - WRC						20
21	Physicians Part B - WRC						21
22	Total adjusted wage related cost (see instructions)						22

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
1	Employee Benefits						1
2	Administrative & General						2
3	Plant Operation, Maintenance & Repairs						3
4	Laundry & Linen Service						4
5	Housekeeping						5
6	Dietary						6
7	Nursing Administration						7
8	Central Services and Supply						8
9	Pharmacy						9
10	Medical Records & Medical Records Library						10
11	Social Service						11
12	Nursing and Allied Health Ed. Act.						12
13	Other General Service (specify _____)						13
14	Total (sum lines 1 through 13)						14

SNF WAGE RELATED COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

	Part A - Core List	Amount Reported	
	RETIREMENT COST		
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organizations)		
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
	TAXES		
17	FICA - Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (sum of lines 1 -23)		24
	Part B Other than Core Related Cost		
25	Other Wage Related Costs (specify)_____		25

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART V

	OCCUPATIONAL CATEGORY	Amount Reported 1	Fringe Benefits 2	Adjusted Salaries (col. 1 + col. 2) 3	Paid Hours Related to Salary in col. 3 4	Average Hourly Wage (col. 3 ÷ col. 4) 5	
Direct Salaries							
	Nursing Occupations						
1	Registered Nurses (RNs)						1
2	Licensed Practical Nurses (LPNs)						2
3	Certified Nursing Assistants/Nursing Assistants/Aides						3
4	Total Nursing (sum of lines 1 through 3)						4
5	Physical Therapists						5
6	Physical Therapy Assistants						6
7	Physical Therapy Aides						7
8	Occupational Therapists						8
9	Occupational Therapy Assistants						9
10	Occupational Therapy Aides						10
11	Speech Therapists						11
12	Respiratory Therapists						12
13	Other Medical Staff						13
Contract Labor							
	Nursing Occupations						
14	Registered Nurses (RNs)						14
15	Licensed Practical Nurses (LPNs)						15
16	Certified Nursing Assistants/Nursing Assistants/Aides						16
17	Total Nursing (sum of lines 14 through 16)						17
18	Physical Therapists						18
19	Physical Therapy Assistants						19
20	Physical Therapy Aides						20
21	Occupational Therapists						21
22	Occupational Therapy Assistants						22
23	Occupational Therapy Aides						23
24	Speech Therapists						24
25	Respiratory Therapists						25
26	Other Medical Staff						26

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SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-4

	HOME HEALTH AGENCY STATISTICAL DATA		
1	County		1

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

	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)	Staff	Contract	Total	
		1	2	3	
4	Enter the number of hours in your normal work week				4
5	Administrator and Assistant Administrator(s)				5
6	Directors and Assistant Director(s)				6
7	Other Administrative Personnel				7
8	Direct Nursing Service				8
9	Nursing Supervisor				9
10	Physical Therapy Service				10
11	Physical Therapy Supervisor				11
12	Occupational Therapy Service				12
13	Occupational Therapy Supervisor				13
14	Speech Pathology Service				14
15	Speech Pathology Supervisor				15
16	Medical Social Service				16
17	Medical Social Service Supervisor				17
18	Home Health Aide				18
19	Home Health Aide Supervisor				19
20	Other (specify)				20

	HOME HEALTH AGENCY CBSA CODES		
21	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		21
22	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 contains the first code).		22

	PPS ACTIVITY DATA	Full Episodes		LUPA Episodes	PEP only Episodes	Total (cols. 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
23	Skilled Nursing Visits						23
24	Skilled Nursing Visit Charges						24
25	Physical Therapy Visits						25
26	Physical Therapy Visit Charges						26
27	Occupational Therapy Visits						27
28	Occupational Therapy Visit Charges						28
29	Speech Pathology Visits						29
30	Speech Pathology Visit Charges						30
31	Medical Social Service Visits						31
32	Medical Social Service Visit Charges						32
33	Home Health Aide Visits						33
34	Home Health Aide Visit Charges						34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)						35
36	Other Charges						36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)						37
38	Total Number of Episodes (standard/non outlier)						38
39	Total Number of Outlier Episodes						39
40	Total Non-Routine Medical Supply Charges						40

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-5

Check applicable box: [ ] RHC [ ] FQHC

Clinic Address and Identification:

1	Street:		County:	1
2	City:	State:	Zip Code:	2
3	Designation (for FQHC's only) - "U" for urban or "R" for rural			3

Source of Federal funds:		Grant Award	Date	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look - Alikes			8
9	Other (specify)			9

		1	2	
10	Does the facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations (1)

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

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

		1	2	
12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report in accordance with IOM CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14	Provider Name:	CCN Number:		14

SNF- BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT RE*H* ABILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-6

Check applicable box: [ ] CMHC [ ] CORF [ ] OPT [ ] OOT [ ] OSP

Enter the number of hours in your normal workweek _____

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

		Staff	Contract	Total (col. 1 + col. 2)	
		1	2	3	
1	Administrator and Assistant Administrator(s)				1
2	Director(s) and Assistant Director(s)				2
3	Other Administrative Personnel				3
4	Direct Nursing Service				4
5	Nursing Supervisor				5
6	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
16	Psychiatric/Psychological Service				16
17	Psychiatric/Psychological Service Supervisor				17
18	Other (specify)				18
19	Other (specify)				19

