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 as overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0037
EXPIRES: 03/31/2025

| COMMUNITY MENTAL HEALTH CENTER COST REPORT IDENTIFICATION DATA, CERTIFICATION AND SETTLEMENT SUMMARY | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S PARTS I, II & III |
|---|---|---|---|

**PART I - COST REPORT STATUS**

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

**PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and 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.

| | SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR | | CHECKBOX | ELECTRONIC SIGNATURE STATEMENT | |
|---|---|---|---|---|---|
| | 1 | | 2 | | |
| 1 | | | | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name | | | | 2 |
| 3 | Signatory Title | | | | 3 |
| 4 | Signature date | | | | 4 |

**PART III - SETTLEMENT SUMMARY**

| | | TITLE XVIII | |
|---|---|---|---|
| | | 1 | |
| 1 | COMMUNITY MENTAL HEALTH CENTER | | 1 |

The above amount represents "due to" or "due from" the Medicare program.

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 0938-0037. The time required to complete this information collection is estimated to average 90 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

| COMMUNITY MENTAL HEALTH CENTER IDENTIFICATION DATA | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET S-1 PARTS I & II |
|---|---|---|---|

PART I - IDENTIFICATION DATA

| | | | PROVIDER CCN | CBSA | DATE CERTIFIED | TYPE OF CONTROL (SEE INSTRUCTIONS) | |
|---|---|---|---|---|---|---|---|
| | 1 | | 2 | 3 | 4 | 5 | |
| 1 | Site Name: | | | | | | 1 |
| 2 | Street: | | P O Box: | | | | 2 |
| 3 | City: | | State: | ZIP Code: | County: | | 3 |
| 4 | Cost Reporting Period (mm/dd/yyyy) | From: | To: | | | | 4 |
| 5 | Is this CMHC part of a HO/CO as defined in §2150 of CMS Pub. 15-1 that claims HO/CO costs in a home office cost statement? Enter "Y for yes or "N" for no in column 1. If yes, enter the HO/CO information below. | | | | | | 5 |
| 6 | Name of HO/CO: | | | | | | 6 |
| 7 | Street: | | P O Box: | HO/CO CCN: | | | 7 |
| 8 | City: | | State: | ZIP Code: | | | 8 |

Medical Malpractice

| | | | | | |
|---|---|---|---|---|---|
| 9 | Is this CMHC legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no. | | | | 9 |
| 10 | If line 9 is "Y", is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy. | | | | 10 |

| | | PREMIUMS | PAID LOSSES | SELF INSURANCE | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 11 | Enter total malpractice premiums in col. 1, total paid losses in col. 2, and total self insurance in col. 3 | | | | 11 |
| 12 | Are malpractice premiums and/or paid losses reported in other than the A&G cost center? Enter "Y" for yes or "N" for no. (see instructions) | | | | 12 |

Miscellaneous

| | | Y/N | DEMONSTRATION TYPE | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 13 | Did this facility participate in any payment demonstration during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2. If the CMHC participated in more than one demonstration, subscript this line accordingly. | | | 13 |
| 14 | 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. | | | 14 |

PART II - STATISTICAL DATA

| | REIMBURSABLE COST CENTERS | WKST | VISITS | | | PATIENT DAYS | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | MEDICARE PATIENTS | OTHER PATIENTS | TOTAL | MEDICARE | OTHER | TOTAL | |
| | | A | 1 | 2 | 3 | 4 | 5 | 6 | |
| 1 | Drugs & Biologicals | 23 | | | | | | | 1 |
| 2 | Occupational Therapy | 24 | | | | | | | 2 |
| 3 | Behavioral Health Treatment/Services | 25 | | | | | | | 3 |
| 4 | Individual Therapy | 26 | | | | | | | 4 |
| 5 | Group Therapy | 27 | | | | | | | 5 |
| 6 | Activity Therapy | 28 | | | | | | | 6 |
| 7 | Family Therapy | 29 | | | | | | | 7 |
| 8 | Psychiatric Testing | 30 | | | | | | | 8 |
| 9 | Education Training | 31 | | | | | | | 9 |
| 10 | Other (specify) | 32 | | | | | | | 10 |
| 11 | TOTAL (sum of lines 1 through 10) | | | | | | | | 11 |
| 12 | Unduplicated Census | | | | | | | | 12 |

