07-23		FC	ORM CMS-2552	2-10		4090	(Cont.)
	rt is required by law (42 USC 1395g; 42 CFR 413.20(b)). F made since the beginning of the cost reporting period being					FORM APPROVI OMB NO. 0938-0 EXPIRES 09-30-2	050
COMPL	CAL AND HOSPITAL HEALTH CARE LEX COST REPORT CERTIFICATION ETTLEMENT SUMMARY			PROVIDER CCN:	PERIOD FROM TO _	WORKSHEET S PARTS I, II & III	
PART I	- COST REPORT STATUS						
	use only 1. [] Electronically prepared cost re 2. [] Manually prepared cost report 3. [] If this is an amended report en 4. [] Medicare Utilization. Enter "I	ter the number of times the p		Time:			
Contract use only		6. Date Received: 7. Contractor No.: 8. [] Initial Report for th 9. [] Final Report for th		10. NPR Date: 11. Contractor's Vend 12. [] If line 5, colur times reopened	nn 1, is 4: Enter numbe	r of	
ACTION THE PA	PRESENTATION OR FALSIFICATION OF ANY N, FINE AND/OR IMPRISONMENT UNDER FE LYMENT DIRECTLY OR INDIRECTLY OF A K ONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFF I HEREBY CERTIFY that I have read the above c submitted cost report and the Balance Sheet and St cost reporting period beginning	DERAL LAW. FURTHERN ICKBACK OR WERE OTH ICER OR ADMINISTRATO ertification statement and tha atement of Revenue and Exp and ending of the provider in accordance	MORE, IF SERVICES ERWISE ILLEGAL, COR OF PROVIDER(S) It I have examined the a emess prepared by and to the best of my le with applicable instru	IDENTIFIED IN THIS CRIMINAL, CIVIL AND accompanying electronical knowledge and belief, this ictions, except as noted. I	REPORT WERE PRO' ADMINISTRATIVE lly filed or manually su _{Provider Name(s) are report and statement a further certify that I am	VIDED OR PROCURED TACTION, FINES AND/OR benitted cost report and and Number(s)} for the are true, correct, a familiar with the	THROUGE
	SIGNATURE OF CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR	CHECKBOX		ELECTRONIC		Г
1	1		2	I have read and agree	onic signature on this co	MENT tion statement. I certify ertification be the legally	1
2	Signatory Printed Name:			Ŭ,			2
4	Signatory Title: Signature date:						3
	Signature date.						
DADTI	II - SETTLEMENT SUMMARY						
PARTI	II - SETTLEMENT SUMMART		TITL	E XVIII	1		Г
		TITLE V	PART A	PART B	HIT	TITLE XIX	
	T	1	2	3	4	5	├ ──
1	HOSPITAL						1
1.01	HOSPITAL- <i>PARHM</i>						1.01
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4

			TITLE	E XVIII			
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
1.01	HOSPITAL- <i>PARHM</i>						1.01
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING-BED SNF						5
5.01	SWING-BED <i>PARHM</i> (CAH ONLY)						5.01
6	SWING-BED NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED RHC						10
11	HOSPITAL-BASED FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL				_		200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete this information collection. If you have comments of 575 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have commenting the accuracy of the time estimate(s), or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attr.: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

COMPL	EX IDENTIFICATION DATA							TO	PARTI	
PART I	I - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX INDENTIFICATION DATA	AL HEALTHCARE COMPLEX INDENTIFICATION DATA lest Address: P.O. Box						10	1	
Hospital	and Hospital Health Care Complex Address:									
	Street:									1
	City:	State:	ZIP Code:	County:						2
Hospital	and Hospital-Based Component Identification:	Commonant	CCN	CDCA	Duoridon	Data	D _o	yment System (P, T, O,	ou M)	
	Component	*					V	XVIII	XIX	-
	0	1 l					6	7	8	-
3	Hospital		_	_			-	,		3
	Subprovider- IPF									4
5	Subprovider- IRF									5
6	()									6
7	Swing Beds-SNF									7
- 8	Swing Beds-NF									8
9	Hospital-Based SNF									9
	Hospital-Based NF									10
	Hospital-Based OLTC Hospital-Based HHA									11
13			_							13
	Hospital-Based Hospice									14
15	1 1									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From:	To:							20
21	Type of control (see instructions)									21
	PRO I Committee of the							1 .	1 .	
	t PPS Information	1 - 4:		I	C !!\\T!! \(C		I I	2	3	22
22				in commit i, enter i	ioi yes oi in ioi iio.					- 22
22.01				for the nortion of the cos	t reporting period occurring	nrior to October 1				22.01
						5 F				
22.02				es or "N" for no,						22.02
	for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "	"N" for no, for the porti	ion of the cost reporting per	riod on or after October	1.					
22.03						s or "N" for				22.03
					ter October 1. (see instruct	tions)				
22.04										22.04
					ter October 1. (see instruct	tions)				
23										23
23					no					23
	is the method of identifying the days in this cost reporting period direction from the method used in	if the prior cost reporting	g period: In column 2, ente			Out-of State	Out-of State	Medicaid	Other	+
						Medicaid	Medicaid eligible	HMO	Medicaid	
						paid days	unpaid days	days	days	
				1		3	4	5	6	
24										24
		d HMO paid and eligible	e but unpaid days in							
	column 5, and other Medicaid days in column 6.			ļ	ļ					
25				Ļ						25
	Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid	HMO paid and eligible	but unpaid days in column	. 5.				2	2	4
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporti	ing posied Enter "1" fo	n rushon on "2" for murol				1	2	3	26
	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting per Enter your standard geographic classification (not wage) status at the end of the cost reporting per			ral.			+			27
21	If applicable, enter the effective date of the geographic reclassification in column 2.	Zinci iii coluiilli 1,					1			- "
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the	e cost reporting period.					1			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of period		enter subsequent dates.				Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effective and the status of the sta	ect in the cost reporting	period.							37
										37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, su	abscript this line for the	number of periods in exces	s of one and enter subsec	quent dates.		Beginning:	Ending:		38
			TD 412 1014 (2)42) ***	200 P	(7 m c (2 m c		Y/N	Y/N		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in				"Y" for yes or "N" for no	•				39
40	Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for n				for no in column ?		+	 		40
70	for disabarase on or often October 1. (con instructions)	io in commin 1, for disch	arges prior to October 1. 1	ance I for yes of IN	ioi no in comini 2,					70

40-504 Rev. 21

HOSPITAL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPLEX IDENTIFICATION DATA				FROM	PART I (CONT.)	
			V	TO	VIV	1
Prospective Payment System (PPS)-Capital			V 1	XVIII 2	XIX 3	-
riospective rayment system (rr-sy-capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions) 45 [Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)			1	2	3	45
46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III, and Wkst. L-1,	Pt. I. through Pt. III.					46
47 Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no.	, ,					47
48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						48
				•	•	•
Teaching Hospitals			1	2	3	
56 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for		eporting periods				56
beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved to the column 2 is "Y", or if the column 2 is "Y", or if this hospital was involved to the column 2 is "Y", or if the column 2 is "Y", or if the column 3 is "Y", or i	-					
approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior and you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.						
57 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME						57
or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 41.	3.77(e)(1)(iv) and (v), rega					
of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4						
58 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						58
59 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						59
			NAHE 413.85	NAHE MA		4
60 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "	N" for no in column 1 TF	oolumn Lie "V" ana r	1	2	3	60
are you claiming nursing and affect nearth education (NATE) costs for any programs that meet the criteria under 42 CFR 415.83? (see instructions) Effect 1 for yes or impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N° 10r no in column 1. 11	column 1 is 1, are you				60
				337 1 1	Pass-Through	
				Worksheet A	Qualification	
				Line #	Criterion Code	
60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			1	2	3	60.01
00.01 It line ou is yes, complete commiss 2 and 3 for each program. (see instructions)					I	00.01
	Y/N			IME	Direct GME	1
	1	2	3	4	5	
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						61
				IME	Direct GME	
			1	2	3	
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (e.g., and primary care FTEs added under section 5503 of ACA).	see instructions)					61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions) 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line)	(1.02) (:					61.04 61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that renonprimary care or non-general surgery. (see instructions)	(See Histractions)					61.06
2.100 Enter the amount of 7674 32505 award that is being used for eap tener major if 1725 that are majorinary ear or non-general surgery. (see instructions)				Unweighted	Unweighted	01.00
				IME	Direct GME	
		Program Name	Program Code	FTE Count	FTE Count	
		1	2	3	4	Ī
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions)						61.10
Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE	unweighted count.					
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE	unweighted count.					61.20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					1	
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions)						62
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see	nstructions)					62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings			1	2	3	
184 cum prospinate una Chami respueda in comprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64 through 67. (see inst	ructions)		1	Z	3	63
os francisco de manago de	ructions)		ļ			- 05
			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	
			Nonprovider Site	in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 201	0.		1	2	3	
64 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotati	ons occurring in all non-pro	ovider settings.				64
Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.						
Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	_					
			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	
	Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	4
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary	1	2	3	4	5	65
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary						65
care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that						
trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

FORMER AND HOSPITAL SET ALT CASE SECURITY AND HOSPITAL SET ALT CA	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings—Effective for cost reporting periods beginning on or after July 1, 2010 66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all morprovider settings. Enter in column 2, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted non-primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of sewedylated primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of sewedylated primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of sewedylated primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (solumn 3 divided by (solumn 3) evolumn 4), (see instructions) Divest GME in Accordance with the FY 2023 IPPS Final Rule, SFT FR 4906-549072 (August 10, 2022) (8) For a cost reporting period beginning prior to Oxfober 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule FTE 4000 and the FT	n Name	Program Code 2	Unweighted FTEs Nonprovider Site 1 Unweighted FTEs Nonprovider Site	FROMTO Unweighted FTEs in Hospital 2 Unweighted FTEs in Hospital	PART I (CONT.) Ratio (col. 1 ÷ (col. 1 + col. 2)) 3 Ratio (col. 3/	66
Section 550s of the ACV Cream Ver FTE Recident in Neppowellar Sering—Effects for our reporting peoled legislation or a thir lot 1, 2019 4 Clinical content, Let market or developed languing or a people languing or a thir lot 1, 2019 4 TTE data insued to your keepalt. Flour's repulse National Plant and the people of the pe	Enter in column 1, the number of unweighted pre-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted nor FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2). (see instructions) 67	n Name	Program Code 2	Nonprovider Site 1 Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital 2 Unweighted FTEs in Hospital	(col. 1 + col. 2)) 3 Ratio (col. 3/	66
Section Section Contract from FTD Revision in Newcorder Sentage Lifetiver for consequent periods beginning on order July 1, 2010. Sentage Section Section Contract from FTD Revision in Newcorder Sentage Lifetiver for contract periods of the sentage of the senta	66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all neoprovider settings. Enter in column 2, the number of unweighted non-primary care FTE residents attributable to rotations occurring in all neoprovider settings. 67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that transition in your hospital. Enter in of (column 3 divided by (column 4 + column 4), (see instructions) Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) (68] For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule Impatient Psychiatric Facility (IPP), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 17 If If line 70 is yes: 18 Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting field on or before November 15, 2004? Enter "Y" for yes or "N" for no. 18 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412-242 (d)(Min)(D)? Enter "Y" for yes or "N" for no. 18 If this a facility an impatient Rehabilitation Facility (IRP), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 29 Column 1: Did the facility have an approved GME teaching program in accordance with 42 CFR 412-242 (d)(Min)(D)? Enter "Y" for yes or "N" for no. 20 If this fa	n Name	Program Code 2	Nonprovider Site 1 Unweighted FTEs Nonprovider Site	in Hospital 2 Unweighted FTEs in Hospital	(col. 1 + col. 2)) 3 Ratio (col. 3/	66
Section 150 of the A.C.A. Current Van FT. Routhers in Reciproscope Strategy—Pillow for an experience ground beginning on an all-oldy 1, 100 of	66 Elter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted non-primary care FTE residents and the program of the column 2. (see instructions) 67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTE residents attributed in your beginning prior to October 1, 2022, dd you obtain permission from your MAC to apply the new DOME formula in accordance with the FY 2023 IPPS Final Rule (Impatent Psychiatric Facility (IPP), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71 If If time 70 is yes: 82 Column 1: Dot the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 83 If column 2 is It indused which program year began during this cost reporting period. (see instructions) 10 Inpute Rehabilitation Facility (IPF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 84 If	n Name	Program Code 2	Unweighted FTEs Nonprovider Site	2 Unweighted FTEs in Hospital	Ratio (col. 3/	66
66 Earl a schear L, the number of averagetion temperature of averagetion temperature of averagetion temperature of the service of the schedule of the service of the servic	Enter in column 1, the number of unweighted non-primary care resident PTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted non-primary care PTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) 67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 4, the number of unweighted primary care PTEs residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care PTEs residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care PTEs residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident PtEs that trained in your hospital. Enter in columns 2, the number of unweighted primary care PTEs residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care PTEs residents attributed in your hospital. Enter in olumns 2, the number of unweighted primary care PTEs residents attributed by column 3 + column 3 + column 3 + column 4, the number of unweighted primary care PTEs residents attributed attributed primary care PTEs residents attributed in your primary care PTEs residents attributed in your primary care PTEs residents attributed primary care PTEs residents attributed in your primary care PTEs residents attributed primary care PTEs residents and provided PTEs attributed by column 3 + column 3 + column 3 + vite PTES PTES PTES PTES PTES PTES PTES PTES	n Name	Program Code 2	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/	66
Fig. flat strained a your keppeni. Line's in column 3, the raise of scolumn 1 is sequent to the column 3, the greater scolumn 1, the greater scale is column 3, the raise of strained personal residence is column 3, the raise of s	FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program 1 67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Direct GME in Accordance with the FY 2023 IPPS Final Rule. 87 FR 49065-49072 (August 10, 2022) 68 For a corresporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule Impatient Psychiatric Facility PPS 70 Is this facility an inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 1 If If Imp 7 is yes: Column 1: Did this facility than ean approved GME teaching program in the most recent cost reporting period. (see instructions) Impatient Relabilitation Facility IPPS 75 Is this facility an inpatient Relabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 1 If If Imp 75 is yes: Column 2: Did this facility train residents in an exceedance with 42 CFR 412.240 (II) (III)	n Name	Program Code 2	Nonprovider Site	in Hospital		
Popular Name Popular Code Noopproaches Noop	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule Type State Psychiatric Pacility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no. 70 Is this facility an Inpatiente Psychiatric Pacility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no. 71 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in accordance with 42 CFR 412-424 (A) (A)(A)(D)? Enter 'Y' for yes or 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 3: If column 2 is Y, indicate which program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital Pys 80 Is this a long term care hospital (LTCH)? Enter 'Y' for yes or 'N' for no. 10 If the 7s is yes Column 1: Is		2	Nonprovider Site	in Hospital		
Fig. Exter is column , the program same associated with each of your pristary care programs in which you trained residents. Exter is column 2, the program code. Exter is column 2, the program code code code code code code code code	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care residents Entributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FITS that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4). (see instructions) Direct GME in Accordance with the FY 2023 IPPS Final Rule, \$5 FR 40965-49072 (August 10, 2022). 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule Type of the Pychiatric Facility PPS 70 Is this facility an Inputenter Pychiatric Facility (IPF), or does it contain an IPF subprovided? Enter 'Y' for yes or 'N' for no. 71 If If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. 72 Column 3: If column 2 is Y, indicate which program year begun during this cost reporting period. (see instructions) 13 Inputent Rehabilitation Facility PPS 75 Is this facility an Engatise Rehabilitation Facility (IRF), or does it contain an IRF subprovided? Enter 'Y' for yes or 'N' for no. 76 If Inc 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. 77 If Inc 75 is yes: Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412-424 (A) (N) (N) (D)? Enter 'Y' for yes or 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cont reporting period. (see instructions) 18 Is this a large teach of the facility train residents in a new teaching program in accordance with 42 CFR 413-40(N) (N) (2			(col. 3 + col. 4))	
67 Eart a column. Le program mote associated with such of your printing year yeapure in which you transfer indexing. Enter it column 2, the program coles. Enter column 3, the market of unavoidage plantary care residual TEA that trained is your lengths. Enter it column 3 in column 3	column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 - column 4)). (see instructions) Direct GME in Accordance with the FY_2023 IPPS Final Rule, 87 FR 49065-9072 (August 10, 2022). 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY_2023 IPPS Final Rule. For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY_2023 IPPS Final Rule. For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY_2023 IPPS Final Rule. For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY_2023 IPPS Final Rule. For a cost reporting period to the formula in accordance with the FY_2023 IPPS Final Rule. For a cost reporting the formula in accordance with 42 CFR 412.424 (40) (iii)(D)? Enter "Y" for yes or "N" for no. For a column 1 is for dumn 2 is Y, indicate which program you began during this cost reporting period. (see instructions) Impattern Rehabilitation Facility PPS For yes or "N" for no. For a column 2 is PA indicated which program you began during this cost reporting period. (see instructions) Impattern Rehabilitation Facility have an approved GME teaching program in accordance with 42 CFR 412.424 (40) (10) (iii)(D)? Enter "Y" for yes or "N" for no. Column 3 if rodumn 2 vs. indicate which program you be began during this cost reporting period. (see instructions) For a column 1 is 1 with a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. For a column	ule, 87 FR 490		3	4	-	4
and the number of emerglated primary care PETE Products antiboulbe to containe occurring in all one provider actings. Exercise in columns, de the number of emerglated primary care PETE Products in the and on your broadpart part in and one your beautiful providers. The antibody of the performance o	olumn 3, the number of unweighted primary care FETE existents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 recolumn 4)). (see instructions) Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022). (8) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule. [Inputern Psychiatric Facility PPS] (7) Is this facility an Inputient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. [Inputern Rehabilitation Facility PPS] (7) Is this facility that in residents in a new teaching program in the most recent cost report filed on or before November 15, 2004? Enter "V" for yes or "N" for no. (see 42 CFR 412 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412-424 (40)(1)(iii)(D)? Enter "Y" for yes or "N" for no. [Inputern Rehabilitation Facility PPS] (7) Is this facility an Inputient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. (8) If this 2 is yes. (8) Is this facility an Inputient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. (8) Column 3: If olimn 2 is Y, indicate which program in a accordance with 42 CFR 412-424 (6)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (8) Is this facility train residents in a new teaching program in accordance with 42 CFR 412-424 (6)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Enter Teach Hospital PPS (8) Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Enter How the facility train residents in a new teaching program in accordance with 42 CFR 412-424 (6)(1)(iii)(D)? Enter "Y" for yes or "N" for no. ETER	ule, 87 FR 490	065-49072 (August 10.				67
monesplent persons corrections FTPs that framed in your hospital. Ever me column 5, the cits of Column 5 in victorium 5 in vic	Unrest GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule 1 Inpatient Psychiatric Facility PPS 70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71 If fine 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75 Is this facility in Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period ending on or before November 15, 2004? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program in accordance with 42 CFR 412-424 (0)(1)(iii)(D)? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program in accordance with 42 CFR 412-424 (0)(1)(iii)(D)? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period ending on or before November 15, 2004? Enter "V" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period (see instructions) 80 Is this a long term care hospital (LTCH)? Enter "V" for yes or "N" for no. EIEFA Providers 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "V" for yes or "N" for no. 82 Is this is new hospital under 42 CFR 413-40(f)(1)(f) Enter "Y" for yes or "N" for no. 83 Is this in a ETCH co-located within another hospital classified	ule, 87 FR 490	065-49072 (August 10	<u> </u>			07
Direct CME in Accordance with the FY 2021 PFS Final Red., 87 FR. 69065-69072 (August 10, 2002): St. Fax - next reporting period Regioner grows to Deathor 1, 2022, oil you down in personant from your MAC to apply the new Direction for the period of t	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule Inpatient Psychiatric Facility PPS 70 Is this facility pPS 70 Is this facility and inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71 If Inc 2 Did this facility area an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 71 Column 1: Did the facility have an approved GME teaching program in accordance with 42 CFR 412-424 (01) (inii)(D)? Enter "Y" for yes or "N" for no. 72 Is this facility and inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 73 Is the facility and inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 74 If Inc 75 is yes: 75 Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 75 Column 2: Did this facility train residents in a new teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 76 Column 3: If column 2 is Y, indicate which program year began during this cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 77 Column 3: If column 2 is Y, indicate which program year began during this cost reporting period (see instructions) 88 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes or "N" for no. 89 Is this a song term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 80 Is this a long term care hospital an extended neoplastic disease care hospi	ule, 87 FR 490	065-49072 (August 10				
46 Fee a cost reporting period by Quantity (Page 2014) 1	Injustment Psychiatric Facility PPS	ule, 87 FR 490	065-49072 (August 10		,		
Implicit Psychiatric Facility PFS 70 1st the facility an impatent exploitation Facility (IPF), or does it contains an IPF subprovider? Enter "" for you or "N" for no. Column 1: Did the facility is an impatent exploitation Facility (IPF), or does it contains an IPF subprovider? Enter "" for you or "N" for no. Column 2: Did this facility is an impatent exploitation Facility (IPF), or does it contains an IPF subprovider? Enter "" for you or "N" for no. Column 2: Did this facility is an impatent exploitation Facility (IPF), or does it contains an IPF subprovider? Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Column 3: Did the facility have an approved Coll. Enter "" for you or "N" for no. Lang Term. Care Haspital PFS. So I faith as new Inception and a substitute of the college program in the most recent cost reporting period Enter "" for you or "N" for no. Lang Term. Care Haspital PFS. So I faith as new Inception and a substitute of the college period Enter "" for you or "N" for no. Lang Term. Care Haspital PFS. So I faith as new Inception and a substitute of the college period Enter "" for you or "N" for no. Lang Term. Care Haspital PFS. So I faith as new Inception and a substitute of the co	Inpatient Psychiatric Facility PPS 70. Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71. If frine 70 is yess. Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 3: If column 2 is I, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75. Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 76. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period during on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in the most recent cost reporting period anding on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 3: If column 2: Is y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80. Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 81. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. 85. Is this a new hospital under 42 CFR 413.40(f)(J)(i) TEFRA? Enter "Y" for yes or "N" for no. 86. Did this facility seashish as new Other subprovider (excluded undin) under 22 CFR 413.40(f)(J)(i) Enter "Y" for yes or "N" for no. 87. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(x)? Enter "Y" for yes or "N" for no. 88. Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. 89. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the perman	ule, 87 FR 490	065-49072 (August 10.			1	
1 2 3	70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.42 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2: Pst, indicate which program year began during this cost reporting period. (see instructions) Typestern Rehabilitation Facility PPS 75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 76 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 3: If column 2: by indicate which program year began during this cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 3: If column 2: by indicate which program year began during this cost reporting period. (see instructions) 80 Is this a long term care hospital PPS 80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. 82 Is this a LTCH co-located within another hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 83 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 84 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruColumn 2: Enter the number of approved permanent adjustment to t			, 2022)?		ļ	68
10 Seith Entities an Impatiture Facility (PEP) or does it counting melt 9 subprovides? Ease "" for ros. 11 Film 70 to 19 seith for facility in the real register time tensity register and report field on or before November 15, 2007 Ease "" for ryes or "N" for no. (see 42 CFR 412.424(6)(1)(0)(C)) Column 2. Did the facility in the real register time the resistance with 4 CFR 412.424(6)(1)(0)(C)) (action 3. He column 1 is V ₁ inflates which programs in the most record are report field on or before November 15, 2007 Ease "" for ros or "N" for no. Together Redulation Facility OFR 10 and 1 is V ₂ inflates which programs was beginn during the cost reporting period. (see instructions) Together Redulation Facility (OFR) or does it counting a mean of the special districts in a new tractions in RP subprovider? Ease "" for ros or "N" for no. Column 2. Did the facility have an approved CME teaching program in the most record one reporting period CPR 412.424(6)(1)(0)(0)(7) from "" fit yes or "N" for no. Column 2. Did the facility than ease approved CME teaching program in the most record one reporting period. Color instructions of the facility than ease approved CME teaching program in the most record one reporting period. Color instructions of the facility than ease approved CME teaching program in the contraction of the facility than ease approved CME teaching program in accordance with 4 CFR 412.424(6)(1)(0)(0)(7) from "" fit yes or "N" for no. Leag Term. Care Redulation on the resolution of the facility than ease approved to the period of the facility than ease approved CME teached with appropriate of the facility than ease approved to the facility of the facility than ease approved to the facility of the facil	15 this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			T 1	T 2	T 2	т —
77 Him 79 to yes Column 1: Did the facility have an approved GME teaching program in demost recent cost report filled on or before November 15, 2047; Enter "\" for yes or "\" for no. (see 42 CFR 412.424(d)(Xiii)C)) Column 2: Did this facility have an approved GME teaching program in accordance with 42 CFR 412.424 (d)(Xiii)C) Than "\" for yes or "\" for no. Column 2: Did this facility to mir reaches in a new teaching grogam in accordance with 42 CFR 412.424 (d)(Xiii)C) Than "\" for yes or "\" for no. Lappinor Mechanilization Facility PS" 1	Title V and XIX Services [Title 70 is yes: Column 1: If line 70 is yes: Column 2: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS [Inpatient Rehabilitation Facility and Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. [If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 1 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. EFERA Providers Sinch Si			1		3	70
Column 2: Det this facility train residents in an extraction program in accordance with 42 CFR 412-244 (d1) (Xip(X)D)? Enter "Y" for yes or "N" for no. Inquitors Rehabilitation Facility (PTS 11 2 3 15 Let this facility an impacted Rehabilitation Facility (PTS), or does it contain an IRF subprovide? Enter "Y" for yes or "N" for no. Column 2: Det this facility varie residents in a new teaching program in the most recent cost reporting period. General control of the facility have need which program you because the program you subproved of the facility train residents in a new teaching program in the most recent cost reporting period dening on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Det this facility train residents in a new teaching program in a necordance with 42 CFR 412-244 (d1) (Xip(X)D)? Enter "Y" for yes or "N" for no. Long Term Care Houghtal (PTS) 1	Column 2: Did this facility rain residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "\" for yes or "\" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Impatient Rehabilitation Facility PPS 75			+			71
Column 3.1 Fockman 2.6 w, inclinate which program year began during this cost reporting period. (see instructions) 1	Inpatient Rehabilitation Facility PPS 75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 76 If Inc 75 is yes: 77 Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. 76 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412-424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. 76 Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. 81 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital a pervended permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the number of approved permanent adjustment to the TEFRA target amount per discharge. Column 2: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services	412.424(d)(1)(iii)(C))				
Impution Rehabilitation Facility PPS 75 Is this facility an Inpution Rehabilitation Facility (IRF), or does it contain an IRF subprovide? Enter "Y" for yes or "N" for no. 75 Is this facility an Inpution Rehabilitation Facility (IRF), or does it contain an IRF subprovide? Enter "Y" for yes or "N" for no. 75 Is this facility an Inpution Rehabilitation Facility (IRF), or does it contain an IRF subprovide? Enter "Y" for yes or "N" for no. 75 Column 1: Und the facility have an approved GME teaching program in the most recordance with 42 CFR 412-434 (Q(1)/xiii/QD)? Enter "Y" for yes or "N" for no. 75 Column 2: It column 3:	Inpatient Rehabilitation Facility PPS 75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 76 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Odd this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(i)(ii)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruColumn 2: Enter the number of approved permanent adjustment to the TEFRA target amount per discharge. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						
25 Stable Section on Explaints (Rabbilitation Facility (RF), or doos it centain an IRF subprovider? Enter "Y" for yos or "N" for no.	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. If line 7s is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Solution 1: Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Is this is a new hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 1: Is this hospital approved permanent adjustments. Solution 2: Enter the number of approved permanent adjustments of the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			<u> </u>	<u> </u>	<u> </u>	1
25 Stable Section on Explaints (Rabbilitation Facility (RF), or doos it centain an IRF subprovider? Enter "Y" for yos or "N" for no.	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. If line 7s is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Solution 1: Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Is this is a new hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 1: Is this hospital approved permanent adjustments. Solution 2: Enter the number of approved permanent adjustments of the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			1	1 2	7	
Time 7 is yes; Column 1: Did this facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in new teaching program in accordance with 42 CFR 412-424 (4)(1)(iii)(iii)). Enter "Y" for yes or "N" for no. Column 2: Time the complete which program in accordance with 42 CFR 412-424 (4)(iii)(iii)(iii). Enter "Y" for yes or "N" for no. Column 2: Time the number to aboptial (LTCHY): Enter "Y" for yes or "N" for no. Column 2: Time the number to aboptial (LTCHY): Enter "Y" for yes or "N" for no. Column 2: Time the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89, (see instructions) Column 2: Time the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89, (see instructions) Vesta A Line No. Efficieve Data Column 2: Time the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89, (see instructions) Vesta A Line No. Efficieve Data Column 2: Time the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89, (see instructions) Vesta A Line No. Efficieve Data Column 2: Time the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89, (see instructions) Vesta A Line No. Efficieve Data Paproved Permanent Applications and the permanent adjustment to the TEFRA target amount per discharge. Vesta A Line No. Vesta A Line No	1 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80			1		3	75
Column 2: Did the ficility have an approved OME teaching program in the most record coll ending on or before November 15, 2049° Enter "" for yes or "N" for no. Column 3: If column 2: But this collected within another hospital fire Part of the collected within another hospital fire Part of all of the cost reporting period? Enter "" for yes and "N" for no. 1	Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(v)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) is the column 2: Enter the number of approved permanent adjustments. 89 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment approval was based. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services			+			76
Column 2 Fr column 2 Sr / sindicate which program year began during this cost reporting period. (see instructions) 1 2	Column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Long Term Care Hospital PPS 80						
Long Term Care Hospital PPS 80 Is this a long term care hospital (LTCH)* Enter "\" for yes or "\" for no. 1 2 80 Is this a long term care hospital (LTCH)* Enter "\" for yes or "\" for no. 81 Is this a long term care hospital (LTCH)* Enter "\" for yes and "\" for no. 82 Is this a new hospital moder 42 CFR 413-40(1)(1) TEFRA? Enter "\" for yes and "\" for no. 83 Is this a new hospital under 42 CFR 413-40(1)(1) TEFRA? Enter "\" for yes or "\" for no. 85 Did this facility stabilish in anow hospital under 42 CFR 413-40(1)(1) TEFRA? Enter "\" for yes or "\" for no. 87 Is this no-pital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B(vi))* Enter "\" for yes or "\" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "\" for yes or "\" for no. If yes, complete col. 2 and line 89. (see instructions) 89 Column 2: Enter the number of approved permanent adjustment to the TEFRA target amount per discharge? Enter "\" for yes or "\" for no. If yes, complete col. 2 and line 89. (see instructions) 80 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. 80 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment approval was based. 80 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment approval permanent adjustment to the TEFRA target amount per discharge. 80 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for no in the applicable column. 81 Till V and XIX Services 92 Obes this facility have title V and/or XIX inputient hospital services? Enter "\" for yes or "\" for no in the applicable column. 93 Obes this facility have title V and/or XIX inputient hospital services? Enter "\" for yes or "\" for no in the applicable column. 94 Does this f	Long Term Care Hospital PPS 80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. 81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instru-Column 2: Enter the number of approved permanent adjustments.						
Statis a long torm care hospital (LTCI): Enter "I" for yes or "N" for no.	Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Bo Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Solumn 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction 1: If line 88, column 1: If line 88, column 1: Is fline 88, column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						
Statis a long torm care hospital (LTCI): Enter "I" for yes or "N" for no.	Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Bo Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Solumn 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction 1: If line 88, column 1: If line 88, column 1: Is fline 88, column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						_
State Stat	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instru-Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services				1	2	80
TEFRA Providers S Is this a new hospital under 42 CFR 413-40(f)(f)() TEFRA? Enter "Y" for yes or "N" for no.	TEFRA Providers 85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. 87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction of the column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. 89 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. 89 Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. 89 Title V and XIX Services				+		81
St Is this a new hospital under 42 CFR 413-40(f)(1) GFERA? Enter "Y" for yes or "N" for no.	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Both Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. Both It is facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. Both It is hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Both It is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction of the permanent adjustment) is the permanent adjustment approval was based. Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Column 4: Vand XIX Services Vand VIX Services				_1		
Set Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413 40(ft)(fi)? Enter "Y" for yes or "N" for no.	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Stable Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction of the number of approved permanent adjustments. Stable Column 2: Enter the number of approved permanent adjustments.				1	2	Ţ
Strike hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Permanent Adjustment (V/N) Adjustment (V/N) Adjustment (V/N) Adjustment (V/N) Adjustment (V/N) 1 2	88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						85
Approved for Permanent Adjustment (YN) Approved Permanent Adjustment (YN) Per Discharge	88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instruction of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						86
Register	Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services				A 4 6	Noushau af	87
Registrated (V/N) Adjustments 1 2 88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment of the TEFRA target amount per discharge. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment of the TEFRA target amount per discharge. 1 2 3 80 Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? For yes or "N" for no in the applicable column. 92 Are title XIX N P parties occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX 2 Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "V", enter the reduction percentage in the applicable column.	Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						
88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) West. A Line No. Effective Date Per Discharge 1 2 3 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. V XIX Title V and XIX Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1 2 2 3 3 V XIX 1 2 3 Title V and XIX Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title VXIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "V", enter the reduction percentage in the applicable column.	Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						
Column 2: Enter the number of approved permanent adjustments. Approved Permanent Adjustment Andjustment Andjus	Column 2: Enter the number of approved permanent adjustments. 89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services				1		1
Approved Permanent Adjustment Amount Per Discharge Reflective Date Refle	89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services	tructions)					88
Adjustment Amount Per Discharge Refective Date Per Discharge	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						ļ
West. A Line No. Effective Date Per Discharge	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services						
89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment to the TEFRA target amount per discharge. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. V XIX Title V and XIX Services 90 Does this facility have title V and/or XIX impatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column.	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services			Wket A Line No.	Effective Date		
Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. V XIX Title V and XIX Services 9 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 9 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 9 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 9 Does this Vor title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 9 It line 94 is "V", enter the reduction percentage in the applicable column.	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services			1	2		1
Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. V XIX Title V and XIX Services 9 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "V", enter the reduction percentage in the applicable column.	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services			1			89
Title V and XIX Services V XIX 1 2 2 9 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 9 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "V" for yes or "N" for no in the applicable column. 9 Are title XIX Fp patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 9 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 9 Does this V or title XIX reduce capital cost? Enter "V" for yes or "N" for no in the applicable column. 9 Does this V or title XIX reduce capital cost? Enter "V" for yes or "N" for no in the applicable column. 9 Title 94 is "V", enter the reduction percentage in the applicable column. 9 Title 94 is "V", enter the reduction percentage in the applicable column.	Title V and XIX Services						
Title V and XIX Services 9 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "V", enter the reduction percentage in the applicable column.							<u> </u>
90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. 91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column.					V		4
91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column.					1		90
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "V", enter the reduction percentage in the applicable column.					+	 	91
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column.							92
95 If line 94 is "Y", enter the reduction percentage in the applicable column.	93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.						93
							94
96 Does title V or title XIX requice operating cost? Enter "Y" for yes or "N" for no in the applicable column.						_	95
					 	 	96 97
97 If line 96 is "Y", enter the reduction percentage in the applicable column. 98 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			2.0 7777		+	+	98
		/ and in colum	nn 7 for title XTX		 	<u> </u>	98.01
		/, and in colun	nn 2 for title XIX.		1	<u> </u>	98.02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, an				+	1	98.03
		column 2 for and in column	title XIX.				
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		column 2 for and in column e XIX.	title XIX.				98.04 98.05