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

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

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

	GROUP	Days	
	1	2	
51	CA2		51
52	CA1		52
53	SE3		53
54	SE2		54
55	SE1		55
56	SSC		56
57	SSB		57
58	SSA		58
59	IB2		59
60	IB1		60
61	IA2		61
62	IA1		62
63	BB2		63
64	BB1		64
65	BA2		65
66	BA1		66
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PA1		76
99	AAA		99
100	Total		100

A notice published in the "Federal Register" Vol. 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 101 through 106: Enter in column 1 the amount of 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 1 column3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (see instructions)

		Expenses	Percentage	Y/N	
		1	2	3	
101	Staffing				101
102	Recruitment				102
103	Retention of employees				103
104	Training				104
105	Other (Specify)				105
106	Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)				106

HOSPICE IDENTIFICATION DATA	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S - 8

PART I - ENROLLMENT DAYS

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col. 1, 2 & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing facility	Title XIX Nursing Facility	All Other	Total (sum of col. 1, 2 & 5)	
		1	2	3	4	5	6	
6	Number of patients receiving hospice care							6
7	Total number of unduplicated Continuous Care hours billable to Medicare							7
8	Average length of stay (line 5 / line 6)							8
9	Unduplicated census count							9

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET A

		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	B	C	1	2	3	4	5	6	7	A
GENERAL SERVICE COST CENTERS										
1	0100	Capital-Related Costs - Buildings & Fixtures								1
2	0200	Capital-Related Costs - Moveable Equipment								2
3	0300	Employee Benefits								3
4	0400	Administrative and General								4
5	0500	Plant Operation, Maintenance and Repairs								5
6	0600	Laundry and Linen Service								6
7	0700	Housekeeping								7
8	0800	Dietary								8
9	0900	Nursing Administration								9
10	1000	Central Services and Supply								10
11	1100	Pharmacy								11
12	1200	Medical Records and Library								12
13	1300	Social Service								13
14	1400	Nursing and Allied Health Education								14
15		Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS										
30	3000	Skilled Nursing Facility								30
31	3100	Nursing Facility								31
32	3200	ICF - Mentally Retarded								32
33	3300	Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS										
40	4000	Radiology								40
41	4100	Laboratory								41
42	4200	Intravenous Therapy								42
43	4300	Oxygen (Inhalation) Therapy								43
44	4400	Physical Therapy								44
45	4500	Occupational Therapy								45
46	4600	Speech Pathology								46
47	4700	Electrocardiology								47

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET A (Cont.)

		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase /Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	B	C	1	2	3	4	5	6	7	
48	4800	Medical Supplies Charged to Patients								48
49	4900	Drugs Charged to Patients								49
50	5000	Dental Care - Title XIX only								50
51	5100	Support Surfaces								51
52		Other Ancillary Service Cost								52
OUTPATIENT SERVICE COST CENTERS										
60	6000	Clinic								60
61	6100	Rural Health Clinic (RHC)								61
62	6200	FQHC								62
63		Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS										
70	7000	Home Health Agency Cost								70
71	7100	Ambulance								71
72		Outpatient Rehabilitation (specify)								72
73	7300	CMHC								73
74		Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS										
80	8000	Malpractice Premiums & Paid Losses							-0-	80
81	8100	Interest Expense							- 0 -	81
82	8200	Utilization Review							- 0 -	82
83	8300	Hospice								83
84		Other Special Purpose Cost								84
89		SUBTOTALS (sum of lines 1 through 84)								89
NON REIMBURSABLE COST CENTERS										
90	9000	Gift, Flower, Coffee Shops and Canteen								90
91	9100	Barber and Beauty Shop								91
92	9200	Physicians' Private Offices								92
93	9300	Nonpaid Workers								93
94	9400	Patients' Laundry								94
95		Other Nonreimbursable Cost								95
100		TOTAL								100

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASE				DECREASE				
			COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	
		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
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
100	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2)										100

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-7

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

ADJUSTMENTS TO EXPENSES | PROVIDER CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET A-8

	Description (1)	Basis for Adjustment (2)	Amount	Expense Classification on Wkst. A to/from which the amount is to be adjusted		
				Cost Center	Line No.	
	0	1	2	3	4	
1	Investment income on restricted funds (Chapter 2)					1
2	Trade, quantity and time discounts on purchases (Chapter 8)					2
3	Refunds and rebates of expenses Chapter 8)					3
4	Rental of provider space by suppliers Chapter 8)					4
5	Telephone services (pay stations excluded) (Chapter 21)					5
6	Television and radio service (Chapter 21)					6
7	Parking lot (Chapter 21)					7
8	Remuneration applicable to provider-based physician adjustment	Worksheet A-8-2				8
9	Home office costs (Chapter 21)					9
10	Sale of scrap, waste, etc. (Chapter23)					10
11	Nonallowable costs related to certain Capital expenditures (Chapter 24)					11
12	Adjustment resulting from transactions with related organizations (Chapter 10)	Worksheet A-8-1				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (Chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Utilization review--physicians' compensation (Chapter 21)			Utilization Review- SNF	82	22
23	Depreciation--buildings and fixtures			Capital Related Cost- Building	1	23
24	Depreciation--movable equipment			Capital Related Cost-Movable	2	24
25	Other Adjustment					25
100	TOTAL (sum of lines 1 through 99) (transfer to Wkst. A, col. 6, line 100)					100

