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 5 **Date: May 2013**

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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Cost Reporting Periods Beginning on or After October 1, 2012.

This transmittal updates Chapter 41, Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Reports, Form CMS-2540-10 to clarify and correct existing instructions, incorporate statutory changes and comply with an Executive order. The effective dates vary.

Significant revisions include:

- Worksheet S-2, Part I, clarified instructions for lines 43 and 44.
- Worksheet D-1, Part II, clarified instructions for lines 1, 2, and 3.
- Modified or added instructions to implement § 3101 of the Middle Class Tax Relief and Job Creation Act of 2012, reducing payments for bad debts for the following:
    - Worksheet E, Part I
    - Worksheet I-3
    - Worksheet J-3
- Modified or added instructions to implement the 2 percent Medicare sequestration adjustment, effective for portions of cost reporting periods that overlap or begin on or after April 1, 2013, as indicated in the Office of Management and Budget (OMB) Report to the Congress on the sequestration for fiscal year (FY) 2013 required by section 251A of the Balanced Budget and Emergency Deficit Control Act, as amended (the "Joint Committee sequestration").
    - Worksheet E, Part I
    - Worksheet H-4
    - Worksheet I-3
    - Worksheet J-3

- Update specs for Worksheet S-2, Part I
- Added specs for new lines on Worksheets E, Part 1, H-4, I-3, and J-3
- Modified edit 1045S
- Added edit 1046S

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

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

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

* 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.--A liability limit refers to the maximum sum of money an insurance company will pay per lawsuit and per policy year. For example, a standard liability limit for physician professional liability is $1 million in damages per lawsuit and a total of $3 million for all lawsuits during the policy year (often referred to as $1 million/$3 million).

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, which protects providers for 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

Line 44.--If *line 43 is* yes, enter the home office chain number *and* enter the name and address of the home office on lines 45, 46 and 47.

Line 45, columns 1, 2 and 3.--Enter the name of the home office in column 1, and enter the name of the contractor of the home office in column 2. Enter the contractor number in column 3.

Line 46, columns 1 and 2.--Enter the street address in column 1, or the post office box number in column 2.

Line 47, columns 1, 2 and 3.--Enter the city, State and zip code in columns 1, 2, and 3.

4104.1 Part II – Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Reimbursement Questionnaire.-- The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all providers submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as "The Act"). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of the cost report. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost report and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately, after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Line Descriptions

Lines 1 through 18 are required to be completed by all Skilled Nursing Facilities.

Line 1.--Indicate whether the provider has changed ownership. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the provider has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Indicate whether the provider is 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. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, Chapter 10 and 42 CFR 413.17)

Line 4.--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you do not engage public accountants to prepare your financial statements, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit reconciliation with the cost report.

Line 6.--Indicate whether costs were claimed for Nursing School. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7.--Indicate whether costs were claimed for Allied Health Programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s) with the cost report and annotate for each, whether the provider is the legal operator of the program.

NOTE: For purposes of lines 6 and 7, the provider is the legal operator of a nursing school and/or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

Line 8.--Indicate whether approvals and/or renewals were obtained during the cost reporting period for Nursing School and/or Allied Health programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89ff and CMS Pub. 15-1, §§306-324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed. If you are claiming bad debts for inpatient and Part B SNF services, complete a separate Exhibit 1 or internal schedule for each category. Also, complete a separate Exhibit 1, as applicable, for bad debts of each sub provider.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, §314 and 42 CFR 413.89)

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 a 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 the 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).

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 certifies 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 SNF-based NF, or the SNF-based ICF/MR as applicable. These charges 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 lines 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 currently 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 - CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII

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

Part I - SNF Reimbursement Under PPS

Part II - Reimbursement Settlement for Title V and Title XIX

4130.1 Part I - SNF Reimbursement Under PPS.--Use this part to calculate reimbursement settlement under PPS for program services. A free-standing SNF has been reimbursed for Medicare under PPS for cost reporting periods beginning after July 1, 1998.

Part A Line Descriptions

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.--DRA 2005 SNF Bad Debt--Calculate this line as follows: ((line 6 - line 7) times.7) PLUS the amount on line 7. This is the adjusted SNF reimbursable bad debt in accordance with DRA 2005, section 5004. *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)].

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)].

Line 29.--Enter the *sum of the* amount on line 25 minus lines 26, *27 and 28.99, plus or minus line 28 and its subscripts not previously identified*. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part III, column 3, line 1.