	FAL AND HOSPITAL HEALTH CARE LEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM	WORKSHEET S-2 PART I (CONT.)	
			ТО		
Rural P	roviders		1	2	
105	Does this hospital qualify as a CAH?				105
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106
107					107
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see in	structions)			
108					108
	Physical	Occupational	Speech	Respiratory	_
	rnyskat 1	2	3	4	+
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109
				1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no.			1	110
110	Did this incipital participate in the Kurat Community Prospiral Demonstration in the Currier to Streporting period: Line 1 for yes of N for no. If yes, complete Workshee E. Part A, lines 200 through 218, and Worksheet E2, lines 200 through 215, as applicable.				110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1.		1	2	111
111	If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for	tele-health services.			111
		1	2	3	
112	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter	in			112
	column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				
Miscella	neous Cost Reporting Information	1	2	3	
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2.				115
	If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals				
	providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				
				1	1
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			1	116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.				118
		Premiums	Paid losses	Self insurance	
		1	2	3	
118.01	List amounts of malpractice premiums and paid losses:				118.01
			1 1	2	7
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			_	118.02
	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.				119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a				120
10:	rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				10:
	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1 is "Y", enter in column 2 the Worksheet A line number where these tax	es are included	+		121 122
	Did the facility and/or its description of the facility and or its description of the facility and or its description of the facility and or its description of the facility a		+		123
123	Did the facting amounts supprovided (it applicable) purchase professional services, e.g., regal, accomming, tax preparation, towakeeping, payron, aircon management/consuming services, from an unrelated organization enter "Y" for pose or "N" for no.	. m commin 1,			123
	If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CI	SA? In column 2,			
	enter "Y" for ves or "N" for no.				1

Rev. 21 40-507

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-2 PART I (CONT.)	
Certified Transplant Center Information							2	
125 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no. If yes	e anter certification date(s) (mm/dd/xxx	nı) balonı				1	2	125
126 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and terr								126
127 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and term								127
128 If this is a Medicare certified liver transplant program, enter the certification date in column 1 and termi								128
129 If this is a Medicare certified lung transplant program, enter the certification date in column 1 and termin								129
130 If this is a Medicare certified pancreas transplant program, enter the certification date in column 1 and to		n 2.						130
131 If this is a Medicare certified intestinal transplant program, enter the certification date in column 1 and t	ermination date, if applicable, in column	n 2.						131
132 If this is a Medicare certified islet transplant program, enter the certification date in column 1 and termin	nation date, if applicable, in column 2.							132
133 Removed and reserved								133
134 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 are	nd termination date, if applicable, in col	umn 2.						134
All Providers						T 1	2	
140 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter	r "V" for yes or "N" for no in column 1					1	2	140
If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instruct		•						140
	,							
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home of	fice and enter the home office contractor	r name and contractor num	ber.					-
141 Name:		Contractor's Name:			Contractor's Number:			141
142 Street:	P. O. Box:							142
143 City:	State:	Zip Code:						143
							2	_
144 Are provider based physicians' costs included in Worksheet A?						1		144
145 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Ent	er "V" for ves or "N" for no in column l	1						144
If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? E								143
146 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or))					146
If yes, enter the approval date (mm/dd/yyyy) in column 2.	TV for no in column 1. (See CMS 14	10. 15 2, empter 10, § 102.	,,					1.0
147 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147
148 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								148
149 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								149
				-				
					e XVIII	_		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or cl	harges?			Part A	Part B	Title V	Title XIX	
Enter "Y" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13)				1	2	3	4	
155 Hospital								155
156 Subprovider - IPF 157 Subprovider - IRF								156 157
157 Subprovider - ICF 158 Subprovider - Other								158
159 SNF								159
160 HHA								160
161 CMHC								161
- · · ·								
Multicampus								
165 Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter								165
166 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, Z		E/Campus in column 5. (s			1	1		166
	Name		County	State	Zip Code	CBSA	FTE/Campus	_
	0		1	2	3	4	5	_
				<u>I</u>	1	<u> </u>		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						1	2	_
167 Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.								167
168 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonab	le cost incurred for the HIT assets. (see	e instructions)						168
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception		for yes or "N" for no. (see	instructions)					168.01
169 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the trans								169
170 Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively								170
171 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare co	st plans reported on Wkst. S-3, Pt. I, lin	ne 2, col. 6? Enter "Y" for	yes and "N" for no in column	11.				171

40-508 Rev. 21

12-22	FORM CMS-255	52-10				4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	TOTAL EME 200	PROVIDER CCN:	PERIOD FROM TO		WORKSHI PART II	,	
PART II - HOSPITAL AND HOSPITAL HEALTHCARE	COMPLEX REIMBURSEMENT QUE	ESTIONNAIRE					
General Instruction: Enter Y for all YES responses. Enter N for							
Enter all dates in the mm/dd/yyyy for	rmat.						
COMPLETED BY ALL HOSPITALS							
				MAI	D /		
Provider Organization and Operation				Y/N 1	Date 2		
Has the provider changed ownership immediately price	or to the beginning of the cost reporting no	eriod?		1			1
If yes, enter the date of the change in column 2. (see i							
	,			Y/N	Date	V/I	
				1	2	3	
Has the provider terminated participation in the Medic							2
If yes, enter in column 2 the date of termination and ir							
3 Is the provider involved in business transactions, inclu (e.g., chain home offices, drug or medical supply com							3
staff, management personnel, or members of the board							
other similar relationships? (see instructions)	3 1/	,					
• • • • • • • • • • • • • • • • • • • •							
				Y/N	Type	Date	
Financial Data and Reports				1	2	3	
4 Column 1: Were the financial statements prepared by		alata aameran antan					4
Column 2: If yes, enter "A" for Audited, "C" for Comdate available in column 3. (see instructions) If no, so	-	nete copy of enter					
5 Are the cost report total expenses and total revenues d		tatements?					5
If yes, submit reconciliation.							
<u> </u>							
					Y/N	Y/N	
Approved Educational Activities					1	2	
6 Column 1: Are costs claimed for a nursing program?	Etha muaaman 2						6
Column 2: If yes, is the provider the legal operator of 7 Are costs claimed for allied health programs? If yes, s							7
8 Were nursing programs and/or allied health programs		reporting period?					8
If yes, see instructions.		1 01					
Are costs claimed for Interns and Residents in approve							9
10 Was an approved Intern and Resident GME program			instructions.				10
Are GME costs directly assigned to cost centers other	than I & R in an Approved Teaching Pro	gram on Worksheet A?					11
If yes, see instructions.							
Bad Debts						Y/N	
12 Is the provider seeking reimbursement for bad debts?	If yes, see instructions.						12
13 If line 12 is yes, did the provider's bad debt collection		eriod? If yes, submit copy	y.				13
14 If line 12 is yes, were patient deductibles and/or coins	surance amounts waived? If yes, see instru	ections.					14
Bed Complement							1.5
15 Did total beds available change from the prior cost rep	porting period? If yes, see instructions.						15
			p,	rt A	p _s	rt B	
			Y/N	Date	Y/N	Date	
PS&R Report Data			1	2	3	4	
16 Was the cost report prepared using the PS&R Report	only? If either column 1 or 3 is yes, enter	the					16
paid-through date of the PS&R Report used in column							
17 Was the cost report prepared using the PS&R Report :	for totals and the provider's records for all	ocation?		1			17

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

Cost Re	port Preparer Contact Information				
41	First name:	Last name:		Title:	41
42	Employer:				42
43	Phone number:		E-mail Address:		43

36

38

39

40

36 Are home office costs claimed on the cost report?

If yes, enter in column 2 the fiscal year end of the home office.

37 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.
 38 If line 36 is yes, was the fiscal year end of the home office different from that of the provider?

39 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.
 40 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.

40-510 Rev. 18

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

	- STATISTICAL DATA	1 1		T .		T*	/ O		- / T-:	F 11	T: F	14-		ъ.	1		
		777 1 1				Inpatie	nt Days / Ou	tpatient Visit	s / Trips	Full	Time Equiva	ients		Disc	harges	1	4
		Worksheet															
		A							Total	Total	Employees					Total	
	_	Line	No. of		CAH/REH		Title	Title	All	Interns &	On	Nonpaid		Title	Title	All	
	Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents	Payroll	Workers	Title V	XVIII	XIX	Patients	4
	T	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	<u> </u>
1	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing																1
	Bed, Observation Bed and Hospice days) (see instructions for																
	col. 2 for the portion of LDP room available beds)																
2																	2
	HMO IPF Subprovider																3
	HMO IRF Subprovider																4
	Hospital Adults & Peds. Swing Bed SNF																5
	Hospital Adults & Peds. Swing Bed NF																6
7	Total Adults and Peds. (exclude																7
	observation beds) (see instructions)																
	Intensive Care Unit																8
	Coronary Care Unit																9
	Burn Intensive Care Unit																10
	Surgical Intensive Care Unit																11
	Other Special Care																12
	Nursery																13
	Total (see instructions)																14
	CAH visits																15
	REH hours and visits																15.10
16	Subprovider - IPF																16
17	Subprovider - IRF																17
18	Subprovider - Other																18
19	Skilled Nursing Facility																19
	Nursing Facility																20
21	Other Long Term Care																21
22	Home Health Agency																22
23	ASC (Distinct Part)																23
	Hospice (Distinct Part)																24
	Hospice (non-distinct part)																24.10
	CMHC																25
26	RHC/FQHC (specify)																26
27	Total (sum of lines 14-26)																27
28	Observation Bed Days																28
29	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days - IRF																31
32	Labor & delivery (see instructions)																32
32.01	Total ancillary labor & delivery room																32.01
	outpatient days (see instructions)																
33	LTCH non-covered days																33
33.01	LTCH site neutral days and discharges																33.01
34	Temporary Expansion COVID-19 PHE Acute Care																34

4090 ((Cont.) FORM	CMS-2	552-10					04-23
HOSPIT	TAL WAGE INDEX INFORMATION				PROVIDER CCN:	PERIOD	WORKSHEET	Г S-3
						FROM	PART II	
						ТО		
Part II -	Wage Data							
	-			Reclassification	Adjusted	Paid Hours	Average	
		Wkst. A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(col. 2 ±	to Salaries	(col. 4 ÷	
		Number	Reported	Wkst. A-6)	col. 3)	in column 4	col. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)							1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician and Non Physician-Part B							5
6	Non-physician-Part B for hospital-based RHC and FQHC services							6
7	Interns & residents (in an approved program)							7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF							9
10	Excluded area salaries (see instructions)							10
	OTHER WAGES AND RELATED COSTS							
11	Contract labor: Direct Patient Care							11
12	Contract labor: Top level management and other management and							12
	administrative services							
13	Contract labor: Physician-Part A - Administrative							13
14	Home office and/or related organization salaries and wage-related costs	S						14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
16.01								16.01
16.02	Home office contract Physicians Part A - Teaching							16.02
	WAGE-RELATED COSTS							
17	Wage-related costs (core) (see instructions)							17
18	Wage-related costs (other) (see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related (core)							25.50
25.51	Related organization wage-related (core)							25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)							25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)							25.53

HOSPITAL V	WAGE INDEX INFORMATION	TOR	VI CIVIS-23	32 10	PROVIDER CCN:	PERIOD	WORKSHEET	
IIOSI IIAL V	THE REPLY BY CHARTION				I KO VIDER CCIV.	FROM	PART II & III	55
						TO TO	- TAKT II & III	
Part II - Wage	e Data				I	10	_	
ruren wuge	- Duit	Worksheet		Reclassification	Adjusted	Paid Hours	Average	
		A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(column 2 ±	to Salaries	(column 4 ÷	
		Number	Reported	Worksheet A-6)	column 3)	in column 4	column 5)	
		1	2	3	4	5	6	
OVI	ERHEAD COSTS - DIRECT SALARIES							
26 Emp	ployee Benefits Department	4						26
27 Adn	ninistrative & General	5						27
28 Adn	ninistrative & General under contract (see instructions)							28
29 Maii	intenance & Repairs	6						29
30 Ope	eration of Plant	7						30
31 Lau	ndry & Linen Service	8						31
32 Hou	sekeeping	9						32
33 Hou	sekeeping under contract (see instructions)							33
34 Diet	tary	10						34
35 Diet	tary under contract (see instructions)							35
	eteria	11						36
37 Maii	intenance of Personnel	12						37
38 Nurs	rsing Administration	13						38
39 Cen	tral Services and Supply	14						39
40 Phai		15						40
41 Med	dical Records & Medical Records Library	16						41
42 Soci	ial Service	17						42
43 Othe	er General Service	18						43
	pital Wage Index Summary			_	_	_		
	salaries (see instructions)							1
	luded area salaries (see instructions)							2
	total salaries (line 1 minus line 2)							3
	total other wages and related costs (see instructions)							4
	total wage-related costs (see instructions)							5
	al (sum of lines 3 through 5)							6
7 Tota	al overhead cost (see instructions)	· ·						7

Rev. 10 40-513

Part N - Wage Related Cost	HOSPIT	AL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-3 PART IV	
RETIREMENT COST	Part IV -	Wage Related Cost		10		
RETIREMENT COST 1 401k Employer Contributions 2 Tax Sheltered Annuity (TSA) Employer Contribution 3 Nonqualified Defined Benefit Plan Cost (see instructions) 4 Qualified Defined Benefit Plan Cost (see instructions) 5 Qualified Defined Benefit Plan Cost (see instructions) 6 PLAN ADMINISTRATIVE COSTS (Pind to External Organization): 5 401k/TSA Plan ADMINISTRATIVE COSTS (Pind to External Organization): 5 Health Insurance (Perspeam Administration Fees 7 HEALTH AND INSURANCE COST 8 Health Insurance (Purchased or Self Funded) 8 B. Health Insurance (Purchased or Self Funded) 8 B. Health Insurance (Purchased or Self Funded) 8 B. Health Insurance (Self Funded with a Third Party Administrator) 8 B. Health Insurance (Self Funded with a Third Party Administrator) 8 B. Health Insurance (Self Funded with a Third Party Administrator) 9 Person (Purchased) 9 Person (Purchased) 10 Dental, Hearing and Vision Plan 11 Life Insurance (Purchased) 11 Life Insurance (Purchased) 12 Dental, Hearing and Vision Plan 13 A Deiadulit Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Dental, Hearing and Vision Plan 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 McAlexar (Purchased) 18 Deficiency (Pompensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 19 States (Pompensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tution Reinbertanceont 24 Total Wage Related Cost (Sim of lines 1 through 23)						
RETIREMENT COST	Part A -	Core List				
RETIREMENT COST						
RETIREMENT COST					A	
RETIREMENT COST 1						
1 401k Employer Contributions					Reported	
1 401k Employer Contributions		RETIREMENT COST				1
3 Nonqualified Defined Benefit Plan Cost (see instructions) 4 Qualified Defined Benefit Plan Cost (see instructions) 5 Qualified Defined Benefit Plan Cost (see instructions) 5 PLAN ADMINISTRATIVE COSTS (Paid to External Organization): 5 401k/TSA Plan Administration fees 6 Legal-Accounting Management Fees-Pension Plan 6 Employee Managed Care Program Administration Fees 7 HEALTH AND INSURANCE COST 8 HEALTH AND INSURANCE COST 8 Health Insurance (Self Funded without a Third Party Administrator) 8 No. 1 Health Insurance (Self Funded without a Third Party Administrator) 8 No. 2 Health Insurance (Self Funded with a Third Party Administrator) 8 No. 3 Health Insurance (Purchased) 9 Prescription Drug Plan 9 Prescription Drug Plan 9 Obertal, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 11 Life Insurance (If employee is owner or beneficiary) 11 Dasability Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Worker's Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 State or Federal Unemployment Taxes 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tution Reimbursement 24 Total Wage Related Cost (Sum of lines 1 through 23)	1					1
4 Qualified Defined Benefit Plan Cost (see instructions) PLAN ADMINISTRATIVE COSTS (Paid to External Organization): 5 401k/TSA Plan Administration fees 6 Legal/Accounting/Management Fees-Pension Plan 7 Enployee Managed Care Program Administration Fees 7 THEALTH AND INSURANCE COST 8 Health Insurance (Purchased or Self Funded without a Third Party Administrator) 8 8.01 Health Insurance (Self Funded with a Third Party Administrator) 8 8.02 Health Insurance (Self Funded with a Third Party Administrator) 8 8.03 Health Insurance (Furchased) 8 9 Prescription Drug Plan 9 10 Dental, Hearing and Vision Plan 11 Life Insurance (I funde)eve is owner or beneficiary) 11 Life Insurance (I funde)eve is owner or beneficiary) 12 Accident Insurance (I funde)eve is owner or beneficiary) 13 Disability Insurance (I funde)eve is owner or beneficiary) 14 Long-Term Care Insurance (I funde)eve is owner or beneficiary) 15 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 EICA-Employers Portion Only 18 Medicare Taxes = Employees Fortion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuttion Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23)	2					2
PLAN ADMINISTRATIVE COSTS (Paid to External Organization): 5 401kTSA Plan Administration fees 5 6 Legal/Accounting/Management Fees-Pension Plan 6 6 7 Employee Managed Care Program Administration Fees 7 7 8 HEALTH AND INSURANCE COST 7 8 Health Insurance (Purchased or Self Funded) 8 8 8 9 1 1 1 1 1 1 1 1 1	3	Nonqualified Defined Benefit Plan Cost (see instructions)				3
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 8 8 8 9 Health Insurance (Furchased or Self Funded without a Third Party Administrator) 8 8 8 9 8 8 9 Health Insurance (Self Funded without a Third Party Administrator) 8 8 0 8 8 9 Prescription Drug Plan 9 9 10 Dental, Hearling and Vision Plan 9 9 11 11 Insurance (Infensional Plan 9 9 12 Accident Insurance (If employee is owner or beneficiary) 11 12 Accident Insurance (If employee is owner or beneficiary) 12 13 Disability Insurance (If employee is owner or beneficiary) 13 14 Long-Term Care Insurance (If employee is owner or beneficiary) 14 15 Workers' Compensation Insurance 15 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative 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 19 20 State or Federal Unemployment Taxes 22 20 Care Cost and Allowances 22 22 23 Tuition Reimbursement 23 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost	4	Qualified Defined Benefit Plan Cost (see instructions)				4
Company		PLAN ADMINISTRATIVE COSTS (Paid to External Organization):			•	
Temployee Managed Care Program Administration Fees	5	401k/TSA Plan Administration fees				5
HEALTH AND INSURANCE COST Realth Insurance (Purchased or Self Funded) 8.8	6					6
8 Health Insurance (Purchased or Self Funded) 8 8.01 Health Insurance (Self Funded without a Third Party Administrator) 8.01 8.02 Health Insurance (Self Funded with a Third Party Administrator) 8.02 8.03 Health Insurance (Purchased) 8.03 9 Prescription Drug Plan 9 10 Dental, Hearing and Vision Plan 10 11 Life Insurance (If employee is owner or beneficiary) 11 12 Accident Insurance (If employee is owner or beneficiary) 12 13 Disability Insurance (If employee is owner or beneficiary) 13 14 Long-Term Care Insurance (If employee is owner or beneficiary) 14 15 Worker's Compensation Insurance 15 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 17 18 Medicare Taxes - Employers Portion Only 18 20 State or Federal Unemployment Taxes 20 OTHER 21 21 Executive Deferred Co	7					7
8.01 Health Insurance (Self Funded without a Third Party Administrator) 8.02 Health Insurance (Self Funded with a Third Party Administrator) 8.03 Health Insurance (Purchased) 9 Prescription Drug Plan 10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 11 Life Insurance (If employee is owner or beneficiary) 11 Accident Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 AXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 19 Unemployment Insurance 19 State or Federal Unemployment Taxes 19 Unemployment Insurance 20 OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Total Wage Related Cost		HEALTH AND INSURANCE COST				
8.02 Health Insurance (Self Funded with a Third Party Administrator) 8.03 Health Insurance (Purchased) 9 Prescription Drug Plan 10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 11 Accident Insurance (If employee is owner or beneficiary) 11 Josability Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuttion Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Total Wage Related Cost						8
8.03 Health Insurance (Purchased) 9 Prescription Drug Plan 10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23)		` '				
9 Prescription Drug Plan 10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 11 Accident Insurance (If employee is owner or beneficiary) 11 Disability Insurance (If employee is owner or beneficiary) 11 Disability Insurance (If employee is owner or beneficiary) 11 Disability Insurance (If employee is owner or beneficiary) 11 Disability Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost						
10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowance 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 25 Part B - Other than Core Related Cost						
11 Life Insurance (If employee is owner or beneficiary) 12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost						
12 Accident Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost		, ,				
13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 19 State or Federal Unemployment Taxes OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) Part B - Other than Core Related Cost						
14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost						
15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) 16 TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 25 Part B - Other than Core Related Cost						
16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion) TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) Part B - Other than Core Related Cost						
TAXES 17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) Part B - Other than Core Related Cost		1				
17 FICA-Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost	16		FASB 106 Noncumulative portion)		16
18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost						
19 Unemployment Insurance 19 20 State or Federal Unemployment Taxes 20 OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 21 22 Day Care Cost and Allowances 22 23 Tuition Reimbursement 23 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost						
20 State or Federal Unemployment Taxes OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 25 Part B - Other than Core Related Cost						
OTHER 21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost		1 2				
21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 25 Part B - Other than Core Related Cost	20	* *				20
22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related cost (Sum of lines 1 through 23) 25 Part B - Other than Core Related Cost	21		ach 4 above)(ass instructions)		T	21
23 Tuition Reimbursement 23 24 Total Wage Related cost (Sum of lines 1 through 23) 24 Part B - Other than Core Related Cost		1 /	ight 4 above)(see histractions)			
24 Total Wage Related cost (Sum of lines 1 through 23) Part B - Other than Core Related Cost		· ·				
Part B - Other than Core Related Cost						
	24	Tomi wage remied cost (built of files i unough 23)			<u> </u>	24
	Part B -	Other than Core Related Cost				
· · · · · · · · · · · · · · · · · · ·	25	Other Wage Related Costs (specify)				25