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

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

PART I - 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 Allowable In Cost	Amount Included in Wkst. A., col. 5	Adjustments (col. 4 minus col. 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS (sum of lines 1-9) (Transfer column 6, line 10 to Wkst. A-8, col. 3, line 12)						10

PART II - 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 II 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 Organization(s)			
	(1) Symbol	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

(1) Use the followings 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 organization.
E. Individual is director, officer, administrator or key person of provider and related organization.
F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial or non-financial) specify _____
_____

PROVIDER - BASED PHYSICIANS ADJUSTMENTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-8-2

	Wkst. A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E 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
100		TOTAL								100

	Wkst. A Line No.	Cost Center / Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of Col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of Col. 14	Adjusted R C E Limit	R C E 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
100		TOTAL								100

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS-TRATIVE & GENERAL	
	0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							1
2 Capital-Related Costs - Moveable Equipment							2
3 Employee Benefits							3
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							5
6 Laundry and Linen Service							6
7 Housekeeping							7
8 Dietary							8
9 Nursing Administration							9
10 Central Services and Supply							10
11 Pharmacy							11
12 Medical Records and Library							12
13 Social Service							13
14 Nursing and Allied Health Education							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - Mentally Retarded							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							46
47 Electrocardiology							47
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							49
50 Dental Care - Title XIX only							50
51 Support Surfaces							51
52 Other Ancillary Service Cost							52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3 A	4	
	OUTPATIENT SERVICE COST CENTERS							
60	Clinic							60
61	Rural Health Clinic (RHC)							61
62	FQHC							62
63	Other Outpatient Service Cost							63
	OTHER REIMBURSABLE COST CENTERS							
70	Home Health Agency Cost							70
71	Ambulance							71
72	Outpatient Rehabilitation (specify)							72
73	CMHC							73
74	Other Reimbursable Cost							74
	SPECIAL PURPOSE COST CENTERS							
83	Hospice							83
84	Other Special Purpose Cost							84
89	Subtotals							89
	NON REIMBURSABLE COST CENTERS							
90	Gift, Flower, Coffee Shops and Canteen							90
91	Barber and Beauty Shop							91
92	Physicians' Private Offices							92
93	Nonpaid Workers							93
94	Patients' Laundry							94
95	Other Nonreimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
	0	1	2	3	4 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							1
2 Capital-Related Costs - Moveable Equipment							2
3 Employee Benefits							3
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							5
6 Laundry and Linen Service							6
7 Housekeeping							7
8 Dietary							8
9 Nursing Administration							9
10 Central Services and Supply							10
11 Pharmacy							11
12 Medical Records and Library							12
13 Social Service							13
14 Nursing and Allied Health Education							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - Mentally Retarded							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							46
47 Electrocardiology							47
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							49
50 Dental Care - Title XIX only							50
51 Support Surfaces							51
52 Other Ancillary Service Cost							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
	0	1	2	3	4 A	4	
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustment							98
99 Negative Cost Center							99
102 Cost to be allocated (Per Wkst. B, Pt I.)							102
103 Unit Cost Multiplier (Wkst. B, Pt I.)							103
104 Cost to be allocated (Per Wkst. B, Pt. II)							104
105 Unit Cost Multiplier (Wkst B, Pt. II)							105

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B - 1

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B - 1

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustment								98
99	Negative Cost Center								99
102	Cost to be allocated (Per Wkst. B, Pt I.)								102
103	Unit Cost Multiplier (Wkst. B, Pt I.)								103
104	Cost to be allocated (Per Wkst. B, Pt. II)								104
105	Unit Cost Multiplier (Wkst B, Pt. II)								105

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B - 1

	Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B - 1

	Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDU EDUCATION (Assigned Time)	GENERAL SERVICE COST COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustment								98
99	Negative Cost Center								99
102	Cost to be allocated (Per Wkst. B, Pt I.)								102
103	Unit Cost Multiplier (Wkst. B, Pt I.)								103
104	Cost to be allocated (Per Wkst. B, Pt. II)								104
105	Unit Cost Multiplier (Wkst B, Pt. II)								105

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B PART II			
	Cost Center Description	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART II

	Cost Center Description	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	OUTPATIENT SERVICE COST CENTERS								
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
	OTHER REIMBURSABLE COST CENTERS								
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
	SPECIAL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
	NON REIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART II

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Buildings & Fixtures							1
2	Capital-Related Costs - Moveable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education							14
15	Other General Service Cost							15
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF - Mentally Retarded							32
33	Other Long Term Care							33
	ANCILLARY SERVICE COST CENTERS							
40	Radiology							40
41	Laboratory							41
42	Intravenous Therapy							42
43	Oxygen (Inhalation) Therapy							43
44	Physical Therapy							44
45	Occupational Therapy							45
46	Speech Pathology							46
47	Electrocardiology							47
48	Medical Supplies Charged to Patients							48
49	Drugs Charged to Patients							49
50	Dental Care - Title XIX only							50
51	Support Surfaces							51
52	Other Ancillary Service Cost							52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B PART II	
	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
Cost Center Description	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
100 Total							100

ALLOCATION OF CAPITAL - RELATED COSTS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B PART II

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B PART II	

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET B-2

	Description	Worksheet B		Amount	
		Part No.	Line No.		
	1	2	3	4	
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET C