Line 30.--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.

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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 30 minus lines 30.99, plus or minus line 30 and its subscripts no 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

Line 10.--Enter the number of program covered visits, excluding visits subject to the outpatient mental health services limitation from your contractor records.

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 reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your contractor records.

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.

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 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 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].

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 for services rendered on and after August 1, 2000. 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 parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider 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

This worksheet must be completed for services furnished on and after October 1, 2009. The administrative cost of influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these services rendered on and after October 1, 2009.

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 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.

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].

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.

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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 *beginning* on or after *2012275 (October 1, 2012)*. Prior approval*(s) 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-2, Part I (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
If this is a low Medicare utilization cost report, "Y" for yes, or "N".	19	1	1	X
If line 19 is yes, does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)	19.01	1	1	X
Enter the amount of depreciation reported in this SNF for the method indicated:				
Straight Line	20	1	9	9
Declining Balance	21	1	9	9
Sum of the Years' Digits	22	1	9	9
If depreciation is funded, enter the balance as of the end of the period.	24	1	9	9
Were there any disposals of capital assets during the cost reporting year?(Y/N)	25	1	1	X
Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	26	1	1	X
Did you cease to participate in the Medicare program at the end of the period to which this cost report applies? (Y/N)	27	1	1	X
Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)	28	1	1	X

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. Enter "N" for each component and type of service contained in this facility that does not qualify for the exemption.

Skilled Nursing Facility	29	1-2	1	X
Nursing Facility	30	3	1	X
I C F - M R	31	3	1	X
SNF-Based HHA	32	1-2	1	X
SNF-Based RHC	33	2	1	X
SNF-Based FQHC	34	2	1	X
SNF-Based CMHC	35	2	1	X
SNF-Based OLTC	36	N/A	N/A	N/A

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-2, Part I (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
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 and XIX patients? (Y/N)	37	1	1	X
Are you legally-required to carry malpractice insurance? (Y/N)	38	1	1	X
Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-maid", enter 1. If policy is "occurrence", enter 2.	39	1	1	9
List malpractice premiums in column 1, paid losses in column 2, and self-insurance in column 3	41	1-3	9	9
Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	42	1	1	X
Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?	43	1	1	X
If yes, and there are costs for the home office, enter the applicable home office chain number.	44	1	6	X
If this facility is part of a chain organization, enter the name and address of the home office on the lines below				
Name	45	1	36	X
Contractor Name	45	2	36	X
Contractor Number	45	3	5	X
Street	46	1	36	X
P.O. Box	46	2	9	X
City	47	1	36	X
State	47	2	2	X
Zip Code	47	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-8

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I	1	1-5	9	9
Continuous Home Care Routine Home Care	2	1-5	9	9
Inpatient Respite Care	3	1-5	9	9
General Inpatient Care	4	1-5	9	9
Part II Number of Patients Receiving Hospice Care	6	1-5	9	9
Total number of Unduplicated Continuous Care Hours	7	1 & 3	11	9(8).99
Unduplicated Census Count	9	1-5	9	9

WORKSHEET A

Direct salaries by department	3-15, 30-33, 40-52, 60-63, 70-74, 82-84, 90-95	1	9	-9
Total direct salaries	100	1	9	9
Other direct costs by department	1-15, 30-33, 40-52, 60-63, 70-74, 80-84, 90-95	2	9	-9
Total other direct costs	100	2	9	9
Net expenses for cost allocation by department	1-15, 30-33, 40-52, 60-63, 70-74, 80-84, 90-95	7	9	-9
Total net expenses for cost allocation	100	7	9	9

WORKSHEET A-6

For each expense reclassification:				
Explanation	1-99	0	36	X
Reclassification code	1-99	1	2	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET A-6 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Increases:				
Worksheet A line number	1-99	3	5	99.99
Salary amount	1-99	4	9	9
Non salary amount	1-99	5	9	9
Decreases:				
Worksheet A line number	1-99	7	5	99.99
Salary amount	1-99	8	9	9
Non salary amount	1-99	9	9	9
Total Increases	100	4-5	9	9
Total Decreases	100	8-9	9	9