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

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

4090 (Cont.)	FORM CMS-2552-1	.0						10-12
	AL-BASED HOME HEALTH AGENCY		PROVIDER	R CCN:	PERIOD:		WORKSHI	EET S-4	
STATIS	TICAL DATA				FROM				
			HHA CCN:		то				
	HOME HEALTH ACENOV STATISTICAL DATA		<u> </u>		Country				
	HOME HEALTH AGENCY STATISTICAL DATA				County				
				Title V	Title XVIII		Other	Total	
- 1	Description			1	2	3	4	5	
1 2	Home Health Aide Hours Unduplicated Census Count (see instructions)								1 2
2	Charles Count (see instructions)								
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					Num	ber of Empl	weec	ı
	Enter the number of hours in						Time Equiv	•	
	your normal work week					Staff	Contract	Total	i
	·					1	2	3	1
3	Administrator and Assistant Administrator(s)								3
4	Director(s) and Assistant Director(s)								4
5	Other Administrative Personnel								5
6	Direct Nursing Service								6
7	Nursing Supervisor								7
8	Physical Therapy Service								8
9	Physical Therapy Supervisor								9
10	Occupational Therapy Service								10
11	Occupational Therapy Supervisor								11 12
12 13	Speech Pathology Service								13
13	Speech Pathology Supervisor Medical Social Service								13
15	Medical Social Service Supervisor								15
16	Home Health Aide								16
17	Home Health Aide Supervisor								17
	Other (specify)								18
	HOME HEALTH AGENCY CBSA CODES								10
19 20	Enter the number of CBSAs where you provided services during								19
20	List those CBSA code(s) serviced during this cost reporting per	lod (line 20 contains the first code)							20
	PPS ACTIVITY								
				Full E	pisodes			Total	
				Without	With	LUPA	PEP only	(columns 1	
				Outliers	Outliers	Episodes	Episodes	through 4)	
	0131 127 1 77 1			1	2	3	4	5	
21	Skilled Nursing Visits								21
22	Skilled Nursing Visit Charges				 				22
24	Physical Therapy Visits Physical Therapy Visit Charges								24
25	Occupational Therapy Visits								25
26	Occupational Therapy Visits Occupational Therapy Visits Charges								26
27	Speech Pathology Visits								27
28	Speech Pathology Visit Charges								28
29	Medical Social Service Visits								29
30	Medical Social Service Visit Charges				1				30
31	Home Health Aide Visits								31
32	Home Health Aide Visit Charges								32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)								33
34	Other Charges								34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)								35
36	Total Number of Episodes (standard/non-outlier)								36
37	Total Number of Outlier Episodes								37
38	Total Non-Routine Medical Supply Charges								38

	TAL RENAL DIALYSIS DEPA STICAL DATA	ARTMENT			PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-5	
						TO		
	RENAL DIALYSIS STATIST	TICS Outpa	atient	Tro	ining	н	ome	T
		Outpo	atient	Hemo-	CAPD	Hemo-	CAPD	1
		Regular	High Flux	dialysis	CCPD	dialysis	CCPD	
	DESCRIPTION	1	2	3	4	5	6	1
1	Number of patients in program at end of cost							1
	reporting period							
2	Number of times per							2
	week patient receives							
	dialysis Average patient dialysis							3
3	time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year							5
	dialysis furnished							
- 6	Number of stations Treatment capacity per							7
,	day per station							'
8	Utilization (see instructions)							8
9	Average times							9
	dialyzers re-used							
10	Percentage of patients re-using dialyzers							10
	re-using diaryzers							
	ESRD PPS					1	2	
10.01	Is the dialysis facility approve		y for this cost reporting	period?				10.01
10.02	Enter "Y" for yes or "N" for n Did your facility elect 100% F		0112 Enter "V" for yes	or "N" for no				10.02
10.02	(See instructions for "new" pr	•	.011: Eliter 1 for yes	of N for no.				10.02
10.03	If you responded "N" to line 1		he year of transition for	periods prior to January	l and			10.03
	enter in column 2 the year of t	transition for periods afte	r December 31. (see ins	structions)				
	TRANSPIANT INFORMAT	ION						
11	TRANSPLANT INFORMATI Number of patients on transpl							11
12	Number of patients transplant		ng period					12
13	EPOETIN Net costs of Epoetin furnished	to all maintenance dials	ric notionts by the provi	dar				13
14	Epoetin amount from Worksh			uci				14
15	Number of EPO units furnish							15
16	Number of EPO units furnished	ed relating to the home d	ialysis department					16
	ADANECD							
17	ARANESP Net costs of ARANESP furnis	shed to all maintenance d	ialysis natients by the n	rovider			1	17
18	ARANESP amount from Wor			tovidei				18
19	Number of ARANESP units f	furnished relating to the r	enal dialysis department	i				19
20	Number of ARANESP units f	furnished relating to the h	ome dialysis departmen	t				20
	PHYSICIAN PAYMENT ME	THOD (Enter "X" for an	nlicable method(s))					
21		INITIAL METHOD	pheaste method(s))					21
	•			Net Cost of	Net Cost of	Number of ESA	Number of ESA	
			ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
	Eurthumanaissis Stimuulatina Aa	onto (ECA) Statistica	Description 1	Renal Patients	Home Patients	Dialysis Dept.	Dialysis Dept. 5	-
22	Erythropoiesis-Stimulating Ag Enter in column 1 the ESA de	escription.	1	2	3	4	3	22
	Enter in column 2 the net cost							
	to all renal dialysis patients.							
	Enter in column 3 the net cost							
	to all home dialysis program p Enter in column 4 the number							
	furnished to patients in the rer							
	department.							
	Enter in column 5 the number							Ī
	to patients in the home dialysi (see instructions)	s program.			1		1	1
	(=== mondenous)			1	1	1	1	-
						CCN	Treatments	
- 22	LOW VOLUME If line 10.01 is yes, enter in co	human 1 the CCN for	a nomed district for the th	isted on World-1+ C 2	Dout I line 10 1	1	2	22
23	in time 10.01 is yes, enter in co	numm i the CCN for each	i renai diarysis facility li	isieu on worksheet S-2,	ran i, ime 18, and		ĺ	23

HOSPITAL-BA	ASED COMMUNITY	MENTAL HEALT	H CENTER AND		PROVIDER CCN:	PERIOD:	WORKSHEET S-6		
OTHER OUTPATIENT REHABILITATION					FROM				
PROVIDER STATISTICAL DATA				COMPONENT CCN:	TO				
COMMUNITY	COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)								
Check	[] CMHC	[] OOT							
applicable	[] CORF	[] OSP							
box:	[] OPT								

Enter the number of hours in your normal workweek _____

		Т	Т	T + 1	
		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

40-518 Rev. 10

10-12		FORM CMS-2552-1	0		4090 (Cont.)
	ECTIVE PAYMENT FOR SNF STICAL DATA		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-7	
				Y/N	Date	
1	If this facility contains a hospital-based SNF, were all	patients under managed care or was there no Mo	edicare utilization?	1	2	1
	Enter "Y" for yes and do not complete the rest of this v	worksheet.				
2			"Y" for yes or			2
	"N" for no in column 1. If yes, enter the agreement da	ite (mm/dd/yyyy) in column 2.		<u> </u>		L
			SNF	Swing Bed SNF	TOTAL	
	Group		Days	Days	(sum of col. 2+3)	
	1		2	3	4	
3						3
4	RUL					4
5 6						5
7	1					7
- 8						8
9	RMX					9
10	RML					10
11	RLX					11
12	RUC					12
13	RUB					13
14	RUA					14
15 16	RVC RVB					15 16
17	RVA					17
18	RHC					18
19	RHB					19
20	RHA					20
21	RMC					21
22	RMB					22
23	RMA					23
24	RLB					24
25 26	RLA ES3					25 26
27	ES2					27
28	ES1					28
29	HE2					29
30	HE1					30
31	HD2					31
32	HD1					32
33	HC2					33
34	HC1					34
35 36	HB2 HB1		1			35 36
37	LE2			+		37
38						38

39

40

41 42 43

44 45

46

47

48

49 50

51 52

53

54

LD2

LD1 LC2 LC1

LB2

LB1 CE2

CE1

CD2

CD1

CC1

CB2 CB1

CA2

CA1

	SPECTIVE PAYMENT FOR SNF ISTICAL DATA PROVIDER CCN:				WORKSHEET S-7 (CONT.)	10 12
	Group		SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1		2	3	4	
55	SE3					55
56	SE2					56
57	SE1					57
58	SSC					58
59	SSB					59
60	SSA					60
61	IB2 IB1					61 62
63	IA2					63
64	IA2 IA1					64
65	BB2			-	+	65
66	BB1					66
67	BA2					67
68	BAI					68
69	PE2					69
70	PE1			+		70
71	PD2					71
72	PD1					72
73	PC2					73
74	PC1					74
75	PB2					75
76	PB1					76
77	PA2					77
78	PA1					78
199	AAA					199
200	TOTAL					200
SNF SER	EVICES					
				CBSA at	CBSA on/after	
				Beginning of	October 1 of the	1
				Cost Reporting	Cost Reporting	
				Period	Period (if applicable)]

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

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

Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the

Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).

cost reporting period.

XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)

PROVIDER CCN:

				HOSPICE CCN:	TO	PARTS I THROUGH	n IV
PART I - ENROLLMENT DAYS FOR COST REF	PORTING PERIODS I	BEGINNING BEFOR	E OCTOBER 1, 2015				
			Uı	nduplicated Days			
			Title XVIII	Title XIX		Total	
			Skilled Nursing	Nursing	All	(sum of	
	Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
	1	2	3	4	5	6	1
1 Hospice Continuous Home Care							1

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

Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care 5 Total Hospice Days

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

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

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

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

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

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

12-22	FORM CMS-2:	552-10		4090	(Cont.)
HOSPITAL UNCOMPENSATED AND INDIGENT		PROVIDER CCN:	PERIOD:	WORKSHEET S-10	
CARE DATA			FROM	PART I	
			TO		
PART I - HOSPITAL AND HOSPITAL COMPLEX	DATA				
Uncompensated and Indigent Care Cost-to-Charge Ra	ıtio				
1 Cost to charge ratio (see instructions)					1
Medicaid (see instructions for each line)					
2 Net revenue from Medicaid					2
3 Did you receive DSH or supplemental paym	ents from Medicaid?				3
4 If line 3 is yes, does line 2 include all DSH a	and/or supplemental payments from Medicaid?				4
5 If line 4 is no, enter DSH and/or supplement	al payments from Medicaid				5
6 Medicaid charges					6
7 Medicaid cost (line 1 times line 6)					7
8 Difference between net revenue and costs for	r Medicaid program (see instructions)				8
Children's Health Insurance Program (CHIP) (see ins	tructions for each line)				
9 Net revenue from stand-alone CHIP	·				9
10 Stand-alone CHIP charges					10
11 Stand-alone CHIP cost (line 1 times line 10)					11
12 Difference between net revenue and costs for	r stand-alone CHIP (see instructions)				12
Other state or local government indigent care program	(can instructions for each line)				
13 Net revenue from state or local indigent care	`				13
· ·	ocal indigent care program (not included in lines 6	or 10)			14
15 State or local indigent care program cost (lin		(61 10)			15
5 1 5	or state or local indigent care program (see instruct	tions)			16
To Billerence decired net revenue and educate	i suite of four margements program (see institute	nons)		ı	10
Grants, donations and total unreimbursed cost for Med	dicaid, CHIP and state/local indigent care program	s (see instructions for each line))		
17 Private grants, donations, or endowment inc	ome restricted to funding charity care				17
18 Government grants, appropriations or transfer	ers for support of hospital operations				18
19 Total unreimbursed cost for Medicaid, CHII	P, and state and local indigent care programs (sum	of lines 8, 12, and 16)			19
Uncompensated care cost (see instructions for each li	ne)				
•		Uninsured	Insured	Total	
		patients	patients	(col. 1 + col. 2)	
		1	2	3	
20 Charity care charges and uninsured discount	s (see instructions)				20
21 Cost of patients approved for charity care an	d uninsured discounts (see instructions)				21
Payments received from patients for amount	s previously written off as charity care				22
23 Cost of charity care (see instructions)					23
24 Does the amount on line 20, col. 2, include of	charges for patient days beyond a length-of-stay lin	nit imposed on patients covered			24
by Medicaid or other indigent care program?	?	•			
25 If line 24 is yes, enter the charges for patient	days beyond the indigent care program's length-of	f-stay limit (see instructions)			25
25.01 Charges for insured patients' liability (see in	structions)	•			25.01
26 Bad debt amount (see instructions)					26
27 Medicare reimbursable bad debts (see instru	ictions)				27
27.01 Medicare allowable bad debts (see instruction	ons)				27.01
28 Non-Medicare bad debt amount (see instruct	·				28
29 Cost of non-Medicare and non-reimbursable	Medicare bad debt amounts (see instructions)				29
30 Cost of uncompensated care (line 23, col. 3,	plus line 29)				30
31 Total unreimbursed and uncompensated care	cost (line 19 plus line 30)				31

Rev. 18 40-522.1

4090 (Cont.) FORM CMS-	-2552-10			12-22
HOSPITAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10,	
CARE DATA		FROM	PART II	
		TO		
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1 Cost to charge ratio (see instructions)				1
Medicaid (see instructions for each line)				
2 Net revenue from Medicaid				2
3 Did you receive DSH or supplemental payments from Medicaid?				3
4 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4
5 If line 4 is no, enter DSH and/or supplemental payments from Medicaid				5
6 Medicaid charges				6
7 Medicaid cost (line 1 times line 6)				7
8 Difference between net revenue and costs for Medicaid program (see instructions)				8
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9 Net revenue from stand-alone CHIP				9
10 Stand-alone CHIP charges				10
11 Stand-alone CHIP cost (line 1 times line 10)				11
12 Difference between net revenue and costs for stand-alone CHIP (see instructions)				12
Other state or local government indigent care program (see instructions for each line)				
13 Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)				13
14 Charges for patients covered under state or local indigent care program (not included in line	es 6 or 10)			14
15 State or local indigent care program cost (line 1 times line 14)				15
16 Difference between net revenue and costs for state or local indigent care program (see instr	ructions)			16
	,			
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care progr	rams (see instructions for each line)			
17 Private grants, donations, or endowment income restricted to funding charity care				17
18 Government grants, appropriations or transfers for support of hospital operations				18
19 Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (su	am of lines 8, 12, and 16)			19
Uncompensated care cost (see instructions for each line)	Uninguesd	Incurad	Total	ı
Uncompensated care cost (see instructions for each line)	Uninsured Patients	Insured Patients	Total	
Uncompensated care cost (see instructions for each line)	Uninsured Patients	Patients	(col. 1 + col. 2)	
	Patients			20
20 Charity care charges and uninsured discounts (see instructions)	Patients	Patients	(col. 1 + col. 2)	20
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions)	Patients	Patients	(col. 1 + col. 2)	21
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care	Patients	Patients	(col. 1 + col. 2)	21
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions)	Patients	Patients	(col. 1 + col. 2)	21
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions)	Patients 1	Patients	(col. 1 + col. 2)	21
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay	Patients 1	Patients	(col. 1 + col. 2)	21 22 23
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program?	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24 25
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length 25.01 Charges for insured patients' liability (see instructions)	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24 25 25.01
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length 25.01 Charges for insured patients' liability (see instructions)	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24 25
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length Charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions)	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24 25 25.01 26 27
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length control charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions) 28 Medicare allowable bad debts (see instructions)	Patients 1 limit imposed on patients covered	Patients	(col. 1 + col. 2)	21 22 23 24 25 25.01 26 27 27.01
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length 25.01 Charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27.01 Medicare reimbursable bad debts (see instructions) 28 Non-Medicare bad debt amount (see instructions)	Patients 1 Imit imposed on patients covered n-of-stay limit (see instructions)	Patients	(col. 1 + col. 2)	21 22 23 24 25 25.01 26 27 27.01 28
20 Charity care charges and uninsured discounts (see instructions) 21 Cost of patients approved for charity care and uninsured discounts (see instructions) 22 Payments received from patients for amounts previously written off as charity care 23 Cost of charity care (see instructions) 24 Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length control charges for insured patients' liability (see instructions) 26 Bad debt amount (see instructions) 27 Medicare reimbursable bad debts (see instructions) 28 Medicare allowable bad debts (see instructions)	Patients 1 Imit imposed on patients covered n-of-stay limit (see instructions)	Patients	(col. 1 + col. 2)	21 22 23 24 25 25.01 26 27 27.01

40-522.2 Rev. 18

This page is reserved for future use.

	TAL-BASED FQHC IDEN	TIFICATION DATA					PROVIDER CCN:	PERIOD: FROM:	WORKSHEET S-11 PART I	
							COMPONENT CCN:	TO:		
PART	I - HOSPITAL-BASED FOR	IC IDENTIFICATION DATA					<u> </u>		<u> </u>	
						Type of control	Date	V/I	Date of	
						(see instructions)	Decertified	Decertification	CHOW	
		1				2	3	4	5	
1	Site Name:									1
2	Street:		P.O. Box:							2
3	City:	State:	ZIP Code:	County:	E	" for rural or "U" for ur	ban:			3
4	Is this hospital-based FQF enter the entity's informati		es or controls multiple FQH	Cs? Enter "Y" for yes or "N" for no.	If yes,					4
5	Name of Entity:									5
6	Street:	P.O. Box:		HRSA Award Number:						6
7	City:	State:		ZIP Code:						7
						Y/N	Date Requested	Date Approved	Number of FQHCs	
Consol	idated Cost Report					1	2	3	4	
8				pter 9, §30.8? Enter "Y" for yes or " f column 1 is no, leave line 9 blank.						8
						CCN	CBSA	Date Requested	Date Approved	l
		1				2	3	4	5	
	List of Consolidated Provi	ders:								9
	Site Name:							_		9.01
	al-Based FQHC Operations	: 4: 1		1	1 1 1 11		1	2	3	10
10			ou operate as more than on	e sub-type of an organization, enter	only the applicable alpha					10
- 11	characters in column 2. (s		the DIIC Aut dynine this age	st nomentine menied? If this is a sense	olidated cost report, did the hospital-b	and EOUC senested				11
11				g period? Enter "Y" for yes or "N" for		ased rQTIC reported				11
12				warded (see instructions). Enter the						12
12				e grant subscript this line accordingly						
Medica	d Malpractice		,	<u> </u>	,-					
		HC submit an initial deeming or a	nnual redeeming application	n for medical malpractice coverage u	ander the FTCA with HRSA? Enter "	Y" for				13
	yes or "N" for no in colum	n 1. If column 1 is yes, enter the	effective date of coverage in	column 2.						
Interns	and Residents	•							•	
14	Did this hospital-based FQ	HC receive a THC development g	rant authorized under Part (of Title VII of the PHS Act from I	HRSA? Enter "Y" for					14
	yes or "N" for no in colum	n 1. If yes, enter in column 2, the	number of FTE residents th	at your hospital-based FQHC trained	and received funding through your					
	THC grant in this cost rep		er the total number of visits	performed by residents funded by th	e THC grant in this cost reporting					

40-523.1 Rev. 18

11-16				FORM C	MS-2552-10				4090 (Cont.)				
HOSPI	TAL-BASED FQHC IDENTIFIG	CATION DATA					PROVIDER CCN: COMPONENT CCN: SUBCOMPONENT CCN	PERIOD: FROM TO :	WORKSHEET S-11 PART II				
PART I	I - HOSPITAL-BASED FQHC C	CONSOLIDATED COST REPORT PA	ARTICIPANT IDENTIFIC	CATION DATA	T 5.	T C . 1	T	X7/7	D : C				
					Date Certified	Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW				
		1			2	3	4	5	6				
1	Site Name:									1			
	Street:	P.O. Box:	am a i			In	1 117711 0 1			2			
3	City:	State:	ZIP Code:	County:		Designation - Enter "R" for	or rural or "U" for urban:			3			
Hoenita	l-Based FQHC Operations						1	2	3				
4		s hospital-based FQHC? If you operate see instructions)	e as more than one sub-ty	pe of an organization, enter only th	ne applicable				3	4			
5		eceive a grant under §330 of the PHS								5			
6		ndicate in column 1, the type of HRSA			f the grant award in					6			
	column 2 and enter the grant aw	vard number in column 3. If you receive	ed more than one grant st	abscript this line accordingly.									
Medical	Malpractice												
7		ubmit an initial deeming or annual rede	eming application for med	lical malpractice coverage under th	e FTCA with HRSA?					7			
		in column 1. If column 1 is yes, enter											
		•		-			•		•				
Interns	and Residents												
8		eceive a THC development grant author								8			
		in column 1. If yes, enter in column 2											
		orting period and in column 3, enter the	e total number of visits pe	rformed by residents funded by the	THC grant								
	in this cost reporting period. (see	ee instructions)											

1070	(Cont.)		1 Oldvi Civ	10 2552 10				11 10
HOSPI	TAL-BASED FQHC IDENTIFICATION	DATA			PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET S-11 PART III	
PART	II - HOSPITAL-BASED FQHC STATIST	ICAL DATA					1	$\overline{\mathbf{T}}$
		COMPONENT CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
1	Medical Visits	Ů	-	-		,		1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4

This page is reserved for future use.