	Cost Center Description	Total (from Wkst. B, Pt. I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1	2	3	
ANCILLARY SERVICE COST CENTERS					
40	Radiology				40
41	Laboratory				41
42	Intravenous Therapy				42
43	Oxygen (Inhalation) Therapy				43
44	Physical Therapy				44
45	Occupational Therapy				45
46	Speech Pathology				46
47	Electrocardiology				47
48	Medical Supplies Charged to Patients				48
49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost				52
OUTPATIENT SERVICE COST CENTERS					
60	Clinic				60
61	Rural Health Clinic (RHC)				61
62	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PART I

Check applicable box:	[ ] Title V (1) [ ] Title XVIII [ ] Title XIX (1)
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR [ ] Other _____ [ ] PPS - Must also complete Part II

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

	Cost Center Description	Ratio of Cost to Charges (from Wkst. C, col. 3)	Health Care Program Charges		Healthcare Program Cost		
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
40	Radiology						40
41	Laboratory						41
42	Intravenous Therapy						42
43	Oxygen (Inhalation) Therapy						43
44	Physical Therapy						44
45	Occupational Therapy						45
46	Speech Pathology						46
47	Electrocardiology						47
48	Medical Supplies Charged to Patients						48
49	Drugs Charged to Patients						49
50	Dental Care - Title XIX only						50
51	Support Surfaces						51
52	Other Ancillary Service Cost						52
	OUTPATIENT COST CENTERS						
60	Clinic						60
61	Rural Health Clinic (RHC)						61
62	FQHC						62
63	Other Outpatient Service Cost						63
71	Ambulance (2)						71
100	Total (sum of lines 40 - 71)						100

(1) For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PARTS II & III

TITLE XVIII ONLY

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)		1
2	Program vaccine charges (From your records or the PS&R report)		2
3	Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E, Pt. I, line 1)		3

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

	Cost Center Description	Total Cost (from Wkst. B, Pt. I, col. 18)	Nursing & Allied Health (from Wkst. B, Pt. I, col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (col. 2 / col. 1)	Program Part A Cost (from Wkst. D., Pt. I, col. 4)	Part A Nursing & Allied Health Costs for Pass Through (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
40	Radiology						40
41	Laboratory						41
42	Intravenous Therapy						42
43	Oxygen (Inhalation) Therapy						43
44	Physical Therapy						44
45	Occupational Therapy						45
46	Speech Pathology						46
47	Electrocardiology						47
48	Medical Supplies Charged to Patients						48
49	Drugs Charged to Patients						49
50	Dental Care - Title XIX only						50
51	Support Surfaces						51
52	Other Ancillary Service Cost						52
100	Total (sum of lines 40 - 52)						100

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D-1 PARTS I & II

Check applicable box:	[ ] Title V [ ] Title XVIII [ ] Title XIX
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR

	PART I - CALCULATION OF INPATIENT ROUTINE COSTS		
	INPATIENT DAYS		
1	Inpatient days including private room days		1
2	Private room days		2
3	Inpatient days including private room days applicable to the Program		3
4	Medically necessary private room days applicable to the Program		4
5	Total general inpatient routine service cost		5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6	General inpatient routine service charges		6
7	General inpatient routine service cost/charge ratio (line 5 divided by line 6)		7
8	Enter private room charges from your records		8
9	Average private room per diem charge (private room charges on line 8 divided by private room days on line 2)		9
10	Enter semi-private room charges from your records		10
11	Average semi-private room per diem charge (semi-private room charges on line 10 divided by semi-private room days)		11
12	Average per diem private room charge differential (line 9 minus line 11)		12
13	Average per diem private room cost differential (line 7 times line 12)		13
14	Private room cost differential adjustment (line 2 times line 13)		14
15	General inpatient routine service cost net of private room cost differential (line 5 minus line 14)		15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16	Adjusted general inpatient service cost per diem (line 15 divided by line 11)		16
17	Program routine service cost (line 3 times line 16)		17
18	Medically necessary private room cost applicable to program (line 4 times line 13)		18
19	Total program general inpatient routine service cost (line 17 plus line 18)		19
20	Capital related cost allocated to inpatient routine service costs (from Wkst. B, Pt. II, col. 18, line 30 for SNF; line 31 for NF; or line 32 for ICF/MR)		20
21	Per diem capital related costs (line 20 divided by line 1)		21
22	Program capital related cost (line 3 times line 21)		22
23	Inpatient routine service cost (line 19 minus line 22)		23
24	Aggregate charges to beneficiaries for excess costs (from provider records)		24
25	Total program routine service costs for comparison to the cost limitation (line 23 minus line 24)		25
26	Enter the per diem limitation (1)		26
27	Inpatient routine service cost limitation (line 3 times the per diem limitation line 26) (1)		27
28	Reimbursable inpatient routine service costs (line 22 plus the lesser of line 25 or line 27) (Transfer to Wkst. E, Pt. II, line 4) (see instructions)		28

	PART II - CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
1	Total inpatient days		1
2	Program inpatient days (*see instructions*)		2
3	Total nursing & allied health costs (see instructions)		3
4	Nursing & allied health ratio (line 2 divided by line 1)		4
5	Program nursing & allied health costs for pass-through (line 3 times line 4)		5

(1) Lines 26, 27 and 28 are not applicable for title XVIII, but may be used for title V and or title XIX