| | REIMBURSABLE COST CENTERS | WKST | FTES ON PAYROLL | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | STAFF THERAPISTS | PHYSICIANS | SOCIAL WORKERS | OTHERS | | | |
| | | A | 7 | 8 | 9 | 10 | | | |
| 1 | Drugs & Biologicals | 23 | | | | | | | 1 |
| 2 | Occupational Therapy | 24 | | | | | | | 2 |
| 3 | Behavioral Health Treatment/Services | 25 | | | | | | | 3 |
| 4 | Individual Therapy | 26 | | | | | | | 4 |
| 5 | Group Therapy | 27 | | | | | | | 5 |
| 6 | Activity Therapy | 28 | | | | | | | 6 |
| 7 | Family Therapy | 29 | | | | | | | 7 |
| 8 | Psychiatric Testing | 30 | | | | | | | 8 |
| 9 | Education Training | 31 | | | | | | | 9 |
| 10 | Other (specify) | 32 | | | | | | | 10 |
| 11 | TOTAL (sum of lines 1 through 10) | | | | | | | | 11 |
| 12 | Unduplicated Census | | | | | | | | 12 |

| COST REPORT REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET S-2 |
|---|---|---|---|

| | | Y/N | DATE | V/I | |
|---|---|---|---|---|---|
| | PROVIDER ORGANIZATION AND OPERATION | 1 | 2 | 3 | |
| 1 | Has the provider changed ownership immediately prior to the beginning of the cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, enter the date (mm/dd/yyyy) of the change in column 2. (see instructions) | | | | 1 |
| 2 | Has the provider terminated participation in the Medicare Program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date (mm/dd/yyyy); and, enter 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 entitie (e.g., chain home offices, drug or medical supply companies) that were 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? Enter "Y" for yes or "N" for no in column 1. (see instructions) | | | | 3 |

| | | Y/N | A/C/R | DATE | |
|---|---|---|---|---|---|
| | FINANCIAL DATA AND REPORTS | 1 | 2 | 3 | |
| 4 | Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter "Y" for yes or "N" for no. Column 2: If yes, enter in col. 2: "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy of financial statements or enter date available (mm/dd/yyyy) 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? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation. | | | | 5 |

| | | Y/N | |
|---|---|---|---|
| | BAD DEBTS | | |
| 6 | Is the provider seeking reimbursement for bad debts? Enter "Y" for yes or "N" for no. If yes, see instructions. | | 6 |
| 7 | If line 6 is yes, did the provider's bad debt collection policy change during the cost reporting period? "Y" for yes or "N" for no. If yes, submit a copy. | | 7 |
| 8 | If line 6 is yes, were patient deductibles and/or co-payments waived? Enter "Y" for yes or "N" for no. If yes, see instructions. | | 8 |

| | | Y/N | DATE | |
|---|---|---|---|---|
| | PS&R REPORT DATA | 1 | 2 | |
| 9 | Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions) | | | 9 |
| 10 | Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in col. 1. If yes, enter in col. 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions) | | | 10 |
| 11 | If line 9 or 10 is yes, were adjustments made to PS&R report data for additional claims that have been billed but are not included on the PS&R report used to file the cost report? Enter "Y" for yes or "N" for no. If yes, see instructions. | | | 11 |
| 12 | If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions. | | | 12 |
| 13 | If line 9 or 10 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments: | | | 13 |
| 14 | Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no. If yes, see instructions. | | | 14 |

COST REPORT PREPARER CONTACT INFORMATION

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 15 | First name: | | Last name: | | Title: | | | 15 |
| 16 | Employer: | | | | | | | 16 |
| 17 | Phone number: | | | E-mail Address: | | | | 17 |

| RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A |
|---|---|---|---|

| | | COST CENTERS (Omit Cents) | SALARIES | OTHER | CON-TRACTED PURCHASED SERVICES | TOTAL (sum of col. 1 through col. 3) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 4 ± col. 5) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 6 ± col. 7) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| | | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | 0100 | Cap Rel Costs - Bldgs & Fixt | | | | | | | | | 1 |
| 2 | 0200 | Cap Rel Costs - Mvble Equip | | | | | | | | | 2 |
| 3 | 0300 | Employee Benefits | | | | | | | | | 3 |
| 4 | 0400 | Administrative & General | | | | | | | | | 4 |
| 5 | 0500 | Maintenance & Repairs | | | | | | | | | 5 |
| 6 | 0600 | Operation of Plant | | | | | | | | | 6 |
| 7 | 0700 | Laundry & Linen Service | | | | | | | | | 7 |
| 8 | 0800 | Housekeeping | | | | | | | | | 8 |
| 9 | 0900 | Cafeteria | | | | | | | | | 9 |
| 10 | 1000 | Central Services & Supply | | | | | | | | | 10 |
| 11 | 1100 | Medical Records & Library | | | | | | | | | 11 |
| 12 | 1200 | Pro Ed & Training (Approved) | | | | | | | | | 12 |
| 13 | | Other (specify) | | | | | | | | | 13 |
| | | REIMBURSABLE COST CENTERS | | | | | | | | | |
| 23 | 2300 | Drugs & Biologicals | | | | | | | | | 23 |
| 24 | 2400 | Occupational Therapy | | | | | | | | | 24 |
| 25 | 2500 | Behavioral Health Treatment/Services | | | | | | | | | 25 |
| 26 | 2600 | Individual Therapy | | | | | | | | | 26 |
| 27 | 2700 | Group Therapy | | | | | | | | | 27 |
| 28 | 2800 | Activity Therapy | | | | | | | | | 28 |
| 29 | 2900 | Family Therapy | | | | | | | | | 29 |
| 30 | 3000 | Psychiatric Testing | | | | | | | | | 30 |
| 31 | 3100 | Education Training | | | | | | | | | 31 |
| 32 | | Other (specify) | | | | | | | | | 32 |
| | | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 42 | 4200 | Sheltered Workshops | | | | | | | | | 42 |
| 43 | 4300 | Recreational Programs | | | | | | | | | 43 |
| 44 | 4400 | Resident Day Camps | | | | | | | | | 44 |
| 45 | 4500 | Diagnostic Clinics | | | | | | | | | 45 |
| 46 | 4600 | Physicians' Private Offices | | | | | | | | | 46 |
| 47 | 4700 | Fund Raising | | | | | | | | | 47 |
| 48 | 4800 | Coffee Shops & Canteen | | | | | | | | | 48 |
| 49 | 4900 | Research | | | | | | | | | 49 |
| 50 | 5000 | Investment Property | | | | | | | | | 50 |
| 51 | 5100 | Advertising | | | | | | | | | 51 |
| 52 | 5200 | Franchise Fees & Other Assessments | | | | | | | | | 52 |
| 53 | 5300 | Pro Ed & Training (Not Approved) | | | | | | | | | 53 |
| 54 | 5400 | Meals & Transportation | | | | | | | | | 54 |
| 55 | 5500 | Activity Therapies | | | | | | | | | 55 |
| 56 | 5600 | Psychosocial Programs | | | | | | | | | 56 |
| 57 | 5700 | Vocational Training | | | | | | | | | 57 |
| 58 | | Other (specify) | | | | | | | | | 58 |
| 100 | | TOTAL (sum of lines 1 through 58) | | | | | | | | | 100 |

| RECLASSIFICATIONS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A |
|---|---|---|---|

| | EXPLANATION OF RECLASSIFICATION(S) | CODE [1] | INCREASE | | | | DECREASE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | COST CENTER | LINE NO. | SALARY [2] | NON SALARY [2] | COST CENTER | LINE NO. | SALARY [2] | NON SALARY [2] | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | | | | | | | | | | | 1 |
| 2 | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
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| 39 | | | | | | | | | | | 39 |
| 40 | | | | | | | | | | | 40 |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| 100 | Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9) | | | | | | | | | | 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 5, line as appropriate.

| ADJUSTMENTS TO EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A-8 |
|---|---|---|---|

| | DESCRIPTION [1] | BASIS [2] | AMOUNT | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED | | |
|---|---|---|---|---|---|---|
| | | | | COST CENTER | LINE NO. | |
| | | 1 | 2 | 3 | 4 | |
| 1 | Capital Related Costs - Buildings & fixtures | A | | Capital Related Costs Buildings & Fixtures | 1 | 1 |
| 2 | Capital Related Costs - Movable Equipment | A | | Capital Related Costs Movable Equipment | 2 | 2 |
| 3 | Payments received from specialists | B | | | | 3 |
| 4 | Investment income (chapter 2) | | | | | 4 |
| 5 | Trade, quantity, and time discounts (chapter 8) | B | | | | 5 |
| 6 | Refunds and rebates of expenses (chapter 8) | B | | | | 6 |
| 7 | Laundry and linen service | | | Laundry and Linen Service | 7 | 7 |
| 8 | Cafeteria-employees, guests, etc. | A | | Cafeteria | 9 | 8 |
| 9 | Sale of medical and surgical supplies to other than patients | | | Central Services and Supplies | 10 | 9 |
| 10 | Sale of workshop products or services | | | | | 10 |
| 11 | Coffee shops and canteen | | | | | 11 |
| 12 | Vending Machines | A | | | | 12 |
| 13 | Rental of building or office space to others | | | | | 13 |
| 14 | Sale of scrap, waste, etc. (chapter 23) | | | | | 14 |
| 15 | Related organization transactions (chapter 10) | Wkst. A-8-1 | | | | 15 |
| 16 | Provider-based physician adjustment | Wkst. A-8-2 | | | | 16 |
| 17 | Other adjustments (specify) [3] | | | | | 17 |
| 18 | | | | | | 18 |
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| | | | | | | |
| 50 | TOTAL (sum of lines 1 through 49) (Transfer to Worksheet A, col. 7, line 100.) | | | | | 50 |

[1] Include amounts not already applied against expenses included on Worksheet A, column 4

[2] Basis for adjustment (SEE INSTRUCTIONS).
A. Costs -- if cost, including applicable overhead, can be determined.
B. Amount Received -- if cost cannot be determined.