WORKSHEET A-7

Analysis of changes in capital assets balances for land, land improvements, buildings and fixtures, building improvements, fixed and movable equipment, and in total:				
Beginning balances	1-9	1	9	9
Purchases	1-9	2	9	9
Donations	1-9	3	9	9
Disposals and retirements	1-9	5	9	9
Fully Depreciated Assets	1-9	7	9	9

WORKSHEET A-8

Description of adjustment	25-99	0	36	X
Basis (A or B)	1-7, 9-11, 13-99	1	1	X
Amount	1-7, 9-11, 13-100	2	9	-9
Worksheet A line number	1-7, 9-11, 13-21, 25-99	4	5	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET D, PART II

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Vaccine cost apportionment				
Program vaccine charges	2	1	9	9

WORKSHEET D-1, PART I

Private room days	2	1	9	9
Medically necessary private room days	4	1	9	9
General inpatient routine service charges	6	1	9	9
Private room charge	8	1	9	9
Semi private room charges	10	1	9	9
Aggregate charges to beneficiaries for excess costs	24	1	9	9
Inpatient routine service cost per diem limitation	26*	1	9	9(6).99
Reimbursable inpatient routine service costs	28	1	9	9

* Line 26 is not applicable for Title XVIII, but may be used for Titles V and XIX.

WORKSHEET E, PART I

Part A - Inpatient service PPS provider computation of reimbursement Title XVIII				
Inpatient PPS amount (see instructions)	1	1	9	9
Primary payer amounts	4	1	9	9
Coinsurance	5	1	9	9
Reimbursable bad debts	6	1	9	-9
Reimbursable bad debts dual eligible	7	1	9	-9
Recovery of bad debts – for statistical records only.	9	1	9	9
Utilization review	10	1	9	9
Other adjustments (specify)	14	0	36	X
Other adjustments	14	1	9	-9
Sequestration amount	*14.99*	*1*	*9*	*-9*
Protested amounts	16	1	9	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET E, PART I (Cont.)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part B - Ancillary service computation of reimbursement of lesser of cost or charges (Title XVIII only)				
Primary payer amounts	22	1	9	9
Coinsurance and deductibles	23	1	9	9
Reimbursable bad debts	24	1	9	-9
Reimbursable bad debts for duals	*24.01*	*1*	*9*	*-9*
Adjusted reimbursable bad debts	*24.02*	*1*	*9*	*-9*
Other adjustments (specify)	28	0	36	X
Other adjustments	28	1	9	-9
Sequestration amount	*28.99*	*1*	*9*	*-9*
Protested Amounts	30	1	9	-9

WORKSHEET E, PART II (Titles V and XIX)

Utilization review – physicians' compensation	5	1	9	9
Charge differential	7	1	9	9
Inpatient primary payer amount	9	1	9	9
Inpatient ancillary service charges	11	1	9	9
Outpatient service charges	12	1	9	9
Inpatient routine service charges	13	1	9	9
Charge differential	14	1	9	9
Aggregate amount collected	16	1	9	9
Amount collectible	17	1	9	9
Deductibles (Title V and Title XIX only)	21	1	9	9
Coinsurance	23	1	9	9
Reimbursable bad debt	25	1	9	-9
Unrefunded excess charges	27	1	9	9
Recovery of excess depreciation	28	1	9	9
Other adjustments (specify)	29	0	36	X
Other adjustments (see instructions)	29	1	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 – Parts 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*	*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 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET I-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Adjusted cost per visit	7	1	6	9(3).99
Maximum rate per visit (from your contractor)	8	1 & 2	6	9(3).99
Rate for program covered visits	9	1 & 2	6	9(3).99
Program covered visits excluding mental health services (from your contractor)	10	1 & 2	11	9
Program covered visits for mental health services (from your contractor)	12	1 & 2	11	9
Total Program Charges	15.01	1 & 2	11	9
Total Program Preventive Charges	15.02	1 & 2	11	9
Primary payer amounts	16	1	11	9
Beneficiary deductible (from your contractor)	17	1	11	9
Beneficiary coinsurance (from your contractor)	18	1	11	9
Reimbursable bad debt	22	1	11	*-9*
Adjusted reimbursable bad debts	*22.01*	*1*	*11*	*-9*
Reimbursable bad debt dual eligible beneficiaries	23	1	11	*-9*
Other Adjustment (specify)	24	0	36	X
Other Adjustments	24	1	11	9
Sequestration amount	*25.01*	*1*	*11*	*-9*
Interim payments (Title V & XIX only)	26	1	11	9
Protested amounts	29	1	11	-9