Rev. 17 40-523.4

RECLA	SSIFICATI	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM	WORKSHEET A	
								то		
	COS	ST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		(cilii colla)	1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS	•	Ž	3	·	J	Ü	,	
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing Program								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23		Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31		Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35	0.4006	Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	0.4206	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46

RECLA	SSIFICATI	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM	WORKSHEET A	
								ТО		
	COS	ST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		(omit cents)	JALAKILS 1	2	3	4	5	6	7	1
		ANCILLARY SERVICE COST CENTERS	1	2	,	7	J	Ü	,	
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
77	07700	Allogeneic HSCT Acquisition								77
78	07800	CAR T-Cell Immunotherapy								78
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93
93.99	09399	Partial Hospitalization Program								93.99

RECLA	SSIFICAT	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM	WORKSHEET A	
								ТО		
	COS	ST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		OTHER REIMBURSABLE COST CENTERS	I	2	3	4	5	6	7	
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services			+					95
96	09600	Durable Medical Equipment-Rented			+					96
97	09700	Durable Medical Equipment-Sold			+					97
98	09700	Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
102	10200	Opioid Treatment Program								102
- 102	10200	SPECIAL PURPOSE COST CENTERS								102
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107		Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1 through 117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118 through 199)				- 0 -				200

RECLA	SSIFICATIONS						PROVI	DER CCN:	PERIOD: FROM TO	WORKSF	IEET A-6	
				INCRE	ASES			DECREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE	COST CENTER	WKST. A LINE #	SALARY	OTHER	COST CENTER	WKST. A LINE #	SALARY	OTHER	WKST. A-7 REF.	
	LAI LANATION OF RECEASSIFICATION(S)	1	2	3	4	5	6	7	8 8	9	10	1
1											-	1
2												2
3												3
4									T .	1	1	4
5												5
6												6
7										<u> </u>		7
- 8										<u> </u>		8
9										<u> </u>		9
10												10
11												11
12										 		12
13								_				13
14								_	4			14
15		_								+	+	15 16
16 17				1					+	 	+	17
18		-							+		+	18
19									+	 	+	19
20		+		+				_	+	+	+	20
21		+		1				_	+	+	+	21
22		+							+	+	+	22
23		+		1					+	+	+	23
23												23

21 22

35

500

500 Total reclassifications (sum of columns 4 and 5

must equal sum of columns 8 and 9)

⁽¹⁾ A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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

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

	S	COMPLITAT	ION OF RATIOS		ALLOCATION OF OTHER CAPITAL				
Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
	1	2	3	4	5	6	7	8	
1 Capital Related Costs-Buildings and Fixtures									
2 Capital Related Costs-Movable Equipment									
3 Total (sum of lines 1 and 2)				1.000000					
				5	SUMMARY OF CAPIT	AL			
					Insurance	Taxes	Other Capital- Related Costs	Total ⁽²⁾ (sum of	
		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
Description		Depreciation						1.5	
Description		9	10	11	12	13	14	15	
Description 1 Capital Related Costs-Buildings and Fixtures			10	11	12	13	14	15	
:			10	11	12	13	14	15	

⁽²⁾ The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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

03-18		FORM CMS							Cont.)
ADJUS	TMENTS TO EXPENSES		PROVIDER O	CCN:	PERIOD:	WORKS	HEET.	A-8	
					FROM	_			
				_	TO				
					EXPENSE CLASSIFI				
	DESCRIPTION (1)			WORKSHEET A TO/FF				Wkst.	
		BASIS /		Т	THE AMOUNT IS TO I			A-7	
		CODE (2)	AMOUNT		COST CENTE	R L	INE#	Ref.	
	T	1	2		3		4	5	
1	Investment income - buildings and fixtures (chapter 2)				gs and Fixtures		1		1
2	Investment income - movable equipment (chapter 2)			Movab	le Equipment		2		2
3	Investment income - other (chapter 2)								3
4	(4
5	Refunds and rebates of expenses (chapter 8)								5
6	1 1 7 11 (1 -7								6
7	Telephone services (pay stations excluded) (chapter 21)								7
- 8	Television and radio service (chapter 21)								8
9	Parking lot (chapter 21)								9
10	Provider-based physician adjustment	Worksheet A-8-2							10
11	Sale of scrap, waste, etc. (chapter 23)								11
12	Related organization transactions (chapter 10)	Worksheet A-8-1							12
13	Laundry and linen service								13
14	Cafeteria-employees and guests								14
15	Rental of quarters to employee and others								15
16	Sale of medical and surgical								16
	supplies to other than patients								
17	Sale of drugs to other than patients								17
18	Sale of medical records and abstracts								18
19	Nursing and allied health education (tuition,								19
	fees, books, etc.)								
20	Vending machines								20
21	Income from imposition of interest,								21
	finance or penalty charges (chapter 21)								
22	Interest expense on Medicare overpayments and								22
	borrowings to repay Medicare overpayments								
23	Adjustment for respiratory therapy								23
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respira	tory Therapy		65		
24	Adjustment for physical therapy costs								24
	in excess of limitation (chapter 14)	Worksheet A-8-3		Physica	l Therapy		66		
25	Utilization review - physicians' compensation (chapter 21)			Utilizat	ion Review - SNF		114		25
26	Depreciation - buildings and fixtures			Buildin	gs and Fixtures		1		26
27	Depreciation - movable equipment			Movab	le Equipment		2		27
28	Non-physician Anesthetist			Nonphy	ysician Anesthetist		19		28
29	Physicians' assistant								29
30	Adjustment for occupational therapy costs								30
	in excess of limitation (chapter 14)	Worksheet A-8-3		Occupa	ational Therapy		67		
30.99	Hospice (non-distinct) (see instructions)			Adults	and Pediatrics		30		30.99
31	Adjustment for speech pathology costs								31
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech	Pathology		68		
32	CAH HIT adjustment for depreciation								32
33	Other adjustments (specify) (3)								33
50	TOTAL (sum of lines 1 through 49)								50
	(Transfer to Worksheet A, column 6, line 200)								

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1

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

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

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

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

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

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

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

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

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

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

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

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

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

ROVID	ER-BASED PHYSICIANS	S ADJUSTMENTS					PROVIDER CCN:	PERIOD: FROM TO _	WORKSHEET A-8-2	2
	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	+
2										
3										+
4										
5										
6										
7										
8										
9										
10										
	TOTAL								 	20
	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										
2										_
3										
- 4						<u> </u>				
6									1	+
7									†	
8										
9										
10										1
11	TOTAL	<u> </u>								20

4090 (Cont.) FORM CMS-2552-10									
	NABLE COST DETERMINATION FOR THERAPY SERVICES SHED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A-8- PARTS I & II	-3,		
Check app	pplicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology								
PART I -	- GENERAL INFORMATION								
	Total number of weeks worked (excluding aides) (see instructions)						1		
2	Line 1 multiplied by 15 hours per week						2		
3	3 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)								
4 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)									
5 Number of unduplicated offsite visits - supervisors or therapists (see instructions)									
6	6 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which								
	supervisor and/or therapist was not present during the visit(s)) (see instructions)						7		
7 Standard travel expense rate									
8	Optional travel expense rate per mile						8		
		G :	Tri .	4 14 4	4:1				
		Supervisors	Therapists	Assistants 3	Aides 4	Trainees 5	_		
0.1	Total hours worked	1	Δ	3	4		9		
	AHSEA (see instructions)					_	10		
	Standard travel allowance (columns 1 and 2, one-half of column 2,						11		
	line 10; column 3, one-half of column 3, line 10)								
12	Number of travel hours (see instructions)						12		
13	Number of miles driven (see instructions)						13		
	, , , , , , , , , , , , , , , , , , ,	•							
PART II -	- SALARY EQUIVALENCY COMPUTATION								
	Supervisors (column 1, line 9 times column 1, line 10)						14		
	Therapists (column 2, line 9 times column 2, line 10)						15		
	Assistants (column 3, line 9 times column 3, line10)						16		
	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17		
	Aides (column 4, line 9 times column 4, line 10)						18		
	Trainees (column 5, line 9 times column 9, line 10)						19		
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20		
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occ the amount from line 20. Otherwise complete lines 21 through 23.			lines 21 and 2, and enter	on line 23				
	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory ther	rapy or columns 1 through 3, line 9 for all other	ers)				21		
	Weighted allowance excluding aides and trainees (line 2 times line 21)	-					22		
23	Total salary equivalency (see instructions)						23		

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

${\color{blue} \textbf{PART IV-STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION-SERVICES OUTSIDE PROVIDER SITE } \\$

Stand	lard	Tra	vel E	Exper	ıs

	36	Therapists (line 5 times column 2, line 11)	36
	37	Assistants (line 6 times column 3, line 11)	37
_	38	Subtotal (sum of lines 36 and 37)	38
-	39	Standard travel expense (line 7 times the sum of lines 5 and 6)	39

Optional Travel Allowance and Optional Travel Expense

40	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	40
41	Assistants (column 3, line 12.01 times column 3, line 10)	41
42	Subtotal (sum of lines 40 and 41)	42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	43

Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate.

44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)	44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)	45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)	46

33	1 ortion of overtime aready included in nourly computation at the ATISEA (multiply		33
	line 47 times line 52)		
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5, the sum of columns 1, 3, and 4, for respiratory		56
	therapy, and columns 1 through 3 for all others.)		
		•	
PART V	I - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
	Salary equivalency amount (from line 23)		57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35))		58
59	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)		63
64	Total cost of outside supplier services (from provider records)		64
65	Excess over limitation (line 64 minus line 63; if negative, enter zero)		65
		<u> </u>	· · · · · · · · · · · · · · · · · · ·

COST A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST	CAPITAL RELATED COSTS							
COS	T CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	GENERAL SERVICE COST CENTERS	U	1	2	4	4A	3	0	/	
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment							+		2
	Employee Benefits Department									4
	Administrative and General									5
	Maintenance and Repairs							+		6
	Operation of Plant	+						 	+	7
	Laundry and Linen Service	+						 	+	8
	Housekeeping									9
	Dietary									10
	Cafeteria									11
	Maintenance of Personnel									12
	Nursing Administration									13
										14
	Pharmacy									15
16	Medical Records & Medical Records Library									16
	Social Service									17
18	Other General Service (specify)									18
	Nonphysician Anesthetists									19
20	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider (specify)									42
43	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART I	
								ТО		
		NET EXPENSES FOR COST		ITAL D COSTS						T
COST	CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	U	1	2	4	4A	5	6	/	+
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									82
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy							_		78
	OUTPATIENT SERVICE COST CENTERS									00
	Rural Health Clinic (RHC)				ļ	ļ		+		88
	Federally Qualified Health Center (FQHC) Clinic									89 90
	Emergency Observation Beds									91 92
	Observation Beds Other Outpatient Service (specify)									92
	Partial Hospitalization Program									93.99

COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
	NET EXPENSES FOR COST		ITAL D COSTS	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	4 D. W. W.	Many		
COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT			ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
-	0	1	2	4	4A	5	6	7	1
OTHER REIMBURSABLE COST CENTERS									4
94 Home Program Dialysis									94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold									97
98 Other Reimbursable (specify)									98
99 Outpatient Rehabilitation Provider (specify)									99
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
101 Home Health Agency									101
102 Opioid Treatment Program									102
SPECIAL PURPOSE COST CENTERS									
105 Kidney Acquisition									105
106 Heart Acquisition									106
107 Liver Acquisition									107
108 Lung Acquisition									108
109 Pancreas Acquisition									109
110 Intestinal Acquisition									110
111 Islet Acquisition									111
112 Other Organ Acquisition (specify)									112
115 Ambulatory Surgical Center (Distinct Part)									115
116 Hospice									116
117 Other Special Purpose (specify)									117
118 SUBTOTALS (sum of lines 1 through 117)									118
NONREIMBURSABLE COST CENTERS									
190 Gift, Flower, Coffee Shop, & Canteen									190
191 Research									191
192 Physicians' Private Offices									192
193 Nonpaid Workers									193
194 Other Nonreimbursable (specify)									194
200 Cross Foot Adjustments									200
201 Negative Cost Centers									201
202 TOTAL (sum lines 118 through 201)									202

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

COST AI	LOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	(cont.)					
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS					1-						
	Operating Room											50
	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology											53
	Radiology-Diagnostic											54
55	Radiology-Therapeutic											55
56	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											82
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											4
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

COST ALLOCATION - GENERAL SERVICE COSTS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
OTHER REPORTED AND E GOOT GENTERS	8	9	10	11	12	13	14	15	16	17	
OTHER REIMBURSABLE COST CENTERS											0.4
94 Home Program Dialysis											94
95 Ambulance Services											95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
101 Home Health Agency											101
102 Opioid Treatment Program											102
SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition											106
107 Liver Acquisition											107
108 Lung Acquisition											108
109 Pancreas Acquisition											109
110 Intestinal Acquisition											110
111 Islet Acquisition											111
112 Other Organ Acquisition (specify)											112
115 Ambulatory Surgical Center (Distinct Part)											115
116 Hospice											116
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1 through 117)											118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen		-									190
191 Research											191
192 Physicians' Private Offices											192
193 Nonpaid Workers											193
194 Other Nonreimbursable (specify)											194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118 through 201)											202

12-22 FORM CMS-2552-10 4090 (Cont.)

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

4090 (Cont.)		rui	XIVI CIVIS-233	2-10						12-22
COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD:	WORKSHEET B,	
								FROM	PART I	
								TO		
								INTERN &		
		NON-		INTERNS &	INTERNS &			RESIDENT		
	OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	PARAMEDICAL		COST & POST		
COST CENTER DESCRIPTIONS	GENERAL	ANES-	NURSING	SALARY AND	PROGRAM	EDUCATION		STEPDOWN		
	SERVICE	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
ANCILLARY SERVICE COST CENTERS										
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan						1		†		57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										82
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
77 Allogeneic HSCT Acquisition										77
78 CAR T-Cell Immunotherapy										78
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93
93.99 Partial Hospitalization Program								1		93.99
75.77 I aradi Hospitanzation Hogiani		I		1		1	1	1	I	15.77

COST Al	LLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	10	.,	20	2.1	22	23	21	23	20	
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	Opioid Treatment Program										102
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
	Heart Acquisition										106
	Liver Acquisition										107
	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

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

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED	CAP RELATE	ITAL D COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	U	1	2	ZA.	4	3	0	/	-
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
										62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
										76
	Allogeneic HSCT Acquisition									77
	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
										93
93.99	Partial Hospitalization Program									93.99

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

ALLOCA	ATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS	0		10	11	12	13	17	13	10	17	+-
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											
	Employee Benefits Department											
	Administrative and General											4
	Maintenance and Repairs	1										-
	Operation of Plant	1										
	Laundry and Linen Service											8
	Housekeeping			1								9
10	Dietary				1							10
	Cafeteria					1						1
12	Maintenance of Personnel											1
13	Nursing Administration											1
14	Central Services and Supply								1			1
	Pharmacy											1.
16	Medical Records & Medical Records Library											1
	Social Service											1
	Other General Service (specify)											1
	Nonphysician Anesthetists											1
	Nursing Program											2
	Intern & Res. Service-Salary & Fringes (Approved)											2
	Intern & Res. Other Program Costs (Approved)											2
23	Paramedical Education Program (specify)											2
	INPATIENT ROUTINE SERVICE COST CENTERS											
	Adults and Pediatrics (General Routine Care)											3
	Intensive Care Unit											3
	Coronary Care Unit											3
	Burn Intensive Care Unit											3
	Surgical Intensive Care Unit											3
	Other Special Care Unit (specify)											3
	Subprovider IPF											4
	Subprovider IRF											4
	Subprovider (specify)											4
	Nursery											4
	Skilled Nursing Facility			ļ	ļ							4
	Nursing Facility Other Long Term Care											4

ALLOCA	ATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	8	,	10	11	12	13	14	13	10	17	+
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
53	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy Occupational Therapy											66
	Speech Pathology											68
	Electrocardiology										+	69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

ALLOCA	ATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS	8	,	10	11	12	13	17	13	10	17	
	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											102
	Kidney Acquisition											105
	Heart Acquisition											106
	Liver Acquisition											107
	Lung Acquisition											108
	Pancreas Acquisition											109
	Intestinal Acquisition											110
	Islet Acquisition											111
	Other Organ Acquisition (specify)											112
	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											113
	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
	Gift, Flower, Coffee Shop, & Canteen											190
	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	TOTAL (sum lines 118 through 201)											202

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

ALLOCA	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	TOTAL 26	-
	ANCILLARY SERVICE COST CENTERS	10	.,	20	2.	22	23	2.	23	20	
	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
	Laboratory										60
	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program										93.99

ALLOC.	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	OTHER REIMBURSABLE COST CENTERS	18	19	20	21	22	23	24	25	26	_
0.4	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
90	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
											100
	Home Health Agency										100
	Opioid Treatment Program										101
102	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
	Heart Acquisition										105
	Liver Acquisition										107
											107
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
_	Hospice										113
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
110	NONREIMBURSABLE COST CENTERS										110
190	Gift, Flower, Coffee Shop, & Canteen										190
	Research	_									191
	Physicians' Private Offices								1	1	192
	Nonpaid Workers								1	1	193
194	Other Nonreimbursable (specify)										194
											200
	Negative Cost Centers								Ì		201
	TOTAL (sum lines 118 through 201)										202

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

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM		
							TO		
		CAPITAL RE	LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	1
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor Room and Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
	Laboratory								60
61	PBP Clinical Laboratory Services-Program Only								61
	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged to Patients								71
	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
	Renal Dialysis								74
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)								76
	Allogeneic HSCT Acquisition								77
	CAR T-Cell Immunotherapy								78
	OUTPATIENT SERVICE COST CENTERS								
	Rural Health Clinic (RHC)								88
	Federally Qualified Health Center (FQHC)								89
	Clinic								90
	Emergency								91
	Observation Beds								92
	Other Outpatient Service (specify)								93
	Partial Hospitalization Program					†	 	1	93.99

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B-1	
		CAPITAL RE	LATED COST	EMPLOYEE		ADMINIS-	MAIN-		Т
COS	ST CENTER DESCRIPTIONS	BLDGS. & FIXTURES (SQUARE	MOVABLE EQUIPMENT (DOLLAR	BENEFITS DEPARTMENT (GROSS	RECONCIL-	TRATIVE & GENERAL (ACCUM.	TENANCE & REPAIRS (SQUARE	OPERATION OF PLANT (SQUARE	
		FEET)	VALUE)	SALARIES)	IATION 5A	COST)	FEET)	FEET)	4
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
	Other Reimbursable (specify)								98
	Outpatient Rehabilitation Provider (specify)								99
									100
	Home Health Agency								101
	Opioid Treatment Program								102
	SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
	Lung Acquisition								108
109	Pancreas Acquisition								109
	Intestinal Acquisition								110
	Islet Acquisition								111
	Other Organ Acquisition (specify)								112
	Ambulatory Surgical Center (Distinct Part)								115
	Hospice								116
	Other Special Purpose (specify)								117
	SUBTOTALS (sum of lines 1 through 117)								118
	NONREIMBURSABLE COST CENTERS								
	Gift, Flower, Coffee Shop, & Canteen								190
191									191
	Physicians' Private Offices								192
	Nonpaid Workers								193
	Other Nonreimbursable (specify)								194
	Cross foot adjustments								200
201									201
202	4 , , ,								202
203	Unit cost multiplier (Worksheet B, Part I)								203
	Cost to be allocated (per Worksheet B, Part II)								204
	Unit cost multiplier (Worksheet B, Part II)								205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)								206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207

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

COST A	LLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
										FROM		
										TO		
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
		& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
COST	CENTER DESCRIPTIONS	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	
		LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	SPENT)	
		8	9	10	11	12	13	14	15	16	17	1
	ANCILLARY SERVICE COST CENTERS											
50	Operating Room											50
51	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology											53
54	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope				ĺ	ĺ		ĺ				56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy											66
	Occupational Therapy											67
	Speech Pathology											68
	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis	-			 	 		 				74
	ASC (Non-Distinct Part)	_			-	-		-				75
	Other Ancillary (specify)	-			 	 		 				76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
/8	OUTPATIENT SERVICE COST CENTERS											/8
90	Rural Health Clinic (RHC)											00
					-	-		-				88 89
	Federally Qualified Health Center (FQHC)				 	 		 		1	-	
90	Clinic					-						90
	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

COST A	LLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
										FROM		
										TO		
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
		& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
COST	CENTER DESCRIPTIONS	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	
		LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	SPENT)	
		8	9	10	11	12	13	14	15	16	17	1
	OTHER REIMBURSABLE COST CENTERS											
	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
102	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
	Pancreas Acquisition											109
	Intestinal Acquisition											110
	Islet Acquisition											111
	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross foot adjustments											200
201	Negative cost centers											201
202	Cost to be allocated (per Worksheet B, Part I)											202
203	Unit cost multiplier (Worksheet B, Part I)											203
204	Cost to be allocated (per Worksheet B, Part II)											204
	Unit cost multiplier (Worksheet B, Part II)											205
206	NAHE adjustment amount to be allocated (per Wkst. B-	2										206
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)											207

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	
									TO TO		
		1	NON-		INITEDNIC 0.	RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
COSI	CENTER DESCRIPTIONS	(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	(ASGND TIME)	20	21	22	23	24	25	26	-
	GENERAL SERVICE COST CENTERS	10	17	20	21	ZZ	23	27	23	20	
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General	1									5
6	Maintenance and Repairs										6
7	Operation of Plant	7									7
8	Laundry and Linen Service	7									8
9	Housekeeping										Ģ
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy										1.
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)		1								18
19	Nonphysician Anesthetists										19
20	Nursing Program										20
21	Intern & Res. Service-Salary & Fringes (Approved)					1					21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit										31
32	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	Subprovider IPF										40
	Subprovider IRF										4
	Subprovider (specify)										42
	Nursery										43
	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

COST Al	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	
									TO TO		
			MOM		DITEDNIC 0	DEGIDENTS	D + D +		INTERN &		т —
		OTHER	NON-	MIDONIC		RESIDENTS	PARA-				
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
		(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	ANCILLARY SERVICE COST CENTERS										
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
	Whole Blood & Packed Red Blood Cells						1				62
63	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients	_	<u> </u>								71
	Implantable Devices Charged to Patients	_	<u> </u>								72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy	-	+								78
	OUTPATIENT SERVICE COST CENTERS										1 /8
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)						-				89
	Clinic		 		-						90
	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)		ļ								93
93.99	Partial Hospitalization Program										93.99

COST AI	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	•
									TO TO	·	
			NON-		INTERNS &	RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
COSI	CENTER DESCRIPTIONS	(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	(ASGND TIVIL)	20	21	22	23	24	25	26	-
	OTHER REIMBURSABLE COST CENTERS	10	17	20	21	LL	23	21	23	20	
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
102	Opioid Treatment Program	•									102
	SPECIAL PURPOSE COST CENTERS										
	Kidney Acquisition										105
	Heart Acquisition										106
	Liver Acquisition										107
	Lung Acquisition										108
	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
117	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
192	Physicians' Private Offices										192
	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)										202
	Unit cost multiplier (Worksheet B, Part I)										203
	Cost to be allocated (per Worksheet B, Part II)										204
205	Unit cost multiplier (Worksheet B, Part II)										205
	NAHE adjustment amount to be allocated (per Wkst. B-2)										206
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										207

	TEPDOWN ADJUSTMENTS PI	ROVIDER CCN:	PERIOD: FROM TO		WORKSHEET B-2	
				SHEET		
	DESCRIPTION				AMOUNT	
	DESCRIPTION			LINE NO.		
	1		2	3	4	
	Adjustment for EPO costs in Renal Dialysis cost center		1	74		1
2	Adjustment for EPO costs in Home Program Dialysis cost center		1	94		3
3	Adjustment for ARANESP costs in Renal Dialysis cost center		1	74		3
4	Adjustment for ARANESP costs in Home Program Dialysis cost center		1	94		4
	Adjustment for ESA costs in Renal Dialysis cost center (see instructions)		1	74		5
	Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)		1	94		6
7	Adjustment for ESA costs in Home I regram Starysis cost center (see instructions)			- /1		7
_						
8						8
9						9
10						10
11						11
12						12
13			1	1		13
14						14
						14
15						15
16						16
17						17
18						18
19						19
20			1	1		20
21						21
						21
22						22
23						23
24						24
25						25
26			1			26
27			1			27
28						28
						20
29						29
30						30
31						31
32						32
33			1			33
34						34
35						35
36						36
				_		30
37			-	1		37
38			ļ	ļ		38
39						39
40						40
41						41
42						42
43			1	1		43
44				1		44
			!	1		44
45			ļ			45
46				Į		46
47						47
48						48
49						49
50						50
51			 	 		51
			!	1		51
52						52
53]		53
54						54
55						55
56			1			56
57			 	1		57
58			1			58
				1		50
59				l .		59

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

Rev. 18 40-563

Cost Centre Discriptions	НЕЕТ С
1	ent
To Electroencephalography	
1 Medical Supplies Charged to Patients	6
Implantable Provises Charged to Patients	7
27 Drugs Charged to Patients	7
73 Renal Dialysis	7
75 ASC (Non-Distinct Part)	7.
76 Other Ancillary (specify)	7-
77 Allogenic IBCT Acquisition	7
Test CAR T-Cell Immunotherapy	7
OUTPATIENT SERVICE COST CENTERS 88 Rural Health Clinic (RHC) 90 Clinic 91 Energency 91 Energency 92 Observation Beds (see instructions) 93 Other Outpatient Service (specify) 94 Other Outpatient Service (specify) 95 A melalitation Program 95 Other Reimbursable Cost Centers 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 90 Outpatient Rehabilitation Provider (specify) 91 Outpatient Rehabilitation Provider (specify) 92 A melalitation Provider (specify) 93 Outpatient Rehabilitation Provider (specify) 94 Outpatient Rehabilitation Provider (specify) 95 Outpatient Rehabilitation Provider (specify) 96 Outpatient Rehabilitation Provider (specify) 97 Outpatient Rehabilitation Provider (specify) 98 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 90 Outpatient Rehabilitation Provider (specify) 91 Outpatient Rehabilitation Provider (specify) 92 Outpatient Rehabilitation Provider (specify) 93 Outpatient Rehabilitation Provider (specify) 94 Outpatient Rehabilitation Provider (specify) 95 Outpatient Rehabilitation Provider (specify) 96 Outpatient Rehabilitation Provider (specify) 97 Outpatient Rehabilitation Provider (specify) 98 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 90 Outpatient Rehabilitation Provider (specify) 91 Outpatient Rehabilitation Provider (specify) 92 Outpatient Rehabilitation Provider (specify) 93 Outpatient Rehabilitation Provider (specify) 94 Outpatient Rehabilitation Provider (specify) 95 Outpatient Rehabilitation Provider (specify) 96 Outpatient Rehabilitation Provider (specify) 97 Outpatient Rehabilitation Provider (specify) 98 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify) 99 Outpatient Rehabilitation Provider (specify)	7
See Rural Health Clinic (RHC)	7
Rederally Qualified Health Center (FQHC)	
90 Clinic 91 Emergency 92 Observation Beds (see instructions) 93 Other Outpatient Service (specify) 93.99 Partial Hospitalization Program 94 Home Program Dialysis 95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 90 Outpatient Rehabilitation Provider (specify) 91 Outpatient Rehabilitation Provider (specify) 92 Outpatient Rehabilitation Provider (specify) 93 Outpatient Rehabilitation Provider (specify) 94 Outpatient Rehabilitation Provider (specify) 95 Outpatient Rehabilitation Provider (specify) 96 Outpatient Rehabilitation Provider (specify) 97 Outpatient Rehabilitation Provider (specify) 98 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not apply cluby, prgm.) 101 Home Health Agency 102 Opioid Treatment Program 103 Kidney Acquisition 104 Larr Acquisition 105 Kidney Acquisition 106 Heart Acquisition 107 Laver Acquisition 108 Lang Acquisition 109 Pancreas Acquisition 100 Intestinal Acquisition 101 Intestinal Acquisition 102 Opioid Opioid Treatment Program 103 Lang Acquisition 104 Opioid Treatment Program 106 Pancreas Acquisition 107 Laver Acquisition 108 Lang Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Other Organ Acquisition (specify)	8
91 Emergency 92 Observation Beds (see instructions) 93 Observation Beds (see instructions) 93 Observation Beds (see instructions) 93 Observation Evervice (specify) 94 95 97 97 97 97 97 97 97	8
92 Observation Beds (see instructions) 93 Other Outpatient Service (specify) 93.99 Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS 94 Home Program Dialysis 95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appyd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program 103 FECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Lura Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 100 Intestinal Acquisition 101 Intestinal Acquisition 101 Intestinal Acquisition 102 Intestinal Acquisition 103 Intestinal Acquisition 104 Intestinal Acquisition 105 Intestinal Acquisition 106 Intestinal Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 100 Intestinal Acquisition 110 Intestinal Acquisition (specify)	9
93 Other Outpatient Service (specify) 93.99 Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS 94 Home Program Dialysis 95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 100 Intestinal Acquisition 101 Intestinal Acquisition 102 Intestinal Acquisition 103 Liver Acquisition 104 Liver Acquisition 105 Liver Acquisition 106 Intestinal Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	9
93.99 Partial Hospitalization Program	9
OTHER REIMBURSABLE COST CENTERS 94 Home Program Dialysis 95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program 103 SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 111 Intestinal Acquisition 111 Intestinal Acquisition 111 Intestinal Acquisition 111 Intestinal Acquisition 111 Other Organ Acquisition (specify)	9
OTHER REIMBURSABLE COST CENTERS	93.9
94 Home Program Dialysis 95 Ambulance Services 96 96 96 97 98 98 99 99 99 99 99	
95 Ambulance Services 96 Durable Medical Equipment-Rented 97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program 103 SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Intestinal Acquisition 112 Other Organ Acquisition	9.
97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tehng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	9
97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tehng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	9
99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	9
99 Outpatient Rehabilitation Provider (specify) 100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency 102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS 105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	9
101 Home Health Agency	9
101 Home Health Agency	10
102 Opioid Treatment Program SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE CENTERS SPE	10
105 Kidney Acquisition 106 Heart Acquisition 107 Liver Acquisition 108 Lung Acquisition 109 Pancreas Acquisition 110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	10
106 Heart Acquisition	
106 Heart Acquisition	10
107 Liver Acquisition	10
109 Pancreas Acquisition	10
110 Intestinal Acquisition 111 Islet Acquisition 112 Other Organ Acquisition (specify)	10
111 Islet Acquisition 112 Other Organ Acquisition (specify)	10
112 Other Organ Acquisition (specify)	11
	11
	11
115 Ambulatory Surgical Center (Distinct Part)	11
116 Hospice	11
117 Other Special Purpose (specify)	11
200 Subtotal (see instructions)	20
201 Less Observation Beds	20
202 Total (see instructions)	20