[3] Additional adjustments may be made on lines 17 thru 49 and subscripts thereof.

Chapter references are to CMS Pub.15-1

| STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS | 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

| | WKST A LINE NO. | COST CENTER | EXPENSE ITEMS | AMOUNT ALLOWABLE IN COST | AMOUNT INCLUDED IN WKST A, COL 6 | NET ADJUSTMENTS (COL 4 MINUS COL 5) * | |
|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| 1 | | | | | | | 1 |
| 2 | | | | | | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | | | 4 |
| 5 | TOTALS (sum of lines 1 through 4) Transfer col. 6, line 5, to Worksheet A-8, col. 2, line 15. | | | | | | 5 |

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 7, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1, 2 and/or 3, the amount allowable should be indicated in column 4 of this part.

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 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 Medicare.

| | | | | RELATED ORGANIZATIONS AND/OR HO/CO | | | |
|---|---|---|---|---|---|---|---|
| | SYMBOL (1) | NAME | PERCENT OF OWNERSHIP | NAME | PERCENT OF OWNERSHIP | TYPE OF BUSINESS | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| 6 | | | | | | | 6 |
| 7 | | | | | | | 7 |
| 8 | | | | | | | 8 |
| 9 | | | | | | | 9 |
| 10 | | | | | | | 10 |

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

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

| PROVIDER-BASED PHYSICIANS ADJUSTMENTS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-2 |
|---|---|---|---|

| | WKST A LINE NO. | COST CENTER/ PHYSICIAN IDENTIFIER | TOTAL REMUN-ERATION | PROFESSIONAL COMPONENT | PROVIDER COMPONENT | RCE AMOUNTS | PHYSICIAN/ PROVIDER COMPONENT HOURS | UNADJUSTED RCE LIMIT | 5 PERCENT OF UNADJUSTED RCE LIMIT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | | | | | | | | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
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| | | | | | | | | | | |
| 100 | | TOTAL | | | | | | | | 100 |

| | WKST A LINE NO. | COST CENTER/ PHYSICIAN IDENTIFIER | COST OF MEMBERSHIPS & CONTINUING EDUCATION | PROVIDER COMPONENT SHARE OF COLUMN 12 | PHYSICIAN COST OF MALPRACTICE INSURANCE | PROVIDER COMPONENT SHARE OF COLUMN 14 | ADJUSTED RCE LIMIT | RCE 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 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| 100 | | TOTAL | | | | | | | | 100 |

| COST ALLOCATION GENERAL SERVICE COSTS | PROVIDER CCN: | PERIOD: FROM TO | WORKSHEET B |
|---|---|---|---|

| | COST CENTERS | NET EXPENSES FROM WKST A COL 8 | CAPITAL RELATED BLDGS & FIXTURES | CAPITAL RELATED MOVABLE EQUIPMENT | EMPLOYEE BENEFITS | SUBTOTAL (SUM OF COLS 0 THROUGH 3) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPRATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 3A | 4 | 5 | 6 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | Cap Rel Costs - Bldgs & Fixt | | | | | | | | | 1 |
| 2 | Cap Rel Costs - Mvble Equip | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | 4 |
| 5 | Maintenance & Repairs | | | | | | | | | 5 |
| 6 | Operation of Plant | | | | | | | | | 6 |
| 7 | Laundry & Linen Service | | | | | | | | | 7 |
| 8 | Housekeeping | | | | | | | | | 8 |
| 9 | Cafeteria | | | | | | | | | 9 |
| 10 | Central Services & Supply | | | | | | | | | 10 |
| 11 | Medical Records & Library | | | | | | | | | 11 |
| 12 | Pro Ed & Training (Approved)[1] | | | | | | | | | 12 |
| 13 | Other (specify) | | | | | | | | | 13 |
| | REIMBURSABLE COST CENTERS | | | | | | | | | |
| 23 | Drugs & Biologicals | | | | | | | | | 23 |
| 24 | Occupational Therapy | | | | | | | | | 24 |
| 25 | Behavioral Health Treatment/Services | | | | | | | | | 25 |
| 26 | Individual Therapy | | | | | | | | | 26 |
| 27 | Group Therapy | | | | | | | | | 27 |
| 28 | Activity Therapy | | | | | | | | | 28 |
| 29 | Family Therapy | | | | | | | | | 29 |
| 30 | Psychiatric Testing | | | | | | | | | 30 |
| 31 | Education Training | | | | | | | | | 31 |
| 32 | Other (specify) | | | | | | | | | 32 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 42 | Sheltered Workshops | | | | | | | | | 42 |
| 43 | Recreational Programs | | | | | | | | | 43 |
| 44 | Resident Day Camps | | | | | | | | | 44 |
| 45 | Diagnostic Clinics | | | | | | | | | 45 |
| 46 | Physicians' Private Offices | | | | | | | | | 46 |
| 47 | Fundraising | | | | | | | | | 47 |
| 48 | Coffee Shops &Canteen | | | | | | | | | 48 |
| 49 | Research | | | | | | | | | 49 |
| 50 | Investment Property | | | | | | | | | 50 |
| 51 | Advertising | | | | | | | | | 51 |
| 52 | Franchise Fees & Other Assessments | | | | | | | | | 52 |
| 53 | Pro Ed & Training (Not Approved)[2] | | | | | | | | | 53 |
| 54 | Meals & Transportation | | | | | | | | | 54 |
| 55 | Activity Therapies | | | | | | | | | 55 |
| 56 | Psychosocial Programs | | | | | | | | | 56 |
| 57 | Vocational Training | | | | | | | | | 57 |
| 58 | Other (specify) | | | | | | | | | 58 |
| 99 | Negative Cost Centers | | | | | | | | | 99 |
| 100 | TOTAL (sum of lines 1 through 99) | | | | | | | | | 100 |