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART I

	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1	Inpatient PPS amount (see instructions)		1
2	Nursing and Allied Health Education Activities (pass through payments)		2
3	Subtotal (sum of lines 1 and 2)		3
4	Primary payor amounts		4
5	Coinsurance		5
6	Reimbursable bad debts (from your records)		6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		7
8	Adjusted reimbursable bad debts (see instructions)		8
9	Recovery of bad debts - for statistical records only		9
10	Utilization review		10
11	Subtotal (see instructions)		11
12	Interim payments (see instructions)		12
13	Tentative adjustment		13
14	Other adjustment (see instructions)		14
14.99	Sequestration amount (see instructions)		14.99
15	Balance due provider/program (see instructions) (Indicate overpayment in parentheses)		15
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		16

	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17	Ancillary services Part B		17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)		18
19	Total reasonable costs (sum of lines 17 and 18)		19
20	Medicare Part B ancillary charges (see instructions)		20
21	Cost of covered services (lesser of line 19 or line 20)		21
22	Primary payor amounts		22
23	Coinsurance and deductibles		23
24	Reimbursable bad debts (from your records)		24
24.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		24.01
24.02	Adjusted reimbursable bad debts (see instructions)		24.02
25	Subtotal (sum of lines 21 and 24.02, minus lines 22 and 23)		25
26	Interim payments (see instructions)		26
27	Tentative adjustment		27
28	Other Adjustments (Specify _____) (see instructions)		28
28.99	Sequestration amount (see instructions)		28.99
29	Balance due provider/program (see instructions) (indicate overpayments in parentheses)		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		30

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART II

Check applicable box:	[ ] Title V [ ] Title XIX
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR

COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient ancillary services (see instructions)		1
2	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)		2
3	Outpatient services		3
4	Inpatient routine services (see instructions)		4
5	Utilization review - physicians' compensation (from provider records)		5
6	Cost of covered services (sum of lines 1 - 5)		6
7	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		7
8	Subtotal (line 6 minus line 7)		8
9	Primary payor amounts		9
10	Total reasonable cost (line 8 minus line 9)		10
REASONABLE CHARGES			
11	Inpatient ancillary service charges		11
12	Outpatient service charges		12
13	Inpatient routine service charges		13
14	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		14
15	Total reasonable charges		15
CUSTOMARY CHARGES			
16	Aggregate amount actually collected from patients liable for payment for services on a charge basis		16
17	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		17
18	Ratio of line 16 to line 17 (not to exceed 1.000000)		18
19	Total customary charges (see instructions)		19
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
20	Cost of covered services (see instructions)		20
21	Deductibles		21
22	Subtotal (line 20 minus line 21)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Reimbursable bad debts (from your records)		25
26	Subtotal (sum of lines 24 and 25)		26
27	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		27
28	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		28
29	Other adjustments (Specify _____) (see instructions)		29
30	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		30
31	Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		31
32	Interim payments		32
33	Balance due provider/program (line 31 minus line 32) (indicate overpayments in parentheses) (see instructions)		33

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E-1

				Inpatient Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description			1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
2	List separately each retroactive lump sum							3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		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 & 3.99) (Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)							4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter 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	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	*.02*					6.*02*
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contractor Number					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.

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G

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

( ) = contra amount

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G

	Liabilities and Fund Balances	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
	CURRENT LIABILITIES					
35	Accounts payable					35
36	Salaries, wages & fees payable					36
37	Payroll taxes payable					37
38	Notes & loans payable (short term)					38
39	Deferred income					39
40	Accelerated payments					40
41	Due to other funds					41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES (sum of lines 35 - 42)					43
	LONG TERM LIABILITIES					
44	Mortgage payable					44
45	Notes payable					45
46	Unsecured loans					46
47	Loans from owners:					47
48	Other long term liabilities					48
49	Other (specify)					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)					50
51	TOTAL LIABILITIES (sum of lines 43 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement and expansion					58
59	TOTAL FUND BALANCES (sum of lines 52 thru 58)					59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)					60

( ) = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G - 1

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net income (loss) (from Wkst. G-3, line 31)									2
3	Total (sum of line 1 and line 2)									3
4	Additions (credit adjustments)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 5 - 9)									10
11	Subtotal (line 3 plus line 10)									11
12	Deductions (debit adjustments)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 13 - 17)									18
19	Fund balance at end of period per balance sheet (line 11 - line 18)									19

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

PART I - PATIENT REVENUES

	Revenue Center	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
General Inpatient Routine Care Services					
1	Skilled nursing facility				1
2	Nursing facility				2
3	ICF-Mentally Retarded				3
4	Other long term care				4
5	Total general inpatient care services (sum of lines 1 - 4)				5
All Other Care Service					
6	Ancillary services				6
7	Clinic				7
8	Home health agency				8
9	Ambulance				9
10	RHC/FQHC				10
11	CMHC				11
12	SNF based hospice				12
13	Other (specify)				13
14	Total patient revenues (sum of lines 5 - 13) (transfer to Wkst. G-3, col. 3, line 1)				14

PART II - OPERATING EXPENSES

1	Operating Expenses (per Wkst. A, col. 3, line 100)			1
2	Add (Specify)			2
3				3
4				4
5				5
6				6
7				7
8	Total Additions (sum of lines 2 - 7)			8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (sum of lines 9 - 13)			14
15	Total Operating Expenses (sum of lines 1 and 8, minus line 14)			15