12 22			1 ORWI CIVIS 2332 10			1070 (Cont.)
CALCULATION OF OUTPATIE	ENT SERVICE COST TO	0		PROVIDER CCN:	PERIOD:	WORKSHEET C,
CHARGE RATIOS NET OF REL	OUCTIONS FOR MEDI	CAID ONLY			FROM	PART II
					ТО	
Check applicable box:	[] Title V	[] Title XIX				

Cost Center Descriptions		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
	ANCILLARY SERVICE COST CENTERS		<u> </u>	3	7	,	0	,	8	-
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Prgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
	Speech Pathology									68
69	Electrocardiology									69
	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
74	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78

4090 (C	ont.)			FORM CMS-2552-10								
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY									PROVIDER CCN:	PERIOD: FROM	WORKSHEET C. PART II (CONT.)	
										TO		
Check appl	licable box:	[] Title V	[] Title XIX									
Cost Center Descriptions			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction 4	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)		
OI	UTPATIENT SERVIO	CE COST CENTERS		•	-			3		,	Ü	
88 Rural Health Clinic (RHC)										88		
	89 Federally Qualified Health Center (FQHC)											89
	90 Clinic											90
	mergency											91
	bservation Beds (see	instructions)										92
93 O	ther Outpatient Service	ce (specify)										93
93.99 Pa	93.99 Partial Hospitalization Program											93.99
0	THER REIMBURSAI	BLE COST CENTERS	3									
94 H	94 Home Program Dialysis											94
95 A	95 Ambulance Services											95
96 D	96 Durable Medical Equipment-Rented											96
97 D	urable Medical Equip	ment-Sold			_							97
	98 Other Reimbursable (specify)				_							98
99 O	99 Outpatient Rehabilitation Provider (specify)											99

100 Intern-Resident Service (not appvd. tchng. prgm.)

101 Home Health Agency

105 Kidney Acquisition

106 Heart Acquisition

107 Liver Acquisition

108 Lung Acquisition

111

116 Hospice

109 Pancreas Acquisition

110 Intestinal Acquisition

Islet Acquisition

201 Less Observation Beds

112 Other Organ Acquisition (specify)

117 Other Special Purpose (specify)

202 Total (line 200 minus line 201)

115 Ambulatory Surgical Center (Distinct Part)

200 Subtotal (sum of lines 50 through 199)

102 Opioid Treatment Program

100

101

102

105

106

107

108

109

110

111

112

115

116

117

200

201

202

	TIONMENT OF INPATIENT ROUTINE E CAPITAL COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET D, PART I	
Check applicable boxes:	[] Title V	Demonstration	[]PPS []TEFRA						
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description INPATIENT ROUTINE SERVICE COST CENTER	1	2	3	4	5	6	7	
30	Adults & Pediatrics (General Routine Care)	3							30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30 through 199)								200

⁽A) Worksheet A line numbers

		ENT OF INPATIENT ANCILI TAL COSTS	LARY	PROVIDER CCN:	PERIOD:	WORKSHEET D PART II			
SERVIC	E CAPI	TAL COSTS				COMPONENT CCN:	FROM	— PART II	
						COMPONENT CCN:	ТО		
Check	1	[] Title V	[] Hospita	[] Subprovider	(Other)	[] PPS	<u> </u>		
applicab	le	[] Title XVIII, Part A	[] IPF	[] PARHM Der		[] TEFRA			
boxes:		Title XIX	[] IRF	[]	nonsuution	[] 12101			
			1	Capital					
				Related Cost	Total Charges	Ratio of Cost	Inpatient		
				(from Wkst. B	(from Wkst. C,	to Charges	Program	Capital Costs	
				Part II, col. 26)	Pt .I, col. 8)	(col .1 ÷ col. 2)	Charges	(col. 3 x col. 4)	
(A)		Cost Center Description		1	2	3	4	5	
	ANCIL	LARY SERVICE COST CEN	TERS						
50	Operat	ting Room							50
51	Recov	ery Room							51
52	Labor	Room and Delivery Room							52
53	Anesth	nesiology							53
54	Radiol	logy-Diagnostic							54
55	Radiol	logy-Therapeutic							55
56	Radioi	isotope							56
57	Compu	uted Tomography (CT) Scan							57
58	Magne	etic Resonance Imaging (MRI)							58
59	Cardia	c Catheterization							60
60	Labora	atory							60
61	PBP C	Clinical Laboratory Services-Prg	gm. Only						61
62	Whole	Blood & Packed Red Blood C	Cells						62
63	Blood Storing, Processing, & Transfusing								63
64	4 Intravenous Therapy								64
65	Respir	atory Therapy							65
66	Physic	al Therapy							66
67	Occup	ational Therapy							67
68	Speech	h Pathology							68
69	Electro	ocardiology							69
70	Electro	oencephalography							70
71		al Supplies Charged to Patients							71
72	Implar	ntable Devices Charged to Pation	ents						72
73	_	Charged to Patients							73
74		Dialysis							74
75		Non-Distinct Part)							75
76		Ancillary (specify)							76
77		eneic HSCT Acquisition				1	1		77
78		Γ-Cell Immunotherapy							78
		ATIENT SERVICE COST CEN	NTERS						
88		Health Clinic (RHC)							88
89									89
90									90
91	8 7								91
92		vation Beds							92
93		Outpatient Service (specify)							93
93.99		Hospitalization Program	ENTERDO						93.99
		R REIMBURSABLE COST CI	ENTERS						<u> </u>
94		Program Dialysis							94
95		lance Services							95
96		le Medical Equipment-Rented							96
97		le Medical Equipment-Sold							97
98	Other I	Reimbursable (specify)						-	98

⁽A) Worksheet A line numbers

								PROVIDER CCN:		V:	PERIOD FROM TO		WORKSHEET D, PART III	
Check applicab boxes:	le	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] PARHM Dei	monstration		[] PPS [] TEFRA [] Other			1				_1	
			Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1, 2, and 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center D		1A	1	2A	2	3	4	5	6	7	8	9	
30	Adults & Ped (General Rou													30
31	Intensive Car	re Unit												31
32	Coronary Car	re Unit												32
33	Burn Intensiv	ve Care Unit												33
34	Surgical Inter	nsive Care Unit												34
35	Other Special	l Care Unit (specify)												35
40	Subprovider	IPF												40
41	Subprovider	IRF												41
42	Subprovider	(Other)												42
43	Nursery													43
44	Skilled Nursi	ing Facility												44
45	Nursing Faci	lity												45
200	Total (sum of	f lines 30 through 199)												200

⁽A) Worksheet A line numbers

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY CE OTHER PASS-THROUGH COSTS						PROVIDER CCN:	PERIOD: FROM	WORKSHEET D, PART IV	
							COMPONENT CCN:	то	_	
Check applicab boxes:	[] Title V	[] SNF [] NF [] ICF/IID [] Swing-Bed S	SNF	[] PARHM Demon		[] PPS [] TEFRA [] Other	1		·	
		Non Physician Anesthetist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
	Operating Room									50
	Recovery Room									51
52	Labor room and Delivery Room									52
53										53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory ServPrgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Transfusing									63
64	Intravenous Therapy									64
65										65
	Physical Therapy									66
67										67
68	1 17									68
69	1 65									69
	Electroencephalography			.						70
	Medical Supplies Charged To Patients			.						71
	Implantable Devices Charged to Patients			.						72
73										73
74										74
75	1									75
	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78										78
	OUTPATIENT SERVICE COST CENTERS									,,,
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)			†		†			 	89
90				†		†			 	90
91				†		†			 	91
92									 	92
93										93
	Partial Hagnitalization Program									02 00

											(,
	MENT OF INPATIENT/OUTPA							PROVIDER CCN:	PERIOD:	WORKSHEET D,	
SERVICE OT	HER PASS THROUGH COSTS	S							FROM	PART IV (Cont.)	
								COMPONENT CCN:	TO	_	
Check	[] Title V	[] Hospital	[] SNF		[] PARHM Demoi	nstration	[] PPS				
applicable	[] Title XVIII, Part A	[] IPF	[] NF		[] PARHM CAH S	Swing-Bed SNF	[] TEFRA				
boxes:	Title XIX	[]IRF	[] ICF/IID				[] Other				
		[] Subprovider (Other)	[] Swing-Bed S	SNF							
								All		Total	
			Non	Nursing		Allied		Other		Outpatient	
			Physician	Program		Health		Medical	Total cost	Cost	
			Anesthetist	Post-Stepdown	Nursing	Post-Stepdown	Allied	Education	(sum of cols. 1, 2	(sum of cols. 2,	
			Cost	Adjustments	Program	Adjustments	Health	Cost	3, and 4)	3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
OTH	ER REIMBURSABLE COST C	ENTERS									
94 Hom	ne Program Dialysis										94
95 Amb	oulance Services										95
96 Dura	ble Medical Equipment-Rented										96
97 Dura	ble Medical Equipment-Sold										97
98 Othe	r Reimbursable (specify)										98
200 Tota	l (sum of lines 50 through 199)										200

⁽A) Worksheet A line numbers

	THONMENT OF INPATIENT/OUTPATIENT ANCILLARY CE OTHER PASS THROUGH COSTS					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET D, PART IV (Cont.)	
Check applicat boxes:	[] Title V	SNF	[] PARHM Demon		[] PPS [] TEFRA [] Other				
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Delivery Room and Labor Room								52
53									53
54									54
55	Radiology-Therapeutic								55
56									56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory ServPrgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63									63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67									67
68	Speech Pathology								68
69	Electrocardiology								69
70									70
	Medical Supplies Charged To Patients								71
	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	· ·								74
75									75
	Other Ancillary (specify)								76
	Allogeneic HSCT Acquisition								77
78	CAR T-Cell Acquisition								78
	OUTPATIENT SERVICE COST CENTERS								
	Rural Health Clinic (RHC)					1			88
	Federally Qualified Health Center (FQHC)					1			89
90									90
91									91
92						1			92
93									93
0.3 00	Partial Hognitalization Program		1						03 00

07-23				1 (JICIVI CIVID-2332	-10				TU/U ((Cont.)
APPORTION	NMENT OF INPATIENT/OUTP	ATIENT ANCILLARY						PROVIDER CCN:	PERIOD:	WORKSHEET D,	
SERVICE O	THER PASS THROUGH COST	S							FROM	PART IV (Cont.)	
								COMPONENT CCN:	TO		
Check	[] Title V	[] Hospital	[] SNF		[] PARHM Demon	stration	[] PPS				
applicable	[] Title XVIII, Part A	[] IPF	[] NF		[] PARHM CAH S	wing Bed-SNF	[] TEFRA				
boxes:	[] Title XIX	[] IRF	[] ICF/IID				[] Other				
		[] Subprovider (Other)	[] Swing-Bed S	NF							
,								Inpatient		Outpatient	
						Outpatient		Program		Program	
				Total	Ratio	Ratio		Pass-		Pass-	
				Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
				(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
				Part I, col. 8)	(col. 5 ÷ col. 7)	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A)	Cost Center Description			7	8	9	10	11	12	13	
OTI	HER REIMBURSABLE COST C	CENTERS									
94 Hor	ne Program Dialysis										94
95 Am	bulance Services										95
	rable Medical Equipment-Rented	1									96
97 Dur	rable Medical Equipment-Sold										97
98 Oth	er Reimbursable (specify)										98
200 Tot	al (sum of lines 50 through 199)										200

⁽A) Worksheet A line numbers

4090 (1	COIII.)		FOI	KIVI CIVIS-233	2-10				07-23
APPORT	IONMENT OF MEDICAL AND OTHER				PROVIDER CCN:	PERIO	D:	WORKSHEET D.	
HEALTH	I SERVICES COSTS					FROM		PART V	
					COMPONENT CO	N: TO			
Check	[] Title V - O/P [] Hospita	ıl	[] Subprovide	er (Other)	[] Swing-Bed SN		RHM Demonstration		
applicabl	e [] Title XVIII, Part B [] IPF		[] SNF		[] Swing-Bed NF	[] PA	RHM CAH Swing-	Bed SNF	
boxes:	[] Title XIX - O/P [] IRF		[] NF		[] ICF/IID				
PART V	- APPORTIONMENT OF MEDICAL AND OTH	HER HEALTH	SERVICES COST	S					
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	1
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	1
	ANCILLARY SERVICE COST CENTERS								
	Operating Room								50
	Recovery Room								51
	Labor & Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope	1		1	† †		1	 	56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
	Laboratory								60
	PBP Clinical Laboratory ServPrgm. Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Transfusing								63
	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged To Patients								71
	Implantable Devices Charged to Patients								72
	Drugs Charged to Patients								73
	Renal Dialysis			1	 		1	 	74
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)	1		1	 		1	 	76
	Allogeneic HSCT Acquisition	1							77
	CAR T-Cell Immunotherapy	1							78
	OUTPATIENT SERVICE COST CENTERS								
	Rural Health Clinic (RHC)								88
	Federally Qualified Health Center (FQHC)								89
	Clinic				 				90
	Emergency	1			 			 	90
	Observation Bed	1		 	 		 	 	92
	Other Outpatient Service (specify)	1		 	 		 	 	93
		1		1	 		1		
	Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS								93.99
	Home Program Dialysis								94
	Ambulance	1			1				94
	Durable Medical Equipment-Rented	1			 				95
	Durable Medical Equipment-Rented Durable Medical Equipment-Sold	1		1	 		1		96
	Other Reimbursable Cost Center	1		1	 		1	 	98
	Subtotal (see instructions)				-				200
									
	Less PBP Clinic Lab. Services-Program			I	I		I		201
	Only Charges Net Charges (line 200 - line 201)				 			 	202
202	THE CHAIGES (THE 200 - THE 201)		i	1			1		202

30

31

32 33

34

35

36

Semi-private room charges (excluding swing-bed charges)

Average private room per diem charge (line 29 ÷ line 3)

34

36

31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)

Average per diem private room cost differential (line 34 x line 31)

Average per diem private room charge differential (line 32 minus line 33) (see instructions)

General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)

Average semi-private room per diem charge (line 30 ÷ line 4)

Private room cost differential adjustment (line 3 x line 35)

4090 (Cont.)	FORM CN	MS-2552-10				07-23
COMPU	TATION OF INPATIENT			PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERA?	TING COST				FROM	PART II	
				COMPONENT CCN:	ТО		
Check	[] Title V - I/P [] Hos	pital [] PARI	HM Demonstration	[] PPS			
applicab	le [] Title XVIII, Part A [] IPF			[] TEF	RA		
boxes:	[] Title XIX - I/P [] IRF			[] Othe	r		
	[] Sub	provider (other)					
	- HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE						
	PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see	e instructions)					38
39	Program general inpatient routine service cost (line 9 x line						39
40	Medically necessary private room cost applicable to the Prog	gram (line 14 x line 35)					40
41	Total Program general inpatient routine service cost (line 39) + line 40)					41
				Average			
		Total	Total	Per Diem	Program	Program Cost	
		Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2)	Days	(col. 3 x col. 4)	
		1	2	3	4	5	
	Nursery (title V & XIX only)						42
	Intensive Care Type Inpatient						
	Hospital Units						
	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, co						48
48.01	Program inpatient cellular therapy acquisition cost (Worksho	eet D-6, Part III, line 10, column 1)					48.01
49	Total Program inpatient costs (sum of lines 41 through 48.0	1) (see instructions)					49
	PASS-THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program inpatient routine s						50
51	Pass through costs applicable to Program inpatient ancillary	services (from Worksheet D, sum o	of Parts II and IV)				51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital rela	ated, nonphysician anesthetist, and	medical education costs	(line 49 minus line 52)			53
	TARGET AMOUNT AND LIMIT COMPUTATION					T	
	Program discharges						54
55	Target amount per discharge						55
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
56	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						56
57	Difference between adjusted inpatient operating cost and tar	iget amount (line 36 minus line 53)					57
58 59	Bonus payment (see instructions)	a cost somewhat a maried and in 1000		ad britta med-ette-1 - A			58 59
_	Trended costs (lesser of line 53 ÷ line 54, or line 55 from th			eu oy ine market basket)			_
60	Expected costs (lesser of line 53 ÷ line 54, or line 55 from p			lina 60 anta: 41 - 1	£500/ aft.		60
61	Continuous improvement bonus payment (if line 53 ÷ line 5						61
62	amount by which operating costs (line 53) are less than experience Relief payment (see instructions)	celeu costs (titles 34 x 60), or 1 % 61	i ine target amount (tine 3	o, omerwise enter zero.	(see instructions)		62
	Allowable Inpatient cost plus incentive payment (see instruc-	ations					62
63	Anowabie inpatient cost plus incentive payment (see instru	CHOHS					63
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
		and a second a second and a second a second and a second	iad (ass instructions)				64
64	Medicare swing-bed SNF inpatient routine costs through De	control of the cost reporting peri	iou (see instructions)				04
- 45	(title XVIII only) Medicare swing-bed SNF inpatient routine costs after Decer	nhar 21 of the gost remarking a reliable	(con instructions)			_	65
65	(title XVIII only)	noer 51 of the cost reporting period	(see instructions)				0.5
66	Total Medicare swing-bed SNF inpatient routine costs (line	64 plus lina 65) (titla VVIII ambu fa	r CAU con instructions)				66
67	Title V or XIX swing-bed NF inpatient routine costs through)			67
68	Title V or XIX swing-bed NF inpatient routine costs through	1 2		,			68
60	Total title V or XIX swing-bed NF inpatient routine costs after D		noa (mie 13 x mie 20)			+	69

01-22			FORM CMS-25:	52-10		4090 ((Cont.)
	TATION OF INPATIENT TING COST			PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET D-1, PARTS III & IV	
Check applicab boxes:	[] Title V - I/P [] Title XVIII, Part A [] Title XIX - I/P	[] Hospital [] IPF [] IRF [] Subprovider (Ot	[] SNF [] NF	[]	ICF/IID	[] PPS [] TEFRA [] Other	
PART II	II - SNF, NF, AND ICF/IID ONLY						=
70	SNF / NF / ICF/IID routine service cost (I	ine 37)					70
71	Adjusted general inpatient routine service	cost per diem (line 70 ÷ line	2)				71
72	Program routine service cost (line 9 x line	71)					72
73	Medically necessary private room cost app	olicable to Program (line 14 x	x line 35)				73
74	Total Program general inpatient routine se	rvice costs (line 72 + line 73)				74
75	Capital-related cost allocated to inpatient	routine service costs (from W	Vorksheet B, Part II, colum	nn 26, line 45)			75
76	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
77	Program capital-related costs (line 9 x line	76)					77
78	Inpatient routine service cost (line 74 minu	us line 77)					78
79	Aggregate charges to beneficiaries for exc	ess costs (from provider reco	ords)				79
80	Total Program routine service costs for co	mparison to the cost limitation	on (line 78 minus line 79)				80
81	Inpatient routine service cost per diem lim	itation					81
82	Inpatient routine service cost limitation (li	ne 9 x line 81)					82
83	Reasonable inpatient routine service costs	(see instructions)					83
84	Program inpatient ancillary services (see i	nstructions)					84
85	Utilization review - physician compensation	n (see instructions)					85
86	Total Program inpatient operating costs (s	um of lines 83 through 85)					86
PART I	V - COMPUTATION OF OBSERVATION	BED PASS-THROUGH C	OST				
87	Total observation bed days (see instruction	ns)					87
88	Adjusted general inpatient routine cost per	diem (line 27 ÷ line 2)					88
89	Observation bed cost (line 87 x line 88) (s	see instructions)					89
	COMPUTATION OF OBSERVATION B	ED PASS THROUGH COS	T				
		Cost 1	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
90	Capital-related cost						90
91	Nursing Program cost						91
92	Allied Health cost						92
93	All other Medical Education						93

Rev. 17 40-575

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

	I - NOT IN APPROVED TEACHING PROGRAM	ı	Percent of	Expense	Total Inpatient Days
	Cost Centers		Assigned Time	Allocation	All Patients
	Cost Centers	-	Assigned Time	Allocation 2	All Fatients
1	Total cost of services rendered		100.00		3
1	Hospital Inpatient Routine Services:		100.00		
2					
3	Intensive care unit				
4					
5	<u>, </u>				
6					
7	Other Special Care (specify)				
8					
9					
10					
11	1				
12	*				
13					
14	ė į				
15	,				
16	· ·				
17					
18	*				
19					
20	1				
	· · · · · · · · · · · · · · · · · · ·				Total Charges
					(from Wkst. C, Pt. I,
					col. 8, lines 88
	Hospital Outpatient Services:				through 93)
21					,
22					
23					
24					
25					
26	Other Outpatient Service (specify)				
27	Subtotal (sum of lines 21 through 26)				
28	Total (sum of lines 20 and 27)		100.00		
RT I	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B IN	PATIENT ROUTINE CO	OSTS ONLY)		
			Expenses Allocated		
			Expenses Allocated to cost centers		
			•	Swing Bed	Net Cost
			to cost centers	Swing Bed Amount	Net Cost (col. 1 plus col. 2)
	Hospital Inpatient Routine Services:	-	to cost centers on Wkst. B, Pt. I		
29			to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
29	Adults & Pediatrics (general routine care)		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify)		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36)		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38 39	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38 39 40 41	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility		to cost centers on Wkst. B, Pt. I	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38 39 40 41 42	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)		to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)
30 31 32 33 34 35 36 37 38 39 40 41 42	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2	(col. 1 plus col. 2) 3
30 31 32 33 34 35 36 37 38 39 40 41 42	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve	(col. 1 plus col. 2) 3 d Teaching Program
30 31 32 33 34 35 36 37 38 39 40 41 42	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I)	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 RT I	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1	(col. 1 plus col. 2) 3 d Teaching Program
30 31 32 33 34 35 36 37 38 39 40 41 42 RT I	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Not In Approve (from Part I) 1 col. 9, line 9	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 RT I	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient Outpatient	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 RT I	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 RT I	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 10	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 42 43 44 45	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 10 col. 9, line 11	d Teaching Program Amount
30 31 32 33 34 35 36 37 38 39 40 41 42 42 43 44 45 46	Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service	PARTS I AND II ARE	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 10	d Teaching Program Amount

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

DADTI	NOT IN A PROVED	TEACHING PROCES						
PARTI		TEACHING PROGRAM		- D	Title V	Title XVIII	Title XIX	
	Average Cost		h Care Program Inpatien					
	Per Day 4	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5) 8	(col. 4 x col. 6)	(col. 4 x col. 7) 10	4
1	4	5	6	/	8	9	10	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
19								19
20								20
20		Title	es V and XIX Outpatient	and	Titl	es V and XIX Outpatient	and	20
	Ratio of Cost		Fitle XVIII Part B Charge		110	Title XVIII Part B Cost	and	
	to Charges	Title	Title XVIII	Title	Title	Title XVIII att B cost	Title	1
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX	
21	(6011 2 6011 3)	·	Turb	7441	,	Turb	1111	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
PART II	- IN AN APPROVED	TEACHING PROGRAM	I (TITLE XVIII, PART I		IE COSTS ONLY)			
				Expenses				
	Total	Average Cost	Title XVIII	Applicable				
	Inpatient Days -	Per Day	Part B	to Title XVIII				
	All Patients 4	(col. 3 ÷ col. 4)	Inpatient Days 6	(col. 5 x col. 6)				1
29	4	3	Ü	/				29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42								42
PART II		TLE XVIII (TO BE CO			ARE USED)			
		eaching Program		XVIII Costs				ł
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				ł
43	3 line 37	4	5	6				43
43	11110 3 /							43
45			line 22					45
46	line 38		line 22					46
47	line 39		line 22					47
48	line 40		line 22					48

1070 (Cont.)		1 Oldivi C	1110 2332 10				01 23
INPATII	ENT ANCILLARY SERVICE				PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST A	PPORTIONMENT					FROM	-	
					COMPONENT CCN:	ТО		
Check	[] Title V	[] Hospital	[] SNF	[] ICF/IID		[] PPS		
applicab		[] IPF	[] NF	[] PARHM Den		[] TEFRA		
boxes:	[] Title XIX	[] IRF	[] Swing-Bed SNF	[] PARHM CAI	H Swing-Bed SNF	[] Other		
		[] Subprovider (Other)	Swing-Bed NF					
					D.: CC.	T .: .	t con co	
	COST CENTER DESCRIPTION	,			Ratio of Cost	Inpatient	Inpatient Program Cost	IS
	COST CENTER DESCRIPTION	4			to Charges	Program Charges	(col. 1 x col. 2)	4
(A)	DID ATTICLIT DOLUTING CERTIFIC	E COOT CENTERS			1	2	3	
	INPATIENT ROUTINE SERVICE							20
30	Adults and Pediatrics (General Ro	outine Care)						30
31	Intensive Care Unit							31
32	Coronary Care Unit							32
33	Burn Intensive Care Unit							33
34	Surgical Intensive Care Unit							34
35	Other Special Care (specify)							35
40	Subprovider IPF							40
41	Subprovider (Specify)					-		41
43	Subprovider (Specify) Nursery							43
	ANCILLARY SERVICE COST C	PENITEDO						43
		ENTERS						50
50 51	Operating Room Recovery Room				+	 		50
52	Labor Room and Delivery Room				.		+	52
	Anesthesiology							53
53	Radiology-Diagnostic							54
54 55	Radiology-Therapeutic						+	55
56	Radioisotope						+	56
57	Computed Tomography (CT) Sca	n					+	57
58	Magnetic Resonance Imaging (M						+	58
59	Cardiac Catheterization	KI)					+	59
60	Laboratory						+	60
61	PBP Clinical Laboratory Services	Darras Only						61
62	Whole Blood & Packed Red Bloo						+	62
63	Blood Storing, Processing, & Tra						+	63
64	Intravenous Therapy	115.						64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy						+	67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pati	ente						71
72	Implantable Devices Charged to I				 			72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)				†	 		75
76	Other Ancillary (specify)				†	 		76
77	Allogeneic HSCT Acquisition				1	†		77
78	CAR T-Cell Immunotherapy				1	i e		78
, 0	OUTPATIENT SERVICE COST	CENTERS					1	,,,
88	Rural Health Clinic (RHC)				1	I	I	88
89	Federally Qualified Health Center	r (FOHC)						89
90	Clinic	· · /			1	i e		90
91	Emergency							91
92	Observation Beds (see instruction	ns)			1	i e		92
93	Other Outpatient Service (specify							93
93.99	Partial Hospitalization Program	,						93.99
	OTHER REIMBURSABLE COST	Γ CENTERS						
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Ren	ted						96
97	Durable Medical Equipment-Sold				1	i e		97
98	Other Reimbursable (specify)				1	†		98
200	Total (sum of lines 50 through 94	and 96 through 98)				i		200
201	Less PBP Clinic Laboratory Servi		ine 61)			İ		201
	Net charges (line 200 minus line		· · · · · · · · · · · · · · · · · · ·					202

(A) Worksheet A line numbers

v · = v			•		(/		
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES			PROVIDER CCN:	PERIOD:	WORKSHEET D-4,			
FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED				FROM	PART I			
TRANSPLANT PROGRAM			OPO CCN:	TO				
Check [] HEART [] LIVER [] PANCE	EAS []	ISLET						
applicable box: [] KIDNEY [] LUNG [] INTEST	INE							
PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)								
	Inpatient			Organ				
Computation of Inpatient	Routine Organ		Per Diem Costs	Acquisition	Cost			
Routine Service Costs	Charges	(from Wkst. D-1, Part II)	Days	(col. 2 x col. 3)			
Applicable to Organ Acquisition	1	D	2	3	4	1		
1 Adults and Pediatrics		38				1		
2 Intensive Care		43				2		
3 Coronary Care		44				3		
4 Burn Intensive Care Unit		45				4		
5 Surgical Intensive Care Unit		46				5		
6 Other Special Care (specify)		47				6		
7 TOTAL (sum of lines 1 through 6)						7		