[1] Approved Educational Activity [2] Not an Approved Educational Activity

| COST ALLOCATION GENERAL SERVICE COSTS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B |
|---|---|---|---|

| | COST CENTERS | LAUNDRY & LINEN | HOUSE-KEEPING | CAFETERIA | CENTRAL SERVICE & SUPPLY | MEDICAL RECORDS & LIBRARY | PROF EDUCATION & TRAINING | OTHER (SPECIFY) | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | Cap Rel Costs - Bldgs & Fixt | | | | | | | | | 1 |
| 2 | Cap Rel Costs - Mvble Equip | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | 4 |
| 5 | Maintenance & Repairs | | | | | | | | | 5 |
| 6 | Operation of Plant | | | | | | | | | 6 |
| 7 | Laundry & Linen Service | | | | | | | | | 7 |
| 8 | Housekeeping | | | | | | | | | 8 |
| 9 | Cafeteria | | | | | | | | | 9 |
| 10 | Central Services & Supply | | | | | | | | | 10 |
| 11 | Medical Records & Library | | | | | | | | | 11 |
| 12 | Pro Ed & Training (Approved)[1] | | | | | | | | | 12 |
| 13 | Other (specify) | | | | | | | | | 13 |
| | REIMBURSABLE COST CENTERS | | | | | | | | | |
| 23 | Drugs & Biologicals | | | | | | | | | 23 |
| 24 | Occupational Therapy | | | | | | | | | 24 |
| 25 | Behavioral Health Treatment/Services | | | | | | | | | 25 |
| 26 | Individual Therapy | | | | | | | | | 26 |
| 27 | Group Therapy | | | | | | | | | 27 |
| 28 | Activity Therapy | | | | | | | | | 28 |
| 29 | Family Therapy | | | | | | | | | 29 |
| 30 | Psychiatric Testing | | | | | | | | | 30 |
| 31 | Education Training | | | | | | | | | 31 |
| 32 | Other (specify) | | | | | | | | | 32 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 42 | Sheltered Workshops | | | | | | | | | 42 |
| 43 | Recreational Programs | | | | | | | | | 43 |
| 44 | Resident Day Camps | | | | | | | | | 44 |
| 45 | Diagnostic Clinics | | | | | | | | | 45 |
| 46 | Physicians' Private Offices | | | | | | | | | 46 |
| 47 | Fundraising | | | | | | | | | 47 |
| 48 | Coffee Shops &Canteen | | | | | | | | | 48 |
| 49 | Research | | | | | | | | | 49 |
| 50 | Investment Property | | | | | | | | | 50 |
| 51 | Advertising | | | | | | | | | 51 |
| 52 | Franchise Fees & Other Assessments | | | | | | | | | 52 |
| 53 | Pro Ed & Training (Not Approved)[2] | | | | | | | | | 53 |
| 54 | Meals & Transportation | | | | | | | | | 54 |
| 55 | Activity Therapies | | | | | | | | | 55 |
| 56 | Psychosocial Programs | | | | | | | | | 56 |
| 57 | Vocational Training | | | | | | | | | 57 |
| 58 | Other (specify) | | | | | | | | | 58 |
| 99 | Negative Cost Centers | | | | | | | | | 99 |
| 100 | TOTAL (sum of lines 1 through 99) | | | | | | | | | 100 |