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G-3

1	Total patient revenues (from Wkst. G-2, Pt. I, col. 3, line 14)		1
2	Less: contractual allowances and discounts on patients accounts		2
3	Net patient revenues (line 1 minus line 2)		3
4	Less: total operating expenses (fom Wkst. G-2, Pt. II, line 15)		4
5	Net income from service to patients (line 3 minus 4)		5
	Other income:		
6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from communications (telephone and internet service)		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, flower, coffee shops, canteen		20
21	Rental of vending machines		21
22	Rental of skilled nursing space		22
23	Governmental appropriations		23
24	Other miscellaneous revenue (specify _____)		24
25	Total other income (sum of lines 6 - 24)		25
26	Total (line 5 plus line 25)		26
27	Other expenses (specify _____)		27
28			28
29			29
30	Total other expenses (sum of lines 27 - 29)		30
31	Net income (or loss) for the period (line 26 minus line 30)		31

ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H

	COST CENTER DESCRIPTIONS	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related - Bldgs. and Fixtures											1
2	Capital Related - Movable Equipment											2
3	Plant Operation & Maintenance											3
4	Transportation (see instructions)											4
5	Administrative and General											5
	HHA REIMBURSABLE SERVICES											
6	Skilled Nursing Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech Pathology											9
10	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
13	Drugs											13
14	DME											14
15	Telemedicine											15
	HHA NONREIMBURSABLE SERVICES											
16	Home Dialysis Aide Services											16
17	Respiratory Therapy											17
18	Private Duty Nursing											18
19	Clinic											19
20	Health Promotion Activities											20
21	Day Care Program											21
22	Home Delivered Meals Program											22
23	Homemaker Service											23
24	All Others											24
25	Total (sum of lines 1-24)											25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | PROVIDER CCN: HHA CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0 through 4)	ADMINIS-TRATIVE & GENERAL	TOTAL (cols. 4A + 5)	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTERS										
1	Capital Related - Bldgs. and Fixtures									1
2	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25

COST ALLOCATION - HHA STATISTICAL BASIS | PROVIDER CCN: HHA CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET H-1, PART II

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED COSTS MOVABLE EQUIPMENT (Dollar Value or Square Feet)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANS-PORTATION (Mileage)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
		0	1	2	3	4	5A	5	6	
GENERAL SERVICE COST CENTERS										
1	Capital Related - Bldgs. and Fixtures									1
2	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25
26	Cost to be allocated									26
27	Unit Cost Multiplier									27

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: HHA CCN:	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER	From Wkst. H-1, Pt. I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
			0	1	2	3	3A	4	5	6	
1	Administrative and General	5									1
2	Skilled Nursing Care	6									2
3	Physical Therapy	7									3
4	Occupational Therapy	8									4
5	Speech Pathology	9									5
6	Medical Social Services	10									6
7	Home Health Aide	11									7
8	Supplies	12									8
9	Drugs	13									9
10	DME	14									10
11	Telemedicine	15									11
12	Home Dialysis Aide Services	16									12
13	Respiratory Therapy	17									13
14	Private Duty Nursing	18									14
15	Clinic	19									15
16	Health Promotion Activities	20									16
17	Day Care Program	21									17
18	Home Delivered Meals Program	22									18
19	Homemaker Service	23									19
20	All Others	24									20
21	Totals (sum of lines 1-20) (2)										21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.										22

(1) Column 0, line 21 must agree with Wkst. A, col. 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: HHA CCN:	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		7	8	9	10	11	12	13	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	CAPITAL RELATED COSTS BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED COSTS MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	OPERATION OF PLANT (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	
		1	2	3	4A	4	5	6	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	HOUSE-KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	
		7	8	9	10	11	12	13	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (SPECIFY)	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-3, Parts I & II

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	Cost Per Visit Computation	From, Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2. Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Costs (col. 1 + col 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			Cost of Services				
									Part B			Part B		Total Program Cost (sum of cols. 9-10)	
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	Patient Services	line -	1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
3	Occupational Therapy	4													3
4	Speech Pathology	5													4
5	Medical Social Services	6													5
6	Home Health Aide	7													6
7	Total (sum of lines 1-6)														7

	Patient Services by CBSA	CBSA No. (1)	Program Visits			
				Part B		
			Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & 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 8-13)					14

	Supplies and Drugs Cost Computations	From Wkst. H-2, Pt. I, col. 20,	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Cost (cols. 1 + 2)	Total Charges (from HHA records)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services			
									Part B			Part B		
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Other Patient Services	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 SKILLED NURSING FACILITY DEPARTMENTS

		From Wkst. C, col. 3, line -	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Pt. 1 -	
			1	2	3	4	
1	Physical Therapy	44				col. 2, line 2	1
2	Occupational Therapy	45				col. 2, line 3	2
3	Speech Pathology	46				col. 2, line 4	3
4	Cost of Medical Supplies	48				col. 2, line 15	4
5	Cost of Drugs	49				col. 2, line 16	5

(1) The CBSA numbers flow from Wkst. S-4, line 22, and subscripts as indicated should be replicated on lines 8-13.