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

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED		FROM	PART II	
TRANSPLANT PROGRAM	OPO CCN:	TO		
Check [] HEART [] LIVER [] PANCREAS [] ISLET				
applicable box: [] KIDNEY [] LUNG [] INTESTINE				
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE A	AND			
ANCILLARY SERVICE COSTS)				
	Average Cost		Organ	
Computation of the Cost of Inpatient	Per Day		Acquisition	
Services of Interns and Residents Not	(from Wkst. D-2,	Organ	Costs	
In Approved Teaching Program	Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)	i
	D 1	2	3	i
42 Adults & Pediatrics (General routine care)	2			42
43 Intensive Care Unit	3			43

	Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program		fr	Ratio of Cost to Charges com Wkst. D-2, Part I, col. 4)	Organ Acquisition Costs (col. 1 x col. 2)	
		(see instructions)	D	2	3	1
49	Rural Health Clinic (RHC)		21			49
50	Federally Qualified Health Center (FQHC)		22			50
51	Clinic		23			51
52	Emergency		24			52
53	Observation Beds		25			53
	Other Output Couries (onesity)		26			5.4

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

55 TOTAL (sum of lines 49 through 54)

44 Coronary Care Unit
45 Burn Intensive Care Unit
46 Surgical Intensive Care Unit
47 Other Special Care (specify)
48 TOTAL (sum of lines 42 through 47)

03-23	FORM CN	AS-2552-10			4090) (Cont.)
COMPU	JTATION OF ORGAN ACQUISITION COSTS AND CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR A	TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED			FROM	PARTS III & IV	
TRANS	PLANT PROGRAM		OPO CCN:	ТО		
Check	[]HEART []LIVER []PANCREAS	[] ISLET	1			
applicat		[]ISEE1				
	II - SUMMARY OF COSTS AND CHARGES					
			Cost	C	Charges	Т
		Part A	Part B	Part A	Part B	_
		1	2	3	4	7
56	Routine and ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct organ acquisition (see instructions)					59
60	Cost of physicians' services in a teaching hospital (see instructions)					60
61	Total (see instructions)					61
			Usable Organs			
		1	2	3	4	
62	Total usable organs (see instructions)					62
63	Medicare usable organs (see instructions)					63
64	Ratio of Medicare usable organs to total usable organs (see instructions)					64
		_	Cost		1	
		D A			harges	_
		Part A	Part B	Part A	Part B 4	_
65	Medicare Cost and Charges (see instructions)	1	2	3	4	65
66	Revenue for organs sold (see instructions)	+				66
66.01	Partial primary payor amounts applicable to organ acquisition	 			_	66.01
66.02	Partial primary payor amounts applicable to transplants (informational only)					66.02
67	Subtotal (see instructions)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)				+	69
- 0,	The organization cost and charges (see modulous)	1				- 07
PARTI	V - STATISTICS					
			Living Related	Cadaveric	Revenue	
			1	2	3	
70	Organs excised in provider (1)					70
71	Organs purchased from other transplant hospitals (2)					71
72	Organs purchased from non-transplant hospitals					72
73	Organs purchased from OPOs (see instructions)					73
74	Total (sum of lines 70 through 73)					74
75	Organs transplanted					75
75.01	Organs transplanted into Medicare beneficiaries					75.01
75.02	Kidneys transplanted into MA beneficiaries					75.02
75.03	Organs transplanted, Medicare secondary payer					75.03
75.04	Organs transplanted, Other (see instructions)					75.04
76	Organs sold to other hospitals					76
77	Organs sold to OPOs		-		4	77
78	Organs sold to transplant hospitals			+	+	78
79	Organs sold to MRTC without an agreement or VA hospitals			-	+	79
79.01	Kidneys sold to MRTC with an agreement		_	+	+	79.01
80	Organs sold outside the U.S. Organs sent outside the U.S. (no revenue received)		+	+	+	80 81
82	Organs sent outside the U.S. (no revenue received) Organs used for research		+	+		82
83	Unusable/Discarded organs (see instructions)			+		83
84	Total (see instructions)			+		84
	()					0.1

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

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

APPOR	ORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL					PROVIDER CCN: PERIOD: WORKS FROM PART I TO		VORKSHEET D-5, PART I	
Check a	pplicable box: [] Hospital Staff [] Medical Staff								
PART I	- REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIOD:	S ENDING BEFORE JUNE 3	0, 2014						
Line No.	Specialty Description/Physician Identifier	Total Remuneration	Professional Component	RCE Amount 5	Physician/ Professional Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit 8		
1	General Practitioner Family Practice	3	7	3	0	'	0	1	
	Internal Medicine					+		2	
	Surgery					+		3	
	Pediatrics					+		4	
	Obstetrics-Gynecology							5	
	Radiology		 			+		6	
	Psychiatry							7	
	Anesthesiology					†		8	
9	Pathology							9	
	All Other					1		10	
11	Total					†		11	
		-				-	•		
Line No.	Specialty Description/Physician Identifier 10	Cost of Membership & Continuing Education	Professional Component Share of col. 11	Cost of Physician Malpractice Insurance	Professional Component Share of col. 13	Adjusted RCE Limit	Adjust Cost of Physician's Direct Medical & Surgical Services		
1	General Practitioner Family Practice							1	
	Internal Medicine							2	
	Surgery							3	
	Pediatrics							4	
	Obstetrics-Gynecology							5	
	Radiology							6	
	Psychiatry							7	
	Anesthesiology							8	
	Pathology							9	
	All Other					<u> </u>		10	
1.1	Total (transfer the amount in column 16 line 11 to Bort II line 1 column 1 or 2 or annumists)	1						1.1	

09-14	FORM	CMS-2552-10	4090 (Cont.)		
APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPIT	ΓAL PI	ROVIDER CCN:	PERIOD:	WORKSHEET D-5,
				FROM	PART II
				ТО	_
Check	[] Hospital				-
applicat					
box:	[] IRF				
PART I	I - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHIN	IG HOSPITAL FOR CO	ST REPORTING P	ERIODS ENDING BEF	ORE JUNE 30, 2014
				Medical School	Total
			Hospital Staff	Faculty	(col 1 + col 2)
			1	2	3
1	Adjusted Cost of Physician's Direct Medical and Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days				2
3	Average Per Diem (line 1 ÷ line 2)				3
				· I	•
	HEALTH CARE PROGRAM REIMBURSABLE DAYS				
4					4
5	Title V - Outpatient				5
6	<u> </u>				6
7	Title XVIII - Part B				7
8	Title XIX - Inpatient				8
9	Title XIX - Outpatient				9
10	Inpatient and Outpatient Kidney Acquisition				10
11	Inpatient and Outpatient Liver Acquisition				11
12	Inpatient and Outpatient Heart Acquisition				12
13	Inpatient and Outpatient Lung Acquisition				13
14	Inpatient and Outpatient Pancreas Acquisition				14
15	Inpatient and Outpatient Intestine Acquisition				15
16	Inpatient and Outpatient Islet Acquisition				16
17	Other Organ Acquisition				17
				<u> </u>	•
	HEALTH CARE PROGRAM REIMBURSABLE COST				
18	Title V - Inpatient (line 3 x line 4)				18
19	Title V - Outpatient (line 3 x line 5)				19
20	Title XVIII - Part A (line 3 x line 6)				20
21	Title XVIII - Part B (line 3 x line 7)				21
22	Title XIX - Inpatient (line 3 x line 8)				22
23	Title XIX - Outpatient (line 3 x line 9)				23
24	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)				24
25	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)				25
26	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)				26
27	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)				27
28	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)				28
29	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)				29
30	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)				30
31	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)				31
	Transfer the amounts in column 3 as follows:				7
	Add lines 18 and 19, and transfer to Worksheet E-3, Part VII				1
	Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate				1
	Line 21 to Worksheet E, Part B				1

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

TU) U (Com.,		1 Oldvi Civib-2332	-10					07-17
APPOR	ΓΙΟΝΜΕΝΤ	OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET D-5, PART III	
							4	<u> </u>	
PART II	I - REASON	ABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIOD	S ENDING ON OR AFTER	JUNE 30, 2014					
	Wkst. A		Total	Professional	RCE	Physician/ Professional	Unadjusted	5 Percent of Unadjusted	
	Line #	Cost Center / Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total							200
		_							
			Cost of		Cost of			Adjust Cost	
			Membership	Professional	Physician	Professional		of Physician's	
	Wkst. A		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
	Line #	Cost Center / Physician Identifier	Education	Share of Column 11	Insurance	Share of Column 13	RCE Limit	Surgical Services	
1	9	10	11	12	13	14	15	16	1
2							 		1 2
3							 	_	3
4									4
5							 		5
6							 		6
7							-		7
8							 		8
9				1			† 	+	9
10				+		+	 	+	10
200		Total (transfer the amount in column 16, line 200, to Part IV, line 1)					 		200

APPORT	IONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET D-5, PART IV
Check	[] Hospital		10	
applicable				
box:	[] IRF			
PART IV	- APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPIT	AL FOR COST REPORTING	PERIODS ENDING	ON OR AFTER JUNE 30, 2014
1	Adjusted cost of physicians' direct medical and surgical services			1
2	Total inpatient days and outpatient visit days			2
3 .	Average per diem (line 1 ÷ line 2)			3
	HEALTH CARE PROGRAM REIMBURSABLE DAYS			
	Title V - Inpatient			4
	Title V - Outpatient			
	Title XVIII - Part A			6
	Title XVIII - Part B			3
	Title XIX - Inpatient			3
	Title XIX - Outpatient			9
	Inpatient and outpatient kidney acquisition Inpatient and outpatient liver acquisition			10
	Inpatient and outpatient liver acquisition			12
	Inpatient and outpatient lung acquisition			13
	Inpatient and outpatient rung acquisition			12
	Inpatient and outpatient pancreas acquisition			15
	Inpatient and outpatient intestine acquisition			10
17	inpatient and outpatient isiet acquisition			17
	Inpatient allogeneic HSCT acquisition			17.01
	Outpatient allogeneic HSCT acquisition			17.02
17102	outputer unogenere rise rue quistion			17102
	HEALTH CARE PROGRAM REIMBURSABLE COST			
	Title V - Inpatient (line 3 x line 4)			18
	Title V - Outpatient (line 3 x line 5)			19
	Title XVIII - Part A (line 3 x line 6)			20
21	Title XVIII - Part B (line 3 x line 7)			21
22	Title XIX - Inpatient (line 3 x line 8)			22
23	Title XIX - Outpatient (line 3 x line 9)			23
24	Inpatient and outpatient kidney acquisition (line 3 x line 10)			24
25	Inpatient and outpatient liver acquisition (line 3 x line 11)			25
	Inpatient and outpatient heart acquisition (line 3 x line 12)			26
	Inpatient and outpatient lung acquisition (line 3 x line 13)			27
	Inpatient and outpatient pancreas acquisition (line 3 x line 14)			28
	Inpatient and outpatient intestine acquisition (line 3 x line 15)			29
	Inpatient and outpatient islet acquisition (line 3 x line 16)			30
31				31
	Inpatient allogeneic HSCT acquisition (line 3 x line 17.01)			31.01
31.02	Outpatient allogeneic HSCT acquisition (line 3 x line 17.02)			31.02

Transfer amounts as follows:

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

Enie 20 to Worksheet E-3, Part II, line 3 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF);

Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (cost reimbursement)

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

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

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

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

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

ND ANCILLARY SERV Routine Service Acquisition Charges 1	D-1 38 43 44 45 46 47	Per Diem Costs (see instructions) 2 Ratio of Cost	JISITION COSTS Inpatient Acquisition Days 3	Acquisition Costs (col. 2 x col. 3) 4	PERIOD: FROMTO	WORKSHEET D-6, PARTS I & II	1 2 3 4 5
ND ANCILLARY SERV Routine Service Acquisition Charges 1	D-1 38 43 44 45 46 47	Per Diem Costs (see instructions)	Inpatient Acquisition Days 3	Acquisition Costs (col. 2 x col. 3)			2 3 4 5
Routine Service Acquisition Charges 1	D-1 38 43 44 45 46 47	Per Diem Costs (see instructions)	Inpatient Acquisition Days 3	(col. 2 x col. 3)			2 3 4 5
Routine Service Acquisition Charges 1	D-1 38 43 44 45 46 47	Per Diem Costs (see instructions)	Inpatient Acquisition Days 3	(col. 2 x col. 3)			2 3 4 5
Routine Service Acquisition Charges 1	D-1 38 43 44 45 46 47	Per Diem Costs (see instructions)	Inpatient Acquisition Days 3	(col. 2 x col. 3)			2 3 4 5
Acquisition Charges 1	D-1 38 43 44 45 46 47	(see instructions) 2	Acquisition Days 3	(col. 2 x col. 3)			2 3 4 5
Charges 1	38 43 44 45 46 47	2	Days 3	(col. 2 x col. 3)			2 3 4 5
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	38 43 44 45 46 47	2	3				2 3 4 5
16)	43 44 45 46 47	Ratio of Cost	Inpatient				2 3 4 5
16)	43 44 45 46 47	Ratio of Cost	Inpatient				2 3 4 5
16)	44 45 46 47	Ratio of Cost	Invatient				3 4 5
16)	46 47	Ratio of Cost	Invatient				5
16)	47	Ratio of Cost	Inpatient				5
16)	47	Ratio of Cost	Inpatient				
n 6)		Ratio of Cost	Inpatient				
	(6	Ratio of Cost	Inpatient	1			7
sts	(fi	Ratio of Cost	Inpatient				
sts	(6	Ratio of Cost		Outpatient	Inpatient	Outpatient	$\overline{}$
sts	(fi		Ancillary Services	Ancillary Services	Ancillary Services	Ancillary Services	1
sts	(fi	to Charges	Acquisition	Acquisition	Acquisition	Acquisition	1
sts		rom Wkst. C, Pt. I, col. 9)	Charges		Cost	Cost	
513	C	rom WKst. C, Pt. 1, col. 9)	Charges 2	Charges 3	Cost 4	Cost 5	4
	50	1	4	3	4	+ 3	8
	51					 	9
om	52						10
om	53						
						 	11
						 	12
							13
						<u> </u>	14
						<u> </u>	15
g (MRI)							16
							17
							18
							19
							20
& Transfusing							21
							22
							23
Patients	71						24
	73						25
	75						26
	76						27
	90						28
n 28)							30
er to	T) Scan ing (MRI) ervices-Program Only ed Blood Cells & Transfusing to Patients	54 55 55 56 77) Scan 57 T) Scan 57 ing (MRI) 58 59 60 ervices-Program Only 61 ed Blood Cells 62 & Transfusing 63 64 69 to Patients 71 73 75 76	54 55 55 56 77) Scan 57 ing (MRI) 58 59 60 ervices-Program Only 61 ed Blood Cells 62 & Transfusing 63 64 69 to Patients 71 73 75 76	54	54	54	54

1 Number of recipients intended for allogeneic HSCT where the acquisition cost was incurred but the transplant did not occur (see instructions)

PART IV - STATISTICS

Rev. 21 40-583.4

	JLATION OF REIMBURSEMENT EMENT	PROVIDER CCN:	PERIOD: FROM	WORKSHEET E, PART A	
		COMPONENT CCN:	TO		
GL 1	E II I				
	applicable box: [] Hospital [] PARHM Demonstration A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1	DRG amounts other than outlier payments				1
	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instr	ructions)			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see in	structions)			1.04
2	Outlier payments for discharges (see instructions)				2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)				2.03
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)				4
	Indirect Medical Education Adjustment Calculation for Hospitals			•	-
_	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/3	1/1996 (see instructions)			5
	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)				5.01
6	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in		.413.79(e)		6
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 20. MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)	21 (see instructions)			6.26
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report s	traddles July 1, 2011, see	instructions.		7.01
_	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with		7.02		
	programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in	n accordance			8
	with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				<u> </u>
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report stradd		ctions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of AC The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	A. (see instructions)			8.02 8.21
9	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus	s/minus line 8.			9
-	plus lines 8.01 through 8.27 (see instructions)				
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs			11	
12	Current year allowable FTE (see instructions)			12	
13	Total allowable FTE count for the prior year Total allowable FTE count for the growtingto year if that year anded on on offen September 20, 1007, otherwise and			13 14	
15	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise ente Sum of lines 12 through 14 divided by 3	i zeio.			15
16	Adjustment for residents in initial years of the program (see instructions)				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21 22
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)				22.01
22.01	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA			L	22.01
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27 28
28.01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment			•	-
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30
31	Percentage of Medicaid patient days to total patient days (see instructions)				31
32	Sum of lines 30 and 31 Allowable dispreparationate share percentage (see instructions)				32 33
34	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)				34
JT	Uncompensated Care Payment Adjustment		Prior to October 1	On or after October 1	- 54
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)				35.02
_	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		ļ		35.03
	Pro rata share of the MDH's UCP, including supplemental UCP (see instructions) Pro rata share of the SCH's UCP, including supplemental UCP (see instructions)		 		35.04 35.05
36					35.03

07-23	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT			FROM	PART A (Cont.)
		COMPONENT CCN:	TO	
		-		
Check applicable box: [] Hospital [] PARHM Demonstration				

	COMPONENT CCN: TO	1
Check a	applicable box: [] Hospital [] PARHM Demonstration	
	pprocess one of the proposed of the process of the	
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)	
40	Total Medicare discharges (see instructions)	40
41	Total ESRD Medicare discharges (see instructions)	41
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	42
43	Total Medicare ESRD inpatient days (see instructions)	43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	44
45	Average weekly cost for dialysis treatments (see instructions)	45
46	Total additional payment (line 45 times line 44 times line 41.01)	46
47	Subtotal (see instructions)	47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	48
49	Total payment for inpatient operating costs (see instructions)	49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)	50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions) Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).	52
		53
53	Nursing and allied health managed care payment Special add-on payments for new technologies	54
54.01	Islet isolation add-on payment	54.01
55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)	55
55.01	Cellular therapy acquisition cost (see instructions)	55.01
56	Cost of physicians' services in a teaching hospital (see instructions)	56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35)	57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	58
59	Total (sum of amounts on lines 49 through 58)	59
60	Primary payer payments	60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	61
62	Deductibles billed to program beneficiaries	62
63	Coinsurance billed to program beneficiaries	63
64	Allowable bad debts (see instructions)	64
65	Adjusted reimbursable bad debts (see instructions)	65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)	68
70	Other adjustments (specify) (see instructions)	70
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	70.50
70.75	N95 respirator payment adjustment amount (see instructions)	70.75
70.73	Demonstration payment adjustment amount before sequestration	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	70.91
70.92	Bundled Model 1 discount amount (see instructions)	70.92
70.93	HVBP payment adjustment amount (see instructions)	70.93
70.94	HRR adjustment amount (see instructions)	70.94
70.95	Recovery of accelerated depreciation	70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)	70.97
70.99	HAC adjustment amount (see instructions)	70.99
71	Amount due provider (see instructions)	71
71.01	Sequestration adjustment (see instructions)	71.01
71.02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	71.02 71.03
71.03	Sequestration adjustment-raktrial pass-unroughs Interim payments	72
72.01	Interim payments-PARHM	72.01
73	Tentative settlement (for contractor use only)	73
73.01	Tentative settlement. PARHM (for contractor use only)	73.01
74	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)	74
74.01	Balance due provider/program-PARHM (see instructions)	74.01
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	75

.0,0	(2011.)				0, 20
CALC	ULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTI	EMENT		FROM	PART A	
		COMPONENT CCN:	TO		
	applicable box: [] Hospital [] PARHM Demonstration				
PART	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90					90
91	1 , ,				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)				101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)				103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y	" for yes or "N" for no.			200
	Cost Reimbursement	,			
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201
202					202
203	Case-mix adjustment factor (see instructions)				203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstra	ation period)			
204		F)			204
205	Case-mix adjusted target amount (line 203 times line 204)				205
206	Medicare inpatient routine cost cap (line 202 times line 205)				206
	Adjustment to Medicare Part A Inpatient Reimbursement				200
207					207
208	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208
209	Adjustment to Medicare IPPS payments (see instructions)				209
210					210
211					211
211	Comparison of PPS versus Cost Reimbursement			l	211
212	1				212
213	Low-volume adjustment (see instructions)				212
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus l	lina 212) (can instructions)			213
218	inci incuicate rati A irro adjustiticit (difference between PPS and cost reimbursement) (line 212 minus i	ime 215) (see instructions)		I	218

This page is reserved for future use.

CALCU	LATION O				TOTAL CIVIS 2332 TO	PROVIDER CCN:	PERIOD:	WORKSHEET E,	07 23
KEIMB	UKSEMEN	NT SETTLEMENT				COMPONENT CCN:	FROM TO	PART B	
Check applicab			[] Subprovider (Other) [] SNF						
box:] IRF	PARHM Demonstrat	ion					
PART B	•	AL AND OTHER HE	ALTH SERVICES					ı	
2		and other services (see	bursed under OPPS (see	instructions)					1 2
3		REH payments	bursed under OFF3 (see	ilistructions)					3
4		ayment (see instruction	ns)						4
4.01		econciliation amount (4.01
5	Line 2 tim		ent to cost ratio (see inst	ructions)					5
7		nes 3, 4, and 4.01, divi	ided by line 6						7
8		nal corridor payment (8
9			ough costs from Wkst. D,	Pt. IV, col. 13, line 20	00				9
10	Organ acq	quisition t (sum of lines 1 and 1	0) (see instructions)						11
			OF COST OR CHARGE	S					
	Reasonable								
12		service charges	Wilsot D 4 Boot III and	4 line 60)					12
13		quisition charges (iron sonable charges (sum o	n Wkst. D-4, Part III, col. of lines 12 and 13)	4, line 69)					13 14
	Customary	• •	77 mics 12 and 13)						
15			ected from patients liable						15
16			realized from patients liab		vices on a charge				16
17		ine 15 to line 16 (not t	ade in accordance with 42 to exceed 1 000000)	CFR 9413.13(e)					17
18		tomary charges (see in							18
19					eeds line 11) (see instructions)				19
20				olete only if line 11 exc	eeds line 18) (see instructions)				20
22		cost or charges (see ind residents (see instru							22
23		\	teaching hospital (see in	structions)					23
24			n of lines 3, 4, 4.01, 8, ar						24
- 25			RSEMENT SETTLEME nounts (see instructions)	NT					25
25			nounts relating to amount	on line 24 (see instru	ctions)				26
27					es 22 and 23] (see instructions))			27
28			on payments (from Wkst	E-4, line 50)					28
28.50		lity payment amount	costs (from Wkst. E-4, li	no 26)					28.50 29
30		(sum of lines 27, 28,		ne 30)					30
		payer payments	,						31
32		(line 30 minus line 31)							32
33		ABLE BAD DEBTS (F te rate ESRD (from W	EXCLUDE BAD DEBTS	FOR PROFESSIONA	AL SERVICES)				33
34		e bad debts (see instru	, ,						34
35	Adjusted 1	reimbursable bad debt	s (see instructions)						35
36			gible beneficiaries (see in	structions)					36
37		(see instructions) C reconciliation amoun	nt from PS&R						37 38
39		ustments (specify) (se							39
39.50			yment adjustment (see ins						39.50
39.75			nent amount (see instruct						39.75
39.97									39.97 39.98
39.99		of Accelerated depred		meed devices (see ms	in detroils)				39.99
40		(see instructions)							40
40.01		ation adjustment (see i		ration					40.01 40.02
40.02		ration payment adjustnation adjustment-PARF	nent amount after sequest M pass-throughs	IauOII					40.02
41	Interim pa	·	1						41
41.01	Interim pa	ayments-PARHM							41.01
42		settlement (for contra							42 01
42.01		lue provider/program	for contractors use only) (see instructions)						42.01 43
43.01		1 1 5	PARHM (see instructions	5)					43.01
44	Protested	amounts (nonallowab	le cost report items) in ac	cordance with CMS Pt	ub. 15-2, chapter 1, §115.2				44

94 Total (sum of lines 91 and 93)

Rev. 21 40-587

	YSIS OF PAYMENTS TO PR ERVICES RENDERED	OVIDERS					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET E-: PART I	1,
Check applicat box:	[] Hospital [] IPF [] IRF	[] Subprovider (Other) [] SNF [] Swing-Bed SNF	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF							
	<u> </u>						patient			
							art A		Part B	_
г	Description				ŀ	mm/dd/yyyy	Amount 2	mm/dd/yyyy	Amount 4	_
	Total interim payments paid	to provider				1	2	3	-	1
		individual bills, either submitted or to be	e submitted to the intermediary							2
		cost reporting period. If none, write "NO								
3	List separately each retroacti	ive		Program to Provider	.01					3.01
	lump sum adjustment amoun				.02					3.02
	on subsequent revision of the				.03					3.03
	interim rate for the cost repo				.04					3.04
	Also show date of each payn				.05					3.05
	If none, write "NONE" or enter a zero. (1)			.50					3.50	
					.51					3.51
					.52					3.52
					.53					3.53
	C-14-4-1 (£1: 2 01	3.49 minus sum of lines 3.50-3.98)			.54					3.54 3.99
	Total interim payments (sum				.99					3.99
4	(transfer to Wkst. E or Wkst									4
	and column as appropriate)	. L-3, IIIC								
	and column as appropriate)									
- 5	List separately each tentative	e settlement		Program to Provider	.01					5.01
	payment after desk review. A			8	.02					5.02
	date of each payment.				.03				1	5.03
	If none, write "NONE" or en	nter a zero. (1)		Provider to Program	.50					5.50
					.51					5.51
					.52					5.52
		5.49 minus sum of lines 5.50 -5.98)			.99					5.99
6	Determined net settlement ar			Program to Provider	.01					6.01
	due) based on the cost report			Provider to Program	.02					6.02
7	Total Medicare program liab	pility (see instructions)								7
8	Name of Contractor					Contractor Number		NPR Date (Month/D	ay/Year)	8

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

CALCU	LATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-1.			
	MENT FOR HIT	l services	FROM	PART II			
SETTEL	WENT TOK III	COMPONENT CCN:	TO TO	TAKTII			
		COMPONENT CCN:	10				
CI I	fam 54						
Check	[] Hospital						
applicab	e []CAH						
box:							
HEALT	HINFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1	Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)						
2	Medicare days (see instructions)				2		
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)				3		
4	Total inpatient days (see instructions)				4		
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)				5		
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)				6		
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2,	Pt. I, line 168)			7		
8	Calculation of the HIT incentive payment (see instructions)				8		
9	Sequestration adjustment amount (see instructions)				9		
10	Calculation of the HIT incentive payment after sequestration (see instructions)				10		