[1] Approved Educational Activity [2] Not an Approved Educational Activity

| COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM TO | WORKSHEET B-1 |
|---|---|---|---|

| | COST CENTERS | CAPITAL RELATED BLDGS & FIXTURES (SQUARE FEET) | CAPITAL RELATED MOVABLE EQUIPMENT (DOLLAR VALUE) | EMPLOYEE BENEFITS (GROSS SALARIES) | RECON-CILIATION | ADMINIS-TRATIVE & GENERAL (ACCUM COST) | MAIN-TENANCE & REPAIRS (SQUARE FEET) | OPRATION OF PLANT (SQUARE FEET) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4A | 4 | 5 | 6 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | Cap Rel Costs - Bldgs & Fixt | | | | | | | | 1 |
| 2 | Cap Rel Costs - Mvble Equip | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | 4 |
| 5 | Maintenance & Repairs | | | | | | | | 5 |
| 6 | Operation of Plant | | | | | | | | 6 |
| 7 | Laundry & Linen Service | | | | | | | | 7 |
| 8 | Housekeeping | | | | | | | | 8 |
| 9 | Cafeteria | | | | | | | | 9 |
| 10 | Central Services & Supply | | | | | | | | 10 |
| 11 | Medical Records & Library | | | | | | | | 11 |
| 12 | Pro Ed & Training (Approved)(1) | | | | | | | | 12 |
| 13 | Other (specify) | | | | | | | | 13 |
| | REIMBURSABLE COST CENTERS | | | | | | | | |
| 23 | Drugs & Biologicals | | | | | | | | 23 |
| 24 | Occupational Therapy | | | | | | | | 24 |
| 25 | Behavioral Health Treatment/Services | | | | | | | | 25 |
| 26 | Individual Therapy | | | | | | | | 26 |
| 27 | Group Therapy | | | | | | | | 27 |
| 28 | Activity Therapy | | | | | | | | 28 |
| 29 | Family Therapy | | | | | | | | 29 |
| 30 | Psychiatric Testing | | | | | | | | 30 |
| 31 | Education Training | | | | | | | | 31 |
| 32 | Other (specify) | | | | | | | | 32 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 42 | Sheltered Workshops | | | | | | | | 42 |
| 43 | Recreational Programs | | | | | | | | 43 |
| 44 | Resident Day Camps | | | | | | | | 44 |
| 45 | Diagnostic Clinics | | | | | | | | 45 |
| 46 | Physicians' Private Offices | | | | | | | | 46 |
| 47 | Fundraising | | | | | | | | 47 |
| 48 | Coffee Shops &Canteen | | | | | | | | 48 |
| 49 | Research | | | | | | | | 49 |
| 50 | Investment Property | | | | | | | | 50 |
| 51 | Advertising | | | | | | | | 51 |
| 52 | Franchise Fees & Other Assessments | | | | | | | | 52 |
| 53 | Pro Ed & Training (Not Approved)(2) | | | | | | | | 53 |
| 54 | Meals & Transportation | | | | | | | | 54 |
| 55 | Activity Therapies | | | | | | | | 55 |
| 56 | Psychosocial Programs | | | | | | | | 56 |
| 57 | Vocational Training | | | | | | | | 57 |
| 58 | Other (specify) | | | | | | | | 58 |
| 100 | Negative Cost Center | | | | | | | | 100 |
| 101 | Cost to be Allocated | | | | | | | | 101 |
| 102 | Unit Cost Multiplier | | | | | | | | 102 |