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4144)

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-4, Parts I & II

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 through 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
30.99	Sequestration amount (see instructions)			30.99
31	Subtotal (*see instructions*)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (see instructions)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER - BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-5

	Description			Part A mm/dd/yyyy 1	Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider						3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)							4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contractor Number					8

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

ANALYSIS OF SNF - BASED RURAL HEALTH CLINIC / FEDERALLY QUALIFIED HEALTH CENTER COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I-1

Check applicable box: [ ] RHC [ ] FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 +/- col.6)	
			2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility health care staff costs								9
10	Subtotal (sum of lines 1 - 9)								10
	COSTS UNDER AGREEMENT								
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
21	Subtotal (sum of lines 15 - 19)								21
22	Total cost of health care services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC / FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other non reimbursable costs								26
28	Total nonreimbursable costs (sum of lines 23 - 26)								28
	FACILITY OVERHEAD								
29	Facility costs								29
30	Administrative costs								30
31	Total facility overhead (sum of lines 29-30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

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

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

Check applicable box: [ ] RHC [ ] FQHC

PART I - VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of Column 2 or Column 4	
		1	2	3	4	5	
1	Physicians			4200			1
2	Physician Assistants			2100			2
3	Nurse Practitioners			2100			3
4	Subtotal (sum of lines 1 - 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Medical Nutrition Therapist (FQHC only)						8
9	Diabetes Self Management Training (FQHC only)						9
10	Total FTEs and visits (sum of lines 4 - 9)						10
11	Physician Services Under Agreements						11

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC / FQHC SERVICES

12	Total costs of health care services (from Wkst. I-1, col. 7, line 22)		12
13	Total nonreimbursable costs (from Wkst I-1, col 7, line 28)		13
14	Cost of all services - excluding overhead (sum of lines 12 and 13)		14
15	Ratio of RHC / FQHC services (line 12 divided by line 14)		15
16	Total facility overhead (from Wkst. I-1, col. 7, line 31)		16
17	Parent provider overhead allocated to facility (see instructions)		17
18	Total overhead (sum of lines 16 and 17)		18
19	Overhead applicable to RHC / FQHC services (lines 15 X line 18)		19
20	Total allowable cost of RHC / FQHC services (sum of lines 12 and 19)		20

(1) Productivity standards established by CMS are: 4200 visits for each physician, and 2100 visits for each nonphysician practitioner.

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

Check applicable box:	[ ] Title V [ ] Title XVIII [ ] Title XIX
Check applicable box:	[ ] RHC [ ] FQHC

PART I - DETERMINATION OF RATE FOR RHC / FQHC SERVICES			
1	Total allowable cost of RHC/FQHC services (from Wkst. I-2, Pt. II, line 20)		1
2	Cost of vaccines and their administration (from Wkst. I-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total FTEs and visits (from Wkkst. I-2, col. 5, line 10)		4
5	Physicians' visits under agreement (from Wkst. I-2, col. 5, line 11)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

CALCULATION OF LIMIT Lines 8 through 14: Fiscal year providers use columns 1 and 2. Lines 8 through 14: Calendar year providers use column 2 only.		Prior to January 1 1	On or after January 1 2	
8	Rate per visit limit (from your contractor)			8
9	Rate for Program covered visits (see instructions)			9

PART II - CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)			10
11	Program cost excluding costs for mental health services (line 9 x line 10)			11
12	Program covered visits for mental health services (from contractor records)			12
13	Program covered cost for mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (see instructions)			14
15	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 and 2)			15
15.01	Total Program charges (see instructions) (from contractor records)			15.01
15.02	Total Program preventive charges (see instructions) (from provider records)			15.02
15.03	Total Program preventive costs ((line 15.02/line 15.01) times line 15)			15.03
15.04	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17) times .80)			15.04
15.05	Total Program cost (see instructions)			15.05
16	Primary payer amounts			16
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17
18	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			18
19	Net Program cost excluding vaccines (see instructions)			19
20	Program cost of vaccines and their administration (from Wkst. I -4, line 16)			20
21	Total reimbursable Program cost (line 19 plus 20)			21
22	Reimbursable bad debts			22
22.01	Adjusted reimbursable bad debts (see instructions)			22.01
23	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			23
24	Other adjustments			24
25	Net reimbursable amount (see instructions)			25
25.01	Sequestration amount (see instructions)			25.01
26	Interim payments (from Wkst. I-5, line 4)			26
27	Tentative settlement (for contractor use only)			27
28	Balance due component/Program (see instructions)			28
29	Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2			29

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I-4

Check applicable box:	[ ] Title V [ ] Title XVIII [ ] Title XIX
Check applicable box:	[ ] RHC [ ] FQHC

	CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the facility (from Wkst. I-1, col. 7, line 22)			6
7	Total overhead (from Wkst. I-2, line 18)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and its (their) adminstration (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			15
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			16

ANALYSIS OF PAYMENTS TO SNF - BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I - 5

Check applicable box: [ ] RHC [ ] FQHC

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. I-3, line 26)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contractor Number			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.