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

	LATION OF REIMBURSEMENT EMENT - SWING BEDS			PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-2	
521121	SMEANT SWING BEES			COMPONENT CCN:			
						_	
Check] Swing-Bed SNF					
applicab] Swing-Bed NF					
boxes:	[] Title XIX [] PARHM CAH Swing-Bed SNF					т
					PART A	PART B	
	COMPUTATION OF NET COST (OF COVERED SERVICES			TAKI A	7 PARI D	-
	Inpatient routine services - swing be				1	2	1
2	Inpatient routine services - swing be						2
3		, col. 3, line 200, for Part A; and sum of Wkst. D, Pt. V,					3
		(For CAH and swing-bed pass-through, see instructions)					
3.01	Nursing and allied health payment-	PARHM (see instructions)					3.01
4		ents not in approved teaching program (see instructions)					4
5	Program days						5
6		ed teaching program (see instructions)					7
8	Subtotal (sum of lines 1 through 3 p	ensation - SNF optional method only					8
9	Primary payer payments (see instru						9
10	Subtotal (line 8 minus line 9)	ectoris)					10
11	ì	nts (exclude amounts applicable to physician professional	services)				11
12	Subtotal (line 10 minus line 11)						12
13	Coinsurance billed to program patie	ents (from provider records) (exclude coinsurance for physical	sician professional	services)			13
14	80% of Part B costs (line 12 x 80%						14
15	Subtotal (see instructions)						15
16	Other adjustments (specify) (see in	,					16
16.50	Pioneer ACO demonstration payme			`			16.50
16.55	Demonstration payment adjustment	ration project (§410A Demonstration) payment adjustmen	t (see instructions)			16.55 16.99
17	Allowable bad debts (see instruction						10.99
17.01	Adjusted reimbursable bad debts (s	,					17.01
18	Allowable bad debts for dual eligibl	,					18
19	Total (see instructions)						19
19.01	Sequestration adjustment (see instr	ructions)					19.01
19.02	Demonstration payment adjustment						19.02
19.03	Sequestration adjustment-PARHM						19.03
19.25	Sequestration for non-claims based	amounts (see instructions)					19.25
20.01	Interim payments						20.01
20.01	Interim payments-PARHM Tentative settlement (for contractor	ruse only)					20.01
21.01	Tentative settlement-PARHM (for	**					21.01
22		e 19 minus lines 19.01, 19.02, 19.25, 20, and 21)					22
22.01	Balance due provider/program-PAR						22.01
23	Protested amounts (nonallowable co	ost report items) in accordance with CMS Pub. 15-2, chap	pter 1, §115.2				23
		tration Project (§410A Demonstration) Adjustment		W3.7W .0	T		200
200	Is this the first year of the current 5 Cost Reimbursement	-year demonstration period under the 21st Century Cures	Act? Enter "Y" fo	or yes or "N" for no.			200
201		routine service costs (from Wkst. D-1, Pt. II, line 66 (titl	e YVIII hoenitalli		1		201
202		ancillary service costs (from Wkst. D-3, col. 3, line 200 (hed SNF))			202
203	Total (sum of lines 201 and 202)		11 . 111 Uning 1	//			203
204	Medicare swing-bed SNF discharge	es (see instructions)					204
		get Amount Limitation (N/A in first year of the current 5-	year demonstration	period)			
205	Medicare swing-bed SNF target am	nount					205
206		routine cost cap (line 205 times line 204)					206
		ing-Bed SNF Inpatient Reimbursement			ı		
207		§410A Demonstration (see instructions)	2)				207
208		service costs (from Wkst. E-2, col. 1, sum of lines 1 and SNF PPS payments (see instructions)	3)				208
210	Reserved for future use	SINT 113 payments (see instructions)					210
210	Comparison of PPS versus Cost Rei	imbursement					210
215		g-bed SNF PPS payment (line 209 plus line 210) (see ins	tructions)				215

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

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

1	Inpatient hospital services (see instructions)	1
1.01	Nursing and allied health managed care payment (see instructions)	1.01
2	Organ acquisition	2
3	Cost of physicians' services in a teaching hospital (see instructions)	3
4	Subtotal (sum of lines 1 through 3)	4
5	Primary payer payments	5
6	Subtotal (line 4 less line 5).	6
7	Deductibles	7
8	Subtotal (line 6 minus line 7)	8
9	Coinsurance	9
10	Subtotal (line 8 minus line 9)	10
11	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11
12	Adjusted reimbursable bad debts (see instructions)	12
13	Allowable bad debts for dual eligible beneficiaries (see instructions)	13
14	Subtotal (sum of lines 10 and 12)	14
15	Direct graduate medical education payments (from Wkst. E-4, line 49)	15
16	Other pass through costs (see instructions). DO NOT USE THIS LINE.	16
17	Other adjustments (specify) (see instructions)	17
17.50	Pioneer ACO demonstration payment adjustment (see instructions)	17.50
17.99	Demonstration payment adjustment amount before sequestration	17.99
18	Total amount payable to the provider (see instructions)	18
18.01	Sequestration adjustment (see instructions)	18.01
18.02	Demonstration payment adjustment amount after sequestration	18.02
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program (line 18 minus lines 18.01, 18.02,19, and 20)	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22

Rev. 16 40-591

4090 ((Cont.) FOR	M CMS-2552-10			04-20
CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART II	
		COMPONENT CCN:	ТО		
Check	[] Hospital	<u> </u>	1		
applicab	le [] Subprovider IPF				
box:					
PART II	- CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UN	IDER IPF PPS			
1	Not Endaged IDE DDS normant (evoluting outline ECT and modical education at	novements)		1	1
	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education p Net IPF PPS Outlier payment	bayments)			2
3	Net IPF PPS ECT payment				3
	A 7	n or before November 15, 2004, (see instruction	5)		4
4.01					4.01
	that would not be counted without a temporary cap adjustment under 42 CFR §		,		
5	New teaching program adjustment (see instructions)				5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program	n growth period			6
-	of a "new teaching program" (see instructions)				
7	Current year unweighted I&R FTE count for residents within the new program	growth period			7
	of a "new teaching program" (see instructions)				
8	Intern and resident count for IPF PPS medical education adjustment (see instru	ctions)			8
9	Average daily census (see instructions)	,			9
10	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150	-1}.			10
11	Teaching Adjustment (line 1 multiplied by line 10).				11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3, and 11)				12
13	Nursing and allied health managed care payment (see instructions)				13
14	Organ acquisition DO NOT USE THIS LINE				14
15	Cost of physicians' services in a teaching hospital (see instructions)				15
16	Subtotal (see instructions)				16
17	Primary payer payments				17
18	Subtotal (line 16 less line 17).				18
19	Deductibles				19
	,				20
21	Coinsurance				21
22	Subtotal (line 20 minus line 21)				22
23	Allowable bad debts (exclude bad debts for professional services) (see instruction of the contraction of the	ions)			23
24	Adjusted reimbursable bad debts (see instructions)				24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)				25
26 27	Subtotal (sum of lines 22 and 24)	4:			26 27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see inst	ructions)			28
29	Other pass through costs (see instructions) Outlier payments reconciliation				29
30	Other adjustments (specify) (see instructions)				30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)				30.50
30.99	Demonstration payment adjustment amount before sequestration				30.99
31	Total amount payable to the provider (see instructions)				30.33
31.01	Sequestration adjustment (see instructions)				31.01
31.02	Demonstration payment adjustment amount after sequestration				31.02
32	Interim payments				32
33	Tentative settlement (for contractor use only)				33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32, and 33)				34
	Protested amounts (nonallowable cost report items) in accordance with CMS Pu				35

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

04-20		M CMS-2552-10			4090 (Con	t.)
CALCU	JLATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3, PART III	
			COMPONENT CCN:	FROM	PART III	
			COM ONEN CON.			
Check	[] Hospital			•	•	_
applicab	ole [] Subprovider IRF					
box:						
рарт п	II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UI	VIDED IDE DDC				
IAKIII	II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT OF	NDER IKI 113				
1	Net Federal PPS payment (see instructions)					1
2	Medicare SSI ratio (IRF PPS only) (see instructions)					2
3	1 7 /					3
4	1 7					4
5	1 01	riod ending				5
5.01	on or prior to November 15, 2004 (see instructions)					0.1
5.01	1 8				5.	.01
6	closure, that would not be counted without a temporary cap adjustment under 4. New teaching program adjustment (see instructions)	2 CFR 9412.424(d)(1)(11)(F)(1) or (2)			6
7		n growth period			+	7
,	of a "new teaching program" (see instructions)	ii giowiii period				,
8	Current year unweighted I&R FTE count for residents within the new program	growth period				8
Ü	of a "new teaching program" (see instructions)	5.0 mar period				Ü
9	Intern and resident count for IRF PPS medical education adjustment (see instru	ictions)				9
10		/				10
11						11
12	Teaching Adjustment (see instructions)					12
13	Total PPS Payment (see instructions)					13
14	Nursing and allied health managed care payments (see instructions)					14
15	8 1					15
16	17 5 1 7					16
17	,					17
18	71 7 1 7					18
19	Subtotal (line 17 less line 18) Deductibles					19 20
20						21
22	,					22
23						23
24	· /	ions)				24
25	Adjusted reimbursable bad debts (see instructions)					25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)					26
27	Subtotal (sum of lines 23 and 25)					27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see ins	structions)				28
29	Other pass through costs (see instructions)					29
30	Outlier payments reconciliation					30
31	Other adjustments (specify) (see instructions)					31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)				31.	
31.99	Demonstration payment adjustment amount before sequestration				31.	
32 32.01	Total amount payable to the provider (see instructions)				32.	32
32.01	1 7				32.	
32.02	1 2 3					33
34	1 7					34
35	37					35
36		ub 15-2 chapter 1 8115.2				36

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDI	ER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART IV	
			TO	1	

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

Net Federal PPS payment (see instructions) Full standard payment amount Short stay outlier standard payment amount Site neutral payment amount - Cost Site neutral payment amount - IPPS comparable Outlier payments Total PPS payments (sum of lines 1 and 2) Nursing and allied health managed care payments (see ins Organ acquisition DO NOT USE THIS LINE	,	1 1.01 1.02 1.03 1.04 2 3 3 4 4 5 6 6 7
Short stay outlier standard payment amount Site neutral payment amount - Cost Site neutral payment amount - IPPS comparable Outlier payments Total PPS payments (sum of lines 1 and 2) Nursing and allied health managed care payments (see ins Organ acquisition DO NOT USE THIS LINE	,	1.02 1.03 1.04 2 3 4 5
Site neutral payment amount - Cost Site neutral payment amount - IPPS comparable Outlier payments Total PPS payments (sum of lines 1 and 2) Nursing and allied health managed care payments (see ins Organ acquisition DO NOT USE THIS LINE	,	1.03 1.04 2 3 4 5
Site neutral payment amount - IPPS comparable Outlier payments Total PPS payments (sum of lines 1 and 2) Nursing and allied health managed care payments (see ins Organ acquisition DO NOT USE THIS LINE	,	1.04 2 3 4 5 6
2 Outlier payments 3 Total PPS payments (sum of lines 1 and 2) 4 Nursing and allied health managed care payments (see ins 5 Organ acquisition DO NOT USE THIS LINE	,	2 3 4 5 6
3 Total PPS payments (sum of lines 1 and 2) 4 Nursing and allied health managed care payments (see ins 5 Organ acquisition DO NOT USE THIS LINE	,	3 4 5 6
4 Nursing and allied health managed care payments (see ins 5 Organ acquisition DO NOT USE THIS LINE	,	5 6
5 Organ acquisition DO NOT USE THIS LINE	,	5
	structions)	6
	structions)	
6 Cost of physicians' services in a teaching hospital (see inst		7
7 Subtotal (see instructions)		
8 Primary payer payments		8
9 Subtotal (line 7 less line 8)		9
10 Deductibles		10
11 Subtotal (line 9 minus line 10)		11
12 Coinsurance		12
13 Subtotal (line 11 minus line 12)		13
14 Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)	14
15 Adjusted reimbursable bad debts (see instructions)		15
16 Allowable bad debts for dual eligible beneficiaries (see in	nstructions)	16
17 Subtotal (sum of lines 13 and 15)		17
18 Direct graduate medical education payments (from Wkst.)	E-4, line 49)	18
19 Other pass through costs (see instructions)		19
20 Outlier payments reconciliation		20
21 Other adjustments (specify) (see instructions)		21
21.50 Pioneer ACO demonstration payment adjustment (see instr	tructions)	21.50
21.99 Demonstration payment adjustment amount before sequest	tration	21.99
22 Total amount payable to the provider (see instructions)		22
22.01 Sequestration adjustment (see instructions)		22.01
22.02 Demonstration payment adjustment amount after sequestra	ation	22.02
23 Interim payments		23
24 Tentative settlement (for contractor use only)		24
25 Balance due provider/program (line 22 minus lines 22.01,		25
26 Protested amounts (nonallowable cost report items) in account	ordance with CMS Pub. 15-2, chapter 1, §115.2	26

TO BE COMPLETED BY CONTRACTOR

5	Original outlier amount (see instructions)	50
5	Outlier reconciliation adjustment amount (see instructions)	51
- 5	The rate used to calculate the Time Value of Money (see instructions)	52
5	Time Value of Money (see instructions)	53

07-23	FORM CMS-2332-10			4090 (Coi	т.,
CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART V	
			TO		
Check	[] Hospital				
applicab	le [] PARHM Demonstration				
box:					
PART V	- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVIC	ES - COST REIMBURSE	MENT		
1	Inpatient services				1
2	Nursing and allied health managed care payment (see instructions) Organ acquisition				3
3.01	Cellular therapy acquisition cost (see instructions)			2	3.01
3.01	Subtotal (sum of lines 1 through 3.01)				4
- 5	Primary payer payments			- 	5
6	Total cost (see instructions)			- 	6
- 0	COMPUTATION OF LESSER OF COST OR CHARGES			I	-
	Reasonable charges				
7	Routine service charges				7
8	Ancillary service charges				8
9	Organ acquisition charges, net of revenue				9
10	Total reasonable charges				10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis	;			11
12	Amounts that would have been realized from patients liable for payment for services on				12
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)				14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see in	structions)			15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see in	structions)			16
17	Cost of physicians' services in a teaching hospital (see instructions)				17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Direct graduate medical education payments				18
19	Cost of covered services (sum of lines 6 and 17)				19
20	Deductibles (exclude professional component)				20
21	Excess reasonable cost (from line 16)				21
22	Subtotal (line 19 minus lines 20 and 21)				22
23	Coinsurance				23
24	Subtotal (line 22 minus line 23)				24
25 26	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)				25 26
27	Adjusted reimoursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)			+	27
28	Subtotal (sum of lines 24 and 25 or 26)			- 	28
29	Other adjustments (specify) (see instructions)			- 	29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			29	9.50
29.99	Demonstration payment adjustment amount before sequestration				9.99
30	Subtotal (see instructions)			1 2	30
30.01	Sequestration adjustment (see instructions)			30	0.01
30.02	Demonstration payment adjustment amount after sequestration				0.02
30.03	Sequestration adjustment-PARHM				0.03
31	Interim payments				31
31.01	Interim payments-PARHM			31	1.01
32	Tentative settlement (for contractor use only)				32
32.01	Tentative settlement-PARHM (for contractor use only)			32	2.01
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)				33
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.0	01)		33	3.01
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	§115.2			34

Rev. 21 40-595

1050 (20111)	1 014.1 01.15 2002 10		0 /	, 20
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
		FROM	PART VI	
	COMPONENT CCN.:	TO		

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)	
1	Resource Utilization Group (RUGS) payment	1
2	Routine service other pass through costs	2
3	Ancillary service other pass through costs	3
4	Subtotal (sum of lines 1 through 3)	4
	COMPUTATION OF NET COST OF COVERED SERVICES	
5	Medical and other services. Do not use this line. (see instructions)	5
6	Deductibles	6
7	Coinsurance	7
8	Allowable bad debts (see instructions)	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9
10	Adjusted reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	14.50
14.99	Demonstration payment adjustment amount before sequestration	14.99
15	Subtotal (see instructions)	15
15.01	Sequestration adjustment (see instructions)	15.01
15.02	Demonstration payment adjustment amount after sequestration	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	15.75
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

07-23			1 OIUV	CIVID-2332-10			4070 (Cont.
CALCULATI	ON OF REIMBURSE!	MENT SETTLEMENT			PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
						FROM	PART VII
					COMPONENT CCN:	TO	
Check	[] Title V	[] Hospital	[] NF	[] PPS	•		
applicable	[] Title XIX	[] Subprovider	[] ICF/IID	[] TEFRA			
boxes:		[] SNF		[] Other			

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

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

4090 (Cont.) FORM CN	4S-2552-10				07-23
DIRECT	GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
	O OUTPATIENT DIRECT MEDICAL			FROM		
	TION COSTS			TO	-	
			I I CALL D. TIDE	10	_	
Check	[] Title V [] Hospital		[] CAH-Based IPF			
applicab	le [] Title XVIII [] PARHM Demons	stration	[] CAH-Based IRF			
box:	[] Title XIX					
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost repor	ting periods ending on or	hefore December 31 10	96		1
1.01		this perious ending on or	ociore December 51, 17	-70		1.01
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)					
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see ins	tructions)				2
2.26	Rural track program FTE cap limitation adjustment after the cap-building window close	ed under §127 of the CA	A 2021 (see instructions			2.26
3	Amount of reduction to Direct GME cap under §422 of MMA		•			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413	3 70 (m) (see instruction	ne .			3.01
5.01		5.77 (III). (See Ilistruction	15			3.01
2.02	for cost reporting periods straddling 7/1/2011)	1. 1	1. 1.1.1.1. (2)			2.02
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rur	1 0	rural track Medicare GN	1E		3.02
	affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022)					
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due	e to a Medicare GME				4
	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting pe	priode etraddling 7/1/2011	1			4.01
	1 01					
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost					4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the C.		/			4.21
5	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus	lines 3 and 3.01, plus or	minus line 3.02, plus or 1	ninus		5
	line 4, plus lines 4.01 through 4.27					
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current	t year from your records	(see instructions)			6
7	Enter the lesser of line 5 or line 6	, , our records			t	7
	Effect the resset of fine 5 of fine 6		D.:	Other	T.4.1	
			Primary Care	Other	Total	4
			1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for					8
	the current year					
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times					9
	the result of line 5 divided by the amount on line 6. For cost reporting periods beginning	207				
	on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instruction	S.				
10	Weighted dental and podiatric resident FTE count for the current year					10
10.01	Unweighted dental and podiatric resident FTE count for the current year					10.01
11	Total weighted FTE count					11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)					12
13						13
_	Total weighted resident FTE count for the penultimate cost reporting year (see instr.)					
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)					14
15	Adjustment for residents in initial years of new programs					15
15.01	Unweighted adjustment for residents in initial years of new programs					15.01
16	Adjustment for residents displaced by program or hospital closure					16
16.01	Unweighted adjustment for residents displaced by program or hospital closure					16.01
17	Adjusted rolling average FTE count					17
18	Per resident amount					18
18.01	Per resident amount under §131 of the CAA 2021					18.01
19	Approved amount for resident costs					19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots re	eceived under 42 8413 79	0(c)(4)	•	1	20
21	Direct GME FTE unweighted resident count over cap (see instructions)	occirca anaci 12 3 115175	(0)(1)			21
					1	
22	Allowable additional direct GME FTE resident count (see instructions)					22
23	Enter the locality adjustment national average per resident amount (see instructions)				<u> </u>	23
24	Multiply line 22 time line 23	·	·			24
25	Total direct GME amount (sum of lines 19 and 24)					25
	(Inpatient Part A	Managed Care	Managed Care	Total	
		inpatient I art A	Prior to 1/1	-	10141	
	COMPLIE A TION OF BROOD AND BATTLEY TO A P	<u> </u>		On or after 1/1	-	4
	COMPUTATION OF PROGRAM PATIENT LOAD	1	2	2.01	3	
26	Inpatient days (see instructions)					26
27	Total inpatient days (see instructions)					27
28	Ratio of inpatient days to total inpatient days					28
29	Program direct GME amount	l .	İ	†		29
	8			+		
29.01	Percent reduction for MA DGME			1		29.01
30	Reduction for direct GME payments for Medicare Advantage					30
31	Net Program direct GME amount					31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURS	ING PROGRAM AND			
	PARAMEDICAL EDUCATION COSTS)	`				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 2	3 lines 74 and 04)				32
					+	
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 an	u 74)			.	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)					34
35	Medicare outpatient ESRD charges (see instructions)				1	35
26	Medicare autration ESPD direct medical education agets (line 24 v line 25)					26

49 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)

50 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)

49 50

1070	(Cont.)	2332 10			01 23
OUTL	EER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET E-5	
	TO BE COMPLETED BY CONTRACTOR		10		
1	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				1
2	Capital outlier from Wkst. L, Pt. I, line 2				2
3	Operating outlier reconciliation adjustment amount (see instructions)				3
4	Capital outlier reconciliation adjustment amount (see instructions)				4
5	The rate used to calculate the time value of money (see instructions)	·			5
6	Time value of money for operating expenses (see instructions)				6
7	Time value of money for capital related expenses (see instructions)				7

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all period being deemed overpayments (42 USC 1395g).	l interim payments made si	nce the beginning of the c	ost reporting		OMB NO. 0938-1425 EXPIRES 02-28-2025	
					EAT IKES 02-20-2025	<u>'</u>
PAYMENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET E-95	
PART I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAY	MENT ADJUSTMENT	ΓELIGIBILITY AND	DATA	_		
				DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS 2	
Did the hospital or hospital healthcare complex purchase domestic (column 1) "N" for no in each column. If "Y" for either column, complete line 2.	or non-domestic (colu	mn 2) respirators? Ent	er "Y" for yes or	1	2	1
, , , , , , , , , , , , , , , , , , ,				•		
		DOMESTIC	RESPIRATORS	NON-DOMESTI	IC RESPIRATORS	
		TOTAL COST	NUMBER PURCHASED	TOTAL COST	NUMBER PURCHASED	
		1	2	3	4	
Enter the total cost of domestic respirators purchased in column 1 and the num respirators purchased in column 2. Enter the total cost of non-domestic respirators purchased in column 3 and the non-domestic respirators purchased in column 4.						2
PART II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-A	APPROVED SURGIC	AL NOS RESPIRATO	RS			
THAT IS CALCULATION OF COST BITTERENT IN TOR BUILDING MOSTI.	I TROVED SORGICA	IL 100 RESI MATTO	DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS	COST DIFFERENTIAL	
I To the Carroon to the table			l	2	3	
Total cost of NIOSH-approved surgical N95 respirators purchased Number of NIOSH-approved surgical N95 respirators purchased						1 2
3 Average cost per respirator			+	+		3
Hospital-specific unit cost differential for domestic respirators						4
5 Total cost differential for domestic respirators						5
				<u> </u>		
PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO	SH-APPROVED SUR	GICAL N95 RESPIR.	ATORS			
	HOSPITAL PART A	HOSPITAL PART B	IPF SUBPROVIDER PART B	IRF SUBPROVIDER PART B 4	TOTAL 5	
1 Medicare costs	1		3	7	,	1
2 Total facility costs						2
3 Medicare percentage						3
4 Domestic NIOSH approved curgical NOS recognizators payment adjustment	i		i i	1		1

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-1425. The time required to complete this information collection is estimated to be 0.50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

40-599.2

4090 (Cont.)	FORM CN	/18-2332-	10			03-23
BALANCE SHEET			PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-	type			FROM		
accounting records, complete the General Fund colum	mn only)			TO		
			Specific			
	Ger	neral	Purpose	Endowment	Plant	
Assets	Fι	und	Fund	Fund	Fund	
(Omit cents)		1	2	3	4	
CURRENT ASSETS	•			•	•	•
1 Cash on hand and in banks						1
2 Temporary investments						2
3 Notes receivable						3
4 Accounts receivable						4
5 Other receivables						5
6 Allowances for uncollectible notes and						6
accounts receivable						
7 Inventory						7
8 Prepaid expenses						8
9 Other current assets						9
10 Due from other funds				+		10
11 Total current assets (sum of lines 1 through	10)					11
FIXED ASSETS	110)			<u> </u>	<u>I</u>	
12 Land				1	1	12
13 Land improvements						13
14 Accumulated depreciation						14
15 Buildings						15
16 Accumulated depreciation						16
17 Leasehold improvements						17
18 Accumulated depreciation						18
19 Fixed equipment						19
20 Accumulated depreciation						20
21 Automobiles and trucks						21
22 Accumulated depreciation						22
23 Major movable equipment						23
24 Accumulated depreciation						24
25 Minor equipment depreciable						25
26 Accumulated depreciation	<u> </u>					26
27 HIT designated Assets	<u> </u>			+		27
27 H11 designated Assets 28 Accumulated depreciation				+	+	28
29 Minor equipment-nondepreciable	+			+		29
30 Total fixed assets (sum of lines 12 through	20)			+		30
OTHER ASSETS	47)			1		30
	1			T		21
31 Investments 32 Deposits on leases				+	+	31
32 Deposits on leases 33 Due from owners/officers				1		33
34 Other assets	24)					34
35 Total other assets (sum of lines 31 through	54)					35
36 Total assets (sum of lines 11, 30, and 35)						36

10-12	FORM CMS-25	52-10		4090) (Cont.)
BALANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type			FROM	(CONT.)	
accounting records, complete the General Fund column only)			ТО		
· · · · · · · · · · · · · · · · · · ·		Specific			
Liabilities and Fund	General	Purpose	Endowment	Plant	
Balances	Fund	Fund	Fund	Fund	
(Omit cents)	1	2	3	4	
CURRENT LIABILITIES		•	•	•	
37 Accounts payable					37
38 Salaries, wages, and fees payable					38
39 Payroll taxes payable					39
40 Notes and loans payable (short term)					40
41 Deferred income					41
42 Accelerated payments					42
43 Due to other funds					43
44 Other current liabilities					44
45 Total current liabilities (sum of					45
lines 37 thru 44)					
	•	•	•	•	•
LONG TERM LIABILITIES					
46 Mortgage payable					46
47 Notes payable					47
48 Unsecured loans					48
49 Other long term liabilities					49
50 Total long term liabilities (sum of					50
lines 46 thru 49)					
51 Total liabilities (sum of lines 45 and 50)					51
· · · · · · · · · · · · · · · · · · ·	•				
CAPITAL ACCOUNTS					
52 General fund balance					52
53 Specific purpose fund					53
54 Donor created - endowment fund					54
balance - restricted					
55 Donor created - endowment fund					55
balance - unrestricted					
56 Governing body created - endowment					56
fund balance					
57 Plant fund balance - invested in plant					57
58 Plant fund balance - reserve for plant					58
improvement, replacement, and expansion					ĺ
59 Total fund balances (sum of lines 52 thru 58)					59
60 Total liabilities and fund balances (sum of					60
lines 51 and 59)					

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

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

PART I - PATIENT REVENUES

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

PART II - OPERATING EXPENSES

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

4090 ((Cont.) FORM C	CMS-2552-10			01-22
	MENT OF REVENUES XPENSES	PROVIDER CCN:	PERIOD: FROM	WORKSHEET G-3	
			TO		
	Description				
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)				
2	Less contractual allowances and discounts on patients' accounts				
3	Net patient revenues (line 1 minus line 2)				
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)				
5	Net income from service to patients (line 3 minus line 4)				
	OTHER INCOME				
6	Contributions, donations, bequests, etc				
7	Income from investments				
8	Revenues from telephone and other miscellaneous communication services				
9	Revenue from television and radio service				
10	Purchase discounts				1
11	Rebates and refunds of expenses				1
12	Parking lot receipts				1
13	Revenue from laundry and linen service				1
14	Revenue from meals sold to employees and guests				1
15	Revenue from rental of living quarters				1
16	Revenue from sale of medical and surgical supplies to other than patients				1
17	Revenue from sale of drugs to other than patients				1
18	Revenue from sale of medical records and abstracts				1
19	Tuition (fees, sale of textbooks, uniforms, etc.)				1
20	Revenue from gifts, flowers, coffee shops, and canteen				2
21	Rental of vending machines				2
22	Rental of hospital space				2
23	Governmental appropriations				2
24	Other (specify)				2
24.50	COVID-19 PHE Funding				24.
25	Total other income (sum of lines 6-24)				2
26	Total (line 5 plus line 25)				2
27	Other expenses (specify)				2
28	Total other expenses (sum of line 27 and subscripts)				2
29	Net income (or loss) for the period (line 26 minus line 28)				2