(1) Approved Educational Activity (2) Not an Approved Educational Activity

| COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1 |
|---|---|---|---|

| | COST CENTERS | LAUNDRY & LINEN (POUNDS OF LAUNDRY) | HOUSE-KEEPING (HOURS OF SERVICE) | CAFETERIA (MEALS SERVED) | CENTRAL SERVICE & SUPPLY (COSTED REQUIS) | MEDICAL RECORDS & LIBRARY (TIME SPENT) | PROF EDUCATION & TRAINING (ASSIGNED TIME) | OTHER (SPECIFY) | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | |
| | GENERAL SERVICE COST CE | | | | | | | | | |
| 1 | Cap Rel Costs - Bldgs & Fixt | | | | | | | | | 1 |
| 2 | Cap Rel Costs - Mvble Equip | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | 4 |
| 5 | Maintenance & Repairs | | | | | | | | | 5 |
| 6 | Operation of Plant | | | | | | | | | 6 |
| 7 | Laundry & Linen Service | | | | | | | | | 7 |
| 8 | Housekeeping | | | | | | | | | 8 |
| 9 | Cafeteria | | | | | | | | | 9 |
| 10 | Central Services & Supply | | | | | | | | | 10 |
| 11 | Medical Records & Library | | | | | | | | | 11 |
| 12 | Pro Ed & Training (Approved)(1) | | | | | | | | | 12 |
| 13 | Other (specify) | | | | | | | | | 13 |
| | REIMBURSABLE COST CENTERS | | | | | | | | | |
| 23 | Drugs & Biologicals | | | | | | | | | 23 |
| 24 | Occupational Therapy | | | | | | | | | 24 |
| 25 | Behavioral Health Treatment/Services | | | | | | | | | 25 |
| 26 | Individual Therapy | | | | | | | | | 26 |
| 27 | Group Therapy | | | | | | | | | 27 |
| 28 | Activity Therapy | | | | | | | | | 28 |
| 29 | Family Therapy | | | | | | | | | 29 |
| 30 | Psychiatric Testing | | | | | | | | | 30 |
| 31 | Education Training | | | | | | | | | 31 |
| 32 | Other (specify) | | | | | | | | | 32 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 42 | Sheltered Workshops | | | | | | | | | 42 |
| 43 | Recreational Programs | | | | | | | | | 43 |
| 44 | Resident Day Camps | | | | | | | | | 44 |
| 45 | Diagnostic Clinics | | | | | | | | | 45 |
| 46 | Physicians' Private Offices | | | | | | | | | 46 |
| 47 | Fundraising | | | | | | | | | 47 |
| 48 | Coffee Shops &Canteen | | | | | | | | | 48 |
| 49 | Research | | | | | | | | | 49 |
| 50 | Investment Property | | | | | | | | | 50 |
| 51 | Advertising | | | | | | | | | 51 |
| 52 | Franchise Fees & Other Assessments | | | | | | | | | 52 |
| 53 | Pro Ed & Training (Not Approved)(2) | | | | | | | | | 53 |
| 54 | Meals & Transportation | | | | | | | | | 54 |
| 55 | Activity Therapies | | | | | | | | | 55 |
| 56 | Psychosocial Programs | | | | | | | | | 56 |
| 57 | Vocational Training | | | | | | | | | 57 |
| 58 | Other (specify) | | | | | | | | | 58 |
| 100 | Negative Cost Center | | | | | | | | | 100 |
| 101 | Cost to be Allocated | | | | | | | | | 101 |
| 102 | Unit Cost Multiplier | | | | | | | | | 102 |

(1) Approved Educational Activity (2) Not an Approved Educational Activity

| APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C |
|---|---|---|---|

| | REIMBURSABLE COST CENTERS | FROM WKST B, COL. 14, REIMBURSABLE COSTS | TOTAL CHARGES | RATIO OF COST TO CHARGES (COL 1 ÷ COL. 2) | MEDICARE CHARGES | MEDICARE COST (COL 3 X COL 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 23 | Drugs & Biologicals | | | | | | 23 |
| 24 | Occupational Therapy | | | | | | 24 |
| 25 | Behavioral Health Treatment/Services | | | | | | 25 |
| 26 | Individual Therapy | | | | | | 26 |
| 27 | Group Therapy | | | | | | 27 |
| 28 | Activity Therapy | | | | | | 28 |
| 29 | Family Therapy | | | | | | 29 |
| 30 | Psychiatric Testing | | | | | | 30 |
| 31 | Education Training | | | | | | 31 |
| 32 | Other (specify) | | | | | | 32 |
| 50 | TOTAL (lines 23 through 32) | | | | | | 50 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET D |
|---|---|---|---|

| | DESCRIPTION | | |
|---|---|---|---|
| 1 | Gross APC/PPS payments | | 1 |
| 2 | Outlier payments | | 2 |
| 3 | Outlier reconciliation amount (transfer from line 54) | | 3 |
| 4 | Gross reimbursement (sum of lines 1 through 3) | | 4 |
| 5 | Primary payer payments | | 5 |
| 6 | Deductibles billed to program patients (do not include coinsurance) | | 6 |
| 7 | Coinsurance billed to program patients (see instructions) | | 7 |
| 8 | Subtotal (line 4 minus lines 5, 6, and 7) | | 8 |
| 9 | Reimbursable bad debts (see instructions) | | 9 |
| 10 | Adjusted reimbursable bad debts | | 10 |
| 11 | Reimbursable bad debts for dual eligible beneficiaries (see instructions) | | 11 |
| 12 | Subtotal (line 8 plus line 10) | | 12 |
| 13 | Other adjustments (specify) (see instructions) | | 13 |
| 14 | Other demonstration payment adjustment amount before sequestration | | 14 |
| 15 | Amount due prior to the sequestration adjustment (see instructions) | | 15 |
| 16 | Sequestration adjustment (see instructions) | | 16 |
| 17 | Other demonstration payment adjustment amount after sequestration | | 17 |
| 18 | Amount due after sequestration adjustment (see instructions) | | 18 |
| 19 | Interim payments | | 19 |
| 20 | Tentative settlement (for contractor use only) | | 20 |
| 21 | Balance due provider/program (line 18 minus lines 19 and 20) (indicate overpayment in brackets) | | 21 |
| 22 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 22 |