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	
			BUILDS. & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	3A	4	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	Appr. 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 Other							21
22	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS-TRATION	
		5	6	7	8	9	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	Appr. 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 Other						21
22	Totals (sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	
		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	Appr. 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 Other							21
22	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	SUBTOTAL	ALLOCATED A & G (see Pt. II)	TOTAL (sum of cols. 18 and 19 ()	
		16	17	18	19	20	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	Appr. 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 Other						21
22	Totals (Sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

		CAPITAL RELATED					
		BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
	COMPONENT COST CENTER	1	2	3	4A	4	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	App. 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 Other						21
22	Totals (sum of lines 1-21)						22
23	Total cost to be allocated						23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

	COMPONENT COST CENTER	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE - KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours of Service)	
		5	6	7	8	9	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	App. 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 Other						21
22	Totals (sum of lines 1-21)						22
23	Total cost to be allocated						23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

	COMPONENT COST CENTER	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE ( )	
		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. 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 Other							21
22	Totals (sum of lines 1-21)							22
23	Total cost to be allocated							23
24	Unit Cost Multiplier							24

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART I

PART I - APPORTIONMENT OF CMHC COST CENTERS

		Total Costs (from Wkst. J-1, Pt. I, col. 20)	Total Charges	Ratio of Costs to Charges	Title V		Title XVIII		Title XIX		
					Charges	Costs (col. 3 x col. 4)	Charges	Costs (col. 3 x col. 6)	Charges	Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	App. 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 Other*										21
22	Totals (sum of lines 2-21)										22

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART II

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

		Ratio of Costs to Charges	Title V		Title XVIII		Title XIX		
			Charges	Costs (col. 3 x col. 4)	Charges	Costs (col. 3 x col. 6)	Charges	Costs (col. 3 x col. 8)	
		3	4	5	6	7	8	9	
23	Oxygen (Inhalation) Therapy								23
24	Physical Therapy								24
25	Occupational Therapy								25
26	Speech Pathology								26
27	Medical Supplies Charged to Patients								27
28	Drugs Charged to Patients								28
29	Other Costs Furnished by shared Departments								29
30	Total (sum of lines 23 through 29)								30
31	Total component cost (sum of Pt. I, line 22 and Pt. II, line 30) (Transfer to Wkst. J-3)								31

(1) Part II - From Wkst. C, col. 3, lines as applicable

CALCULATION OF REIMBURSEMENT SETTLEMENT OF COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-3

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

		PROGRAM COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 31)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
CUSTOMARY CHARGES			
6	Total charges for program services		6
7	Excess of customary charges over reasonable cost (see instructions)		7
8	Excess of reasonable cost over customary charges (see instructions)		8
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
9	Total reasonable cost (see instructions)		9
10	Part B deductible billed to program patients		10
11	Part B coinsurance billed to program patients (from provider records)		11
12	Net cost (line 9 minus lines 10 and 11)		12
13	Reimbursable bad debts (from provider records) (see instructions)		13
13.01	Adjusted reimbursable bad debts (see instructions)		13.01
14	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		14
15	Net reimbursable amount (see instructions)		15
16	Other adjustments (see instructions) (specify)		16
17	Total cost (line 15 plus or minus line 16)		17
17.01	Sequestration amount (see instructions)		17.01
18	Interim payments (see instructions)		18
19	Tentative settlement (for contractor use only)		19
20	Balance due component/program (*see instructions*)		20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		21

ANALYSIS OF PAYMENTS TO PROVIDER - BASED CMHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J - 4

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. J-3: Pt. I, line 18)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contractor Number			8

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

ANALYSIS OF PROVIDER - BASED HOSPICE COSTS | PROVIDER CCN: HOSPICE CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET K

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

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4157)

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN:

HOSPICE CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-1

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

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

HOSPICE COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER CCN:

HOSPICE CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-2

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

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

HOSPICE COMPENSATION ANALYSIS
CONTRATED SERVICES / PURCHASED SERVICES

PROVIDER CCN:
HOSPICE CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-3

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

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | PROVIDER CCN: HOSPICE CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET K-4 PART I

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

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

COST ALLOCATION - HOSPICE STATISTICAL BASIS | PROVIDER CCN: HOSPICE CCN: | PERIOD : FROM _____ TO _____ | WORKSHEET K-4 PART II

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

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

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

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

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part I

	HOSPICE COST CENTER (1)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part I

	HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	ALLOCATED HOSPICE A & G (see Pt. II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5, PART II

	HOSPICE COST CENTER (1)	CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		1	2	3	4A	4	
1	Administrative and General						1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care						5
6	Nursing Care- Continuous Home Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech/ Language Pathology						9
10	Medical Social Services - Direct						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemakers						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biologicals and Infusion						17
18	Analgesics						18
19	Sedative/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 (incl. E/R Dept.)						26
27	Radiation Therapy						27
28	Chemotherapy						28
29	Other						29
30	Bereavement Program Costs						30
31	Volunteer Program Costs						31
32	Fundraising						32
33	Other Program Costs						33
34	Totals (sum of lines 1 through 33)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier						36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 PART II

	HOSPICE COST CENTER (1)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

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

PROVIDER CCN:

HOSPICE CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-5
PART II

	HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (Specify)	SUBTOTAL	ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst. C, col. 3, line:	Cost to Charge Ratio	Total Hospice Charges (from provider records)	Hospice Shared Ancillary Costs (col. 1 x col. 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	44				1
2	Occupational Therapy	45				2
3	Speech/ Language Pathology	46				3
4	Drugs, Biologicals and Infusion	49				4
5	Labs and Diagnostics	41				5
6	Medical Supplies	48				6
7	Radiation Therapy	40				7
8	Other	52				8
9	Total (sum of lines 1-8)					9

CALCULATION OF PER DIEM COST	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-6

		Tittle XVIII	Title XIX	Other	Total	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Wkst. S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Wkst. S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Wkst. S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Wkst. S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Wkst. S-8, line 5, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other unduplicated days (Wkst. S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13