WORKSHEET I-4

Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	2	1 & 2	8	9.9(6)
Medical supplies cost - pneumococcal and influenza vaccine	4	1 & 2	11	9
Total number of pneumococcal and influenza vaccine injections	11	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 I-4

Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1 & 2	11	9

WORKSHEET I-5

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total interim payments paid to provider	1	2	11	9
Interim payments payable	2	2	11	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X
Adjustment of each retroactive lump sum adjustment:				
Program to provider	3.01-3.49	2	11	9
Provider to program	3.50-3.98	2	11	9
Date of each tentative settlement adjustment (MM/DD/YYYY)	5.01-5.98	1	10	X
Tentative settlement payment				
Program to provider	5.01-5.49	2	11	9
Provider to program	5.50-5.98	2	11	9
Contractor Name	8	1	36	X
Contractor Number	8	2	5	X

WORKSHEET J-1, PARTS I & II

Part I				
Net expenses for cost allocation	1-21	0	9	9
Post step down adjustments (including total)	1-22	17	9	-9
Totals (sum of lines 1-21)	22	0-3 & 4-15	9	9
Part II				
Reconciliation	1-21	4A-15A	9	-9
Cost allocation statistics	1-21	1-15 *	9	9

*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this is a replica of Worksheet B-1.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET J-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I				
Apportioned Outpatient Rehabilitation Costs				
Total component charges	2-21	2	9	9
Title V charges	2-21	4	9	9
Title XVIII charges	2-21	6	9	9
Title XIX charges	2-21	8	9	9
Part II				
Charges for rehabilitation services furnished by shared departments				
Title V charges	23-29	4	9	9
Title XVIII charges	23-29	6	9	9
Title XIX charges	23-29	8	9	9

WORKSHEET J-3

Cost of component service	1	1	9	9
PPS Payments received	2	1	9	9
Outlier payments	3	1	9	9
Primary payment amounts	4	1	9	9
Total reasonable costs (see instructions)	5	1	9	9
Total charges for program services	6	1	9	9
Part B deductible	10	1	9	9
Coinsurance billed	11	1	9	9
Reimbursable bad debts	13	1	9	-9
Adjusted reimbursable bad debts	*13.01*	*1*	*9*	*-9*
Dual Eligible Beneficiaries	14	1	9	*-9*
Other Adjustments (specify)	16	0	36	X
Other Adjustments	16	1	9	-9
Sequestration amount	*17.01*	*1*	*9*	*-9*
Interim payments for title Titles V and XIX (where applicable)	18	1	9	9
Protested amounts	21	1	9	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET J-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total interim payments paid to provider	1	2	9	9
Interim payments payable	2	2	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2	9	9
Provider to program	3.50-3.98	2	9	9
Date of each tentative settlement adjustment (MM/DD/YYYY)	5.01-5.98	1	10	X
Tentative payments after desk review				
Program to provider	5.01-5.49	2	9	9
Provider to program	5.50-5.98	2	9	9
Contractor Name	8	1	36	X
Contractor Number	8	2	5	X

WORKSHEET K

Transportation	1-38	3	11	9
Other Costs	1-38	5	11	9
Reclassification	1-38	7	11	-9
Adjustments	1-38	9	11	-9
Net expense for allocation	39	10	11	9

WORKSHEET K-1, K-2 & K-3

Salaries and Wages, Employee Benefits and Contract Services	3-21 & 27-38	1-8	11	9