| | TO BE COMPLETED BY CONTRACTOR | | |
|---|---|---|---|
| 50 | Original outlier amount (see instructions) | | 50 |
| 51 | Outlier reconciliation adjustment amount (see instructions) | | 51 |
| 52 | The rate used to calculate the Time Value of Money | | 52 |
| 53 | Time Value of Money (see instructions) | | 53 |
| 54 | Total (sum of lines 51 and 53) | | 54 |

| ANALYSIS OF PAYMENTS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES | PROVIDER CCN: | PERIOD: FROM TO | WORKSHEET D-1 |
|---|---|---|---|

| | | | | PART B MM/DD/YYYY 1 | PART B AMOUNT 2 | |
|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to CMHC | | | | | 1 |
| 2 | Interim payments payable on individual bills either, submitted or to be submitted to the contractor, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero. (1) | Program to Provider | .01 | | | 3.01 |
| | | | .02 | | | 3.02 |
| | | | .03 | | | 3.03 |
| | | | .04 | | | 3.04 |
| | | | .05 | | | 3.05 |
| | | Provider to Program | .50 | | | 3.50 |
| | | | .51 | | | 3.51 |
| | | | .52 | | | 3.52 |
| | | | .53 | | | 3.53 |
| | | | .54 | | | 3.54 |
| | SUBTOTAL (sum of lines 3.01 through 3.49, minus sum of lines 3.50 through 3.98) | | .99 | | | 3.99 |
| 4 | TOTAL INTERIM PAYMENTS (sum of lines 1, 2 and 3.99) (Transfer to Wkst. D, line 19) | | | | | 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 through 5.49, minus sum of lines 5.50 through 5.98) | | .99 | | | 5.99 |
| 6 | Determine net settlement amount (balance due) based on the cost report (see instructions) (1) | Program to Provider | .01 | | | 6.01 |
| | | Provider to Program | .02 | | | 6.02 |
| 7 | TOTAL MEDICARE PROGRAM LIABILITY (see instructions) | | | | | 7 |

| | 0 | | 1 | | 2 | | |
|---|---|---|---|---|---|---|---|
| 8 | Name of Contractor | | Contractor Number | | NPR Date (MM/DD/YYYY) | | 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.

| STATEMENT OF REVENUES AND EXPENSES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET F |
|---|---|---|---|

| | DESCRIPTION | | |
|---|---|---|---|
| 1 | Total patient revenue | | 1 |
| 2 | Less: Allowance and discounts on patients' accounts | | 2 |
| 3 | Net patient revenues (line 1 minus line 2) | | 3 |
| 4 | Less: Total operating expenses (per Worksheet A, column 4, line 100) | | 4 |
| 5 | Net income from service to patients (line 3 minus line 4) | | 5 |
| | OTHER INCOME | | |
| 6 | Grants, gifts, and income designated by donor for specific expenses | | 6 |
| 7 | Payments received from specialists | | 7 |
| 8 | Investment income on unrestricted funds | | 8 |
| 9 | Trade, quantity, time and other discounts on purchases | | 9 |
| 10 | Rebates and refunds of expenses | | 10 |
| 11 | Income from laundry and linen service | | 11 |
| 12 | Income from cafeteria - employees, guests, etc. | | 12 |
| 13 | Sale of medical supplies to other than patients | | 13 |
| 14 | Sale of workshop products or services | | 14 |
| 15 | Coffee shops and canteen | | 15 |
| 16 | Vending machines | | 16 |
| 17 | Rental of building or office space to others | | 17 |
| 18 | Sale of scrap, waste, etc. | | 18 |
| 19 | Sale of medical records and abstracts | | 19 |
| 20 | Other (Specify) | | 20 |
| 20.50 | COVID-19 PHE funding | | 20.50 |
| 21 | Total other income (sum of lines 6 through 20) | | 21 |
| 22 | Total (line 5 plus line 21) | | 22 |
| | OTHER EXPENSES | | |
| 23 | Fund raising | | 23 |
| 24 | Gift, coffee shops, and canteen | | 24 |
| 25 | Investment property | | 25 |
| 26 | Other (specify) | | 26 |
| 27 | Total other expenses (sum of lines 23 through 26) | | 27 |
| 28 | Net income (or loss) for the period (line 22 minus line 27) | | 28 |