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 – EDITS

Reject Code	Condition
1080	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [12/01/2010b]
1085	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [12/01/2010b]
1090	A numeric field cannot exceed more than 11 positions. Apply to all cost reports. [12/01/2010b]
1000S	The SNF address, city, State, zip code, and county (Worksheet S-2, Part I, lines 1, 2, and 3, columns 1, 2, and 3 respectively) must be present and valid. [12/01/2010b]
1005S	The cost report ending date (Worksheet S-2, Part I, column 2, line 14) must be on or after 01/01/2011. [12/01/2010b]
1010S	All provider CCN and component numbers displayed on Worksheet S-2, Part I, column 2, lines 4 through 10, 12, and 13, must contain six (6) alphanumeric characters. [12/01/2010b]
1015S	The cost report period beginning date (Worksheet S-2, Part I, column 1, line 14) must precede the cost report ending date (Worksheet S-2, Part I, column 2, line 14). [12/01/2010b]
1020S	The skilled nursing facility name, provider CCN, certification date, and Title XVIII payment mechanism (Worksheet S-2, Part I, line 4, columns 1, 2, 3, and 5, respectively) must be present and valid. [12/01/2010b]
1025S	For each provider/component name reported (Worksheet S-2, Part I, column 1, lines 5 through 13), there must be corresponding entries made on Worksheet S-2, Part I, lines 5 through 10, 12 and 13 for the provider CCN (column 2), the certification date (column 3), and the payment system for either Titles V, XVIII, or XIX (columns 4, 5, or 6, respectively) indicated with a valid code (P, O, or N). (See Table 3D.) If there is no component name entered in column 1, then columns 2 through 6 for that line must be blank.[12/01/2010b]
1030S	For Worksheet S-2, Part I, there must be a response in every file in column 1, lines 15-18, 25-28, 37-38, and 42-43. If line 15, column 1 equals "13" other, specify in column 2. [12/01/2010b]
1035S	For Worksheet S-2, Part I, if the response on line 38 = "Y", then there must be a response on line 39. [12/01/2010b]
1040S	For each provider/component listed on Worksheet S-2, Part I, lines 4 through 10 and their subscripts, there must be corresponding entries made on Worksheet S-2, Part I, lines 29 through 35 and their subscripts, accordingly. For lines 29, 32 and its subscripts, columns 1 and 2 must be completed. For lines 30 and 31, column 3 must be completed and for lines 33 through 35 and their subscripts, column 2 must be completed. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 – EDITS

Reject Code	Condition
1045S	For Worksheet S-2, Part I, if the response on line 43 = "Y", and line 18 is "N", there must be a response on line 44, column 1, lines 45 and 47, all columns and line 46 column 1 or 2. [12/01/2010b] **DO NOT APPLY [07/31/2012]**
1046S	*For Worksheet S-2, Part I, if the response on line 43 = "Y", there must be a response on line 44, column 1, lines 45 and 47, all columns, and line 46 column 1 or 2 and vice versa. [10/31/2012]*
1050S	For Worksheet S-2, Part II, there must be a "Y" or "N" response on lines 1, through 12, column 1 and lines 13 through 18, columns 1 and 3. [12/01/2010b]
1055S	For Worksheet S-2, Part II, if the response on lines 1, 13 or 14, column 1 = "Y", a date must be entered in column 2. If the response on line 2, column 1 = "Y", a date must be entered in column 2 and a "V" or "I" must be entered in column 3. If the response on lines 13 or 14, column 3 = "Y", a date must be entered in column 4. [12/01/2010b]
1060S	Worksheet S-2, Part I, column 2, lines as indicated below may only contain those provider numbers as indicated for that line. The type of provider is also indicated.

Line #	Provider # (1)	Provider Type
4	5000-6499	SNF
7	3100-3199	Home Health Agencies
	7000-8499	" "
	9000-9799	" "
8	3400-3499	SNF-Based RHC
	3975-3999	" "
	8500-8999	" "
9	1000-1199	SNF-Based FQHC
	1800-1989	" "
10	1400-1499	CMHC
	4600-4799	"
	4900-4999	"
12	1500-1799	SNF-Based Hospice
13 – 13.09	3200-3299	SNF-Based CORF
	4500-4599	
	4800-4899	
13.10 – 13.39	6500-6599	SNF-Based OPT, OOT, OSP

(1) The first two characters of the provider number (not listed here) identify the State. The last 4 characters (listed above) identify the type of provider. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10

TABLE 6 - EDITS

1090S	All amounts reported on Worksheet S-3, Part I must not be less than zero.
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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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 A	TITLE XVIII B	TITLE XIX	
		1	2	3	4	
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

SKILLED NURSING FACILITY BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REAHBILITATION 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 (from Wkst. S-3, Pt. I, cols. 3, 4 or 5, line 1 or 2 as applicable)		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		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL	TOTAL	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
			(Square Feet)	(Dollar Value or Square Feet)	(Square Feet)	(Mileage)		(Accumulated Cost)		
		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.

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 (line 29 plus/minus line 30)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (*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							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, 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	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.

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

	COMPONENT COST CENTER	CAPITAL RELATED		EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)				
		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 (line 17 minus lines 18 and 19)		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	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. 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

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