ANALY	SIS OF HOSPITAL-BASED			10	14.17 01.115 2001	- 10		PROVIDER CCN:	PERIOD:	WC	ORKSHEET H	
	HEALTH AGENCY COSTS								FROM			
								HHA CCN:	ТО			
	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION S (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
	Capital Related-Movable Equipment											2
	Plant Operation & Maintenance											3
	Transportation (see instructions)											4
5	Administrative and General											5
	HHA REIMBURSABLE SERVICES											
6	Skilled Nursing Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech Pathology											9
10	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
13	Drugs											13
14	DME											14
	HHA NONREIMBURSABLE SERVICES											
15	Home Dialysis Aide Services											15
16	Respiratory Therapy											16
17	Private Duty Nursing											17
18	Clinic											18
19	Health Promotion Activities											19
20	Day Care Program											20
21	Home Delivered Meals Program											21
22	Homemaker Service									i		22
23	All Others									i		23
24	Total (sum of lines 1 through 23)											24

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

	10	1CIVI CIVID-2332-	10							11-10
				_					WORKSHEET H- PART I	1
NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10) 0			PLANT OPERATION & MAINTENANCE 3					ADMINIS- TRATIVE & GENERAL 5		
										1
										2
										3
										4
										5
										6
										7
										8
										9
										10
										11
										12
										13
										14
										15
										16
										17
										18
										19
					ĺ					20
										21
					ĺ					22
										23
										24
	FOR COST ALLOCATION (from Wkst. H, col. 10)	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10) CAI RELATI BLDGS. & FIXTURES	NET EXPENSES	FOR COST ALLOCATION (from Wkst. BLDGS. & MOVABLE H, col. 10) FIXTURES EQUIPMENT MAINTENANCE	NET EXPENSES	PROVIDED HA CC!	PROVIDER CCN:	PROVIDER CCN:	PROVIDER CCN:	PROVIDER CCN:

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

	ATION OF GENERAL SERVICE TO HHA COST CENTERS								PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART I	
	HHA COST CENTER	From Wkst. H-1	HHA TRIAL		PITAL ED COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	& LINEN	
	()	col. 6,	(1)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	SERVICE	
		line	0	1	2	4	4A	5	6	7	8	1
1	Administrative and General	5										1
2	Skilled Nursing Care	6										2
	Physical Therapy	7										3
	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		14										10
11	Home Dialysis Aide Services	15										11
12	Respiratory Therapy	16										12
13	Private Duty Nursing	17										13
	Clinic	18										14
15	Health Promotion Activities	19										15
	Day Care Program	20										16
	Home Delivered Meals Program	21										17
18	Homemaker Service	22										18
19		23										19
	Totals (sum of lines 1-19) (2)		•									20
21	Unit Cost Multiplier: column 26, line 1, line 20, minus column 26, line 1, rounde											21

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

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

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

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

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

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

ALLOCATION OF G	ST CENTERS		JIMVI CIVIS-2332-			PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-2, PART II	01111
STATISTICAL BASI	S					HHA CCN:	ТО	-	
			ITAL ED COST	EMPLOYEE		ADMINIS-	MAIN-		
HHA COST	CENTER	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL- IATION	TRATIVE & GENERAL (ACCUM. COST)	TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	4	4A	5	6	7	
1 Administrati	ive and General								
2 Skilled Nurs									
3 Physical The									
4 Occupationa									
5 Speech Path									
6 Medical Soc	rial Services								
7 Home Health	h Aide								
8 Supplies									
9 Drugs									
10 DME									
11 Home Dialys	sis Aide Services								
12 Respiratory	Therapy								
13 Private Duty	Nursing								
14 Clinic									
15 Health Prom	notion Activities								
16 Day Care Pro									
17 Home Deliv	ered Meals Program								
18 Homemaker	Service								
19 All Others									
20 Totals (sum	of lines 1-19)								
21 Total cost to	be allocated								
22 Unit Cost M	fultiplier								

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

	ATION OF GENERAL SERVICE		31411 01113 2002			PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	(Cont.)
	TO HHA COST CENTERS						FROM	PART II (CONT.)	
STATIS	TICAL BASIS					HHA CCN:	то	=	
				NON-	I			PARA-	Т
				PHYSICIAN		INTERNS &	& RESIDENTS	MEDICAL	
		SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
	HHA COST CENTER	SERVICE	GENERAL	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	
		(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
		SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	
		17	18	19	20	21	22	23	1
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
	Drugs								9
	DME								10
11	Home Dialysis Aide Services								11
	Respiratory Therapy								12
	Private Duty Nursing								13
	Clinic								14
	Health Promotion Activities								15
	Day Care Program								16
	Home Delivered Meals Program								17
	Homemaker Service								18
19	All Others								19
	Totals (sum of lines 1-19)								20
21	Total cost to be allocated								21
22	Unit Cost Multiplier								22

APPOR	RTIONMENT OF PATIENT SE	RVICE C	OSTS						VIDER CCN:	PERI FROI TO_			VORKSHEET Parts I & II	H-3,	
Check a	applicable box: [] Title	V []	Title XVIII	[] Tit	tle XIX							ı			
PART I -	- COMPUTATION OF THE AGGRE	GATE PRO	OGRAM COST												
Cost Pe	er Visit Computation								Program Vis	its		Cost	of Services		
					Total				Pa	t B		Pa	art B		
		From,	Facility	Shared	HHA		Average		Not			Not		Total	
		Wkst.	Costs	Ancillary	Costs		Cost		Subject to	Subject to		Subject to	Subject to	Program	
		H-2,	(from	Costs	(sum of		Per Visit		Deductibles	Deductibles		Deductibles	Deductibles	Cost	
		Part I,	Wkst. H-2,	(from	col. 1	Total	(col. 3		&	&		&	&	(sum of	
	Patient Services	col. 28,	Part I)	Part II)	+ col. 2)	Visits	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	cols. 9-10)	
		line	1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
2	Occupational Thorany	4													2

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

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

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

5 Medical Social Services 6 Home Health Aide 7 Total (sum of lines 1 through 6)

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

12 22			T OTHER CIVIS	2002 10			1070 (8	0110.)
CALCULATION OF HHA	REIMBURSEMENT				PROVIDER CCN:	PERIOD:	WORKSHEET H-4,	
SETTLEMENT						FROM	Parts I & II	
					HHA CCN:	TO		
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX					

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

			Pa	rt B	
			Not Subject to Deductibles	Subject to Deductibles	
		Part A	& Coinsurance	& Coinsurance	
	Description	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				3
	charge basis (from your records)				
4	Amount that would have been realized from patients liable for payment for services on a				4
	charge basis had such payment been made in accordance with 42 CFR 413.13(b)				
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

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Allowable bad debts (from your records)			27
27.01	Adjusted reimbursable bad debts (see instructions)			27.01
28	Allowable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (see instructions)			29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
30.99	Demonstration payment adjustment amount before sequestration			30.99
31	Subtotal (see instructions)			31
31.01	Sequestration adjustment (see instructions)			31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)			31.75
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			35

4090	(Cont.)	FORM	CMS-	2552-10				12-22
BASED	(SIS OF PAYMENTS TO HOSPITAL- DHHAs FOR SERVICES ERED TO PROGRAM BENEFICIARIES				PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-5	
			Т					T
				F	art A		Part B	
	Description			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount]
	Image and a second			1	2	3	4	
1	Total interim payments paid to provider Interim payments payable on individual bills eit	har submitted or						1 2
2	to be submitted to the intermediary for services cost reporting period. If none, write "NONE" of	rendered in the						
3	List separately each retroactive lump sum	Program	.01					3.01
	adjustment amount based on subsequent revision	to	.02					3.02
	of the interim rate for the cost reporting period.	Provider	.03					3.03
	Also show date of each payment. If none, write		.04					3.04
	"NONE" or enter a zero.(1)	Provider	.05					3.05 3.50
		to	.51					3.51
		Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum							
	of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3	2.00)	.99					3.99
4	(transfer to Wkst. H-4, Part II, column as appro							4
	TO BE COMPLETED BY INTERMEDIARY							
	Ix:	I.S.	0.1		T	1		5.01
5	List separately each tentative settlement paymer after desk review. Also show date of each	n Program to	.01					5.01
	payment. If none, write "NONE" or enter	Provider	.02					5.03
	a zero. (1)	Provider	.50					5.50
	. ,	to	.51					5.51
		Program	.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)	Program						
	based on the cost report (see instructions)	to	.01					
		Provider						6.01
		Provider to	.02					
		Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY		'					7
	(see instructions)				wan n	**		
8	Name of Contractor	Contractor Number			NPR Date: Month, D	ay, Year		8

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

ANALYSIS OF RENAL D	DIALYSIS DEPARTMENT COSTS	TORWI CIVID-23.	PROVIDER CCN:	PERIOD:	WORKSHEET I-1	(Cont.)
				FROM TO	_	
Check applicable box:	[] Renal Dialysis Department [] F	Home Program Dialysis		10		
**	, , , , , , , , , , , , , , , , , , , ,	TOTAL			FTEs per	T
		COSTS	BASIS	STATISTICS	2080 Hours	
		1	2	3	4	7
1 Registered Nurse	s		Hours of Service			1
2 Licensed Practica	l Nurses		Hours of Service			2
3 Nurses Aides			Hours of Service			3
4 Technicians			Hours of Service			4
5 Social Workers			Hours of Service			5
6 Dieticians			Hours of Service			6
7 Physicians			Accumulated Cost			7
8 Non-patient Care	Salary		Accumulated Cost			8
9 Subtotal (sum of	lines 1-8)					9
10 Employee Benefit	ts		Salary			10
11 Capital Related C	osts-Bldgs. & Fixtures		Square Feet			11
12 Capital Related C	osts-Mov. Equip.		Percentage of Time			12
13 Machine Costs &	Repairs		Percentage of Time			13
14 Supplies			Requisitions			14
14.01 Pediatric Medical	Supplies		Requisitions			14.01
15 Drugs			Requisitions			15
16 Other			Accumulated Cost			16
17 Subtotal (sum of	lines 9-16)*					17
18 Capital Related C	osts-Bldgs. & Fixtures		Square Feet			18
19 Capital Related C	osts-Mov. Equip.		Percentage of Time			19
20 Employee Benefit			Salary			20
21 Administrative an			Accumulated Cost			21
	peration-Housekeeping		Square Feet			22
23 Medical Educatio	n Program Costs					23
24 Central Services a	& Supplies		Requisitions			24
25 Pharmacy			Requisitions			25
26 Other Allocated C			Accumulated Cost			26
27 Subtotal (sum of						27
28 Laboratory (see in	,		Charges			28
	py (see instructions)		Charges			29
30 Other (see instruction)			Charges			30
31 Total costs (sum of	of lines 27-30)					31

^{*} Line 17, column 1, should agree with Worksheet A, column 7 for line 74 or line 94, as appropriate, and line 27, column 1, should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94, as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS	TO TREATMENT	MODALITIES								PROVIDER CCN:	PERIOD:	WORKSHEET I-2	
											FROM	_	
											TO		
Check applicable box: [] Renal Dialysis Dep	artment [] I	Home Program Dia	lysis		1		T				1	1	
OUTPATIENT SERVICES													
COMPOSITE PAYMENT RATE		AL AND		PATIENT	EMPLOYEE		, mprour	PEDIATRIC	ROUTINE	SUBTOTAL		TOTAL	
		ED COSTS		SALARY	BENEFITS	DRIVER	MEDICAL	MEDICAL	ANCILLARY	(sum of	ourning an	(col. 9 +	
	BUILDING	EQUIPMENT	RNs	OTHER	DEPARTMENT	DRUGS	SUPPLIES	SUPPLIES 7.01	SERVICES	cols. 1-8)	OVERHEAD	col. 10)	4
1 Total Renal Department Costs	1	2	3	4	5	6	/	7.01	8	9	10	11	
MAINTENANCE													1
													2
2 Hemodialysis													2.01
2.01 AKI-Hemodialysis 2.02 Hemodialysis-Pediatric													
3 Intermittent Peritoneal													2.02
3.01 AKI-Intermittent Peritoneal 3.02 IPD-Pediatric													3.01
TRAINING													3.02
4 Hemodialysis													4
4.01 Hemodialysis-Pediatric													4.01
5 Intermittent Peritoneal													5
5.01 IPD-Pediatric													5.01
6 CAPD													6
6.01 CAPD-Pediatric													6.01
7 CCPD													7
7.01 CCPD-Pediatric													7.01
HOME													
8 Hemodialysis													8
8.01 Hemodialysis-Pediatric													8.01
9 Intermittent Peritoneal													9
9.01 IPD-Pediatric													9.01
10 CAPD													10
10.01 CAPD-Pediatric													10.01
11 CCPD													11
11.01 CCPD-Pediatric													11.01
OTHER BILLABLE SERVICES													
12 Inpatient Dialysis													12
13 Method II Home Patient													13
14 ESAs (included in Renal Department)													14
15 ARANESP (see instructions)													15
16 Other	1									ļ			16
17 Total (sum of lines 2 through 16)													17
18 Medical Educational Program Costs													18
19 Total Renal Costs (line 17 plus line 18)													19

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

Rev. 19 40-619

	JTATION OF AVERAGE COST PER TREATMENT UTPATIENT RENAL DIALYSIS									PROVIDER CCN:		PERIOD: FROMTO		WORKSHEET I-4	
Check a	applicable box: Renal Dialysis Department	[] Home Progra	m Dialysis							1		<u></u>		l	
		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments 4.01	Number of Program Treatments 4.02	Total Program Expenses (see instructions)	Total Program Payment 6	Total Program Payment 6.01	Total Program Payment 6.02	Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02) 7.02	
1	Maintenance - Hemodialysis		_		•			-		****		†	,,,,,		1
1.01	Maintenance - AKI Hemodialysis											1			1.01
	Maintenance - Peritoneal Dialysis											1			2
2.01	Maintenance - AKI Peritoneal Dialysis											1			2.01
3	Training - Hemodialysis											1			3
4	Training - Peritoneal Dialysis											1			4
5	Training - CAPD														5
6	Training - CCPD														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis												1		8
9	Home Program - CAPD	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
10	Home Program - CCPD														10
11	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instructions)														11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)														12

12-22	POF	RM CMS-2552-1	4090 (Cont			
CALCU	JLATION OF REIMBURSABLE		PROVIDER CCN:	PERIOD:	WORKSHEET I-5	
BAD D	EBTS - TITLE XVIII - PART B			FROM		
				ТО		
	Description					
1	Total expenses related to care of program beneficiaries (see instructions)					1
	In the state of th			1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)					2
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)					2.01
2.02	1.3					2.02
2.03	Total payment due (see instructions)					2.03
2.04	Outlier payments					2.04
3	()1					3
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)					3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)					3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)					3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)					4
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)					4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)					4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)					4.03
5 01	Bad debts for deductibles and coinsurance, net of bad debt recoveries					5
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of	bad debt recoveries for				5.01
5.00	services rendered on or after 1/1/2011 but before 1/1/2012	1 1 1 1 1				5.02
5.02	1 /	bad debt recoveries for				5.02
5.03	services rendered on or after 1/1/2012 but before 1/1/2013	21 - 4 4-14				5.03
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of services rendered on or after 1/1/2013 but before 1/1/2014	bad debt recoveries for				3.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoverie	o for		+		5.04
3.04	services rendered on or after 1/1/2014	28 101				3.04
5.05				+		5.05
5.05				+		6
7	Allowable bad debts for dual eligible beneficiaries (see instructions)			+		7
8		ructions)				8
9		auctions)				9
10	8 1 7					10
11	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, lin	ne 33)				11
	Temperature car decis (see included included in the included i	55)				
PART	II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PER	RCENTAGE				
12	Total allowable expenses (see instructions)					12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)					13
14	Facility specific composite cost percentage (line 13 divided by line 12)					14
	III - ESRD PAYMENTS - INFORMATION ONLY					
	Low volume payment amount (see instructions)					15
	TDAPA					16
	TPNIES					17
	CRA TPNIES					18
19						19
20) PPA				1	20

	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART I	
								COMPONENT CCN:	10	-	
PARTI	- ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMUNITY	MENTAL HEALTH	CENTER COST CEN	TERS					1	
1711(11	THE CONTION OF GENERAL SERVICE CO	NET NET	WENTE HEALTH	CENTER COST CEN	IERO		1			1	
		EXPENSES	CAP	PITAL							
CO	MPONENT COST CENTER	FOR COST	RELATE	ED COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
	(omit cents)	ALLOCATION	BLDGS, &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE	OPERATION	& LINEN	
	, ,	(see instru.)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	& REPAIRS	OF PLANT	SERVICE	
		0	1	2	4	4A	5	6	7	8	1
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

01-22					FO.	KM CMS-25	52-10					4090 (Cont.
	CATION OF GENERAL SERVICE COSTS IUNITY MENTAL HEALTH CENTERS	ТО								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM	WORKSHEET J-1, PART I (CONT.)	
										COMI ONENI CCN.	10	_	
PART	- ALLOCATION OF GENERAL SERVICE	E COSTS TO CO	MMUNITY MEN	TAL HEALTH CI	ENTER COST CEN	NTERS				I	<u> </u>		
					MAIN-		CENTRAL		MEDICAL			NON-	
CC	MPONENT COST CENTER				TENANCE	NURSING	SERVICES		RECORDS		OTHER	PHYSICIAN	
	(omit cents)	HOUSE-			OF	ADMINIS-	&		&	SOCIAL	GENERAL	ANES-	
		KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	SERVICE	THETISTS	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
	Speech Pathology												5
	Medical Social Services												6
	Respiratory Therapy												7
	Psychiatric/Psychological Services												8
9	Individual Therapy												9
	Group Therapy												10
	Individualized Activity Therapies												11
	Family Counseling												12
	Diagnostic Services												13
	Approved Patient Training & Education												14
	Prosthetic and Orthotic Devices												15
	Drugs and Biologicals												16
	Medical Supplies												17
	Medical Appliances												18
	Durable Medical Equipment-Rented												19
	Durable Medical Equipment-Sold												20
	All Others												21
22	Totals (sum of lines 1-21)(1)												22

23 Unit Cost Multiplier (see instructions)

Rev. 17

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

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS)						PROVIDER CCN:	PERIOD: FROM_	WORKSHEET J-1, PART I	
							COMPONENT CCN:	то	-	
PART I - ALLOCATION OF GENERAL SERVICE C	OSTS TO COMMUNIT	Y MENTAL HEALTH	CENTER COST CEN	TERS			<u> </u>	<u> </u>	1	
				PARA-		INTERN & RESIDENT		ALLOCATED		
COMPONENT COST CENTER		INTERNS &	RESIDENTS	MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
,	PROGRAM	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	
	20	21	22	23	24	25	26	27	28	1
1 Administrative and General										
2 Skilled Nursing Care										1
3 Physical Therapy										1
4 Occupational Therapy										
5 Speech Pathology										
6 Medical Social Services										
7 Respiratory Therapy										
8 Psychiatric/Psychological Services										
9 Individual Therapy										
10 Group Therapy										
11 Individualized Activity Therapies										
12 Family Counseling										
13 Diagnostic Services										
14 Approved Patient Training & Education										
15 Prosthetic and Orthotic Devices										
16 Drugs and Biologicals										
17 Medical Supplies										
18 Medical Appliances										
19 Durable Medical Equipment-Rented										
20 Durable Medical Equipment-Sold										
21 All Others										
22 Totals (sum of lines 1-21)(1)										
23 Unit Cost Multiplier (see instructions)										

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

09-13				4090 (Cont.) 4090 (
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART II	ALLOCA COMMU
PART I	- ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMU	NITY MENTAL HEALT	TH CENTER COST CEN	TERS - STATISTICAL	BASIS		<u> </u>			PART II
	CMHC COST CENTER (omit cents)	0		PITAL ED COST MOVABLE EQUIPMENT (SQUARE FEET) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 4A	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
1	Administrative and General										1 1
2	Skilled Nursing Care										2 2
3	Physical Therapy										3 3
	Occupational Therapy										4 4
	Speech Pathology										5 5
	Medical Social Services										6 6
7	Respiratory Therapy										7 7
	Psychiatric/Psychological Services										8 8
9	Individual Therapy										9 9
	Group Therapy										10 10
11	Individualized Activity Therapies										11 11
12	Family Counseling										12 12
	Diagnostic Services										13 13
	Approved Patient Training & Education										14 14
15	Prosthetic and Orthotic Devices										15 15
16	Drugs and Biologicals										16 16
17	Medical Supplies										17 17
	Medical Appliances										18 18
19	Durable Medical Equipment-Rented										19 19
20	Durable Medical Equipment-Sold										20 20
21	All Others										21 21
22	Totals (sum of lines 1-21)										22 22
	Total Cost to be Allocated										23 23
24	Unit Cost Multiplier (see instructions)										24 24

Cont.)				1 01	CIVI CIVID 250	2 10						0) 13
ATION OF GENERAL SERVICE COSTS TO									PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1,	
JNITY MENTAL HEALTH CENTERS											PART II (CONT.)	
									COMPONENT CCN:	ТО	_	
- ALLOCATION OF GENERAL SERVICE O	COSTS TO COMM	IIINITY MENTA	I HEALTH CEN	TER COST CEN	TFRS - STATISTI	CAL BASIS				<u>. </u>		
THE CONTROL OF GENERALE BERVICE	COBTB TO COMIN	I WILLIAM	LE THE THE CEN	MAIN-	TERS STATISTI	CAL BASIS	ı	I	ı		NON-	т —
				TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
	HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
()	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
	9	10	11	12	13	14	15	16	17	18	19	1
Administrative and General				-					-,			1
Skilled Nursing Care												2
Physical Therapy												3
Occupational Therapy												4
Speech Pathology												5
Medical Social Services												6
Respiratory Therapy												7
Psychiatric/Psychological Services												8
Individual Therapy												9
Group Therapy												10
Individualized Activity Therapies												11
Family Counseling												12
Diagnostic Services												13
Approved Patient Training & Education												14
Prosthetic and Orthotic Devices												15
Drugs and Biologicals												16
Medical Supplies												17
Medical Appliances												18
Durable Medical Equipment-Rented												19
Durable Medical Equipment-Sold												20
All Others												21
Totals (sum of lines 1-21)											_	22
Total Cost to be Allocated												23
Unit Cost Multiplier (see instructions)	1	1	1	I		1		I	1			24

Sev. 4

	ATION OF GENERAL SERVICE COSTS TO JNITY MENTAL HEALTH CENTERS	PROVIDER CCN:	WORKSHEET J-1, PART II (CONT.)								
								COMPONENT CCN:	то	-	
D + D = 11	ALLOGATION OF SEVERAL SERVICES	0.000.000.000.000		nimen coam ornime	na amumiamiaui nu	110					
PARTII	- ALLOCATION OF GENERAL SERVICE C	OSTS TO COMMUNITY	MENTAL HEALTH C	ENTER COST CENTER		SIS			_		
			DITERNIC	DECIDENTO	PARA-						
		NURSING	SALARY &	RESIDENTS	MEDICAL EDUCATION						
	CORF COST CENTER	PROGRAM	FRINGES	PROGRAM COSTS	(SPECIFY)						
	(omit cents)	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED						
		TIME)	TIME)	TIME) 22	TIME)	24	25	26	27	28	4
- 1	Administrative and General	20	21	22	23	24	25	26	21	28	-
	Skilled Nursing Care										1
											4
	Physical Therapy										3
	Occupational Therapy Speech Pathology									4	4
	Medical Social Services									4	6
	Respiratory Therapy									4	- 2
	Psychiatric/Psychological Services									4	8
	Individual Therapy									4	9
	Group Therapy	-			-						10
	Individualized Activity Therapies	+			+						11
	Family Counseling	-			-						12
	Diagnostic Services	-			-						13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented	+			+						19
	Durable Medical Equipment-Sold	+		†	+						20
	All Others	+		†	+						21
	Totals (sum of lines 1-21)	+		†	+						22
	Total Cost to be Allocated	†	1	 	†						23
	Unit Cost Multiplion (see instructions)	1	1		1						24

Rev. 17

	UTATION OF COMMUNITY MENTAL HI	EALTH CENTER PRO	VIDER COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET J-2,	
		DIETH CENTER THO	VIDER CODID					THE VIBER COIN	FROM	PART I	
								COMPONENT CCN:		-	
										_	
PART I	- APPORTIONMENT OF CMHC COST C	ENTERS									
		(From		Ratio of		Title V		Title XVIII		Title XIX	T
		Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Pt. I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
		col. 28)	Charges	(col. 1 ÷ col. 2)	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	
		1	2	3	4	5	6	7	8	9	1
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
10	Group Therapy										10
	Individualized Activity Therapy										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	All Others (1)										19
20	Totals (sum of lines 1 through 19)										20

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

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

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

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

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

4090	(Cont.)	1	FORM CMS-25	FORM CMS-2552-10					
		OF REIMBURSEMENT SETTLEMENT COMMUNI TH CENTER PROVIDER SERVICES	TY	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-3			
Check applicat box:	ble	[] Title V [] Title VIII [] Title XIX		1		-			
		(1				PROGRAM COST			
1	Cost of	component services (from Wkst. J-2, Pt. II, line 29)				COST	1		
2		ments received excluding outliers					2		
3	Outlier	payments					3		
4	Primary	payer payments					4		
5	Total re	asonable cost (see instructions)					5		
6	Total ch	arges for program services					6		
	CUSTO	MARY CHARGES							
7	Aggrega	ate amount actually collected from patients liable for serv	vices on a charge basis				7		
8	Amount	that would have been realized from patients liable for pa	ayment for services on a charge				8		
	basis ha	d such payment been made in accordance with 42 CFR 4	413.13(e)				8		
9	Ratio of	fline 7 to line 8 (not to exceed 1.000000) (see instruction	ns)				9		
10	Total cu	stomary charges (see instructions)					10		
11	Excess	of customary charges over reasonable cost (see instruction	ons)				11		
12		of reasonable cost over customary charges (see instruction	ons)				12		
		JTATION OF REIMBURSEMENT SETTLEMENT							
13	Total re	asonable cost (from line 5)					13		
14		leductible billed to program patients					14		
15		t (line 13 minus line 14)					15		
16		of reasonable cost over customary charges (from line 12)	1				16		
		l (line 15 minus line 16)					17		
18		ent of costs (80% of line 17) (see instructions)					18		
19		coinsurance billed to program patients (from provider rec	cords)				19		
20		t less actual billed coinsurance (line 17 minus line 19)					20		
21		ble bad debts (from provider records) (see instructions)					21		
22		d reimbursable bad debts (see instructions)					22		
23		ble bad debts for dual eligible beneficiaries (see instruction	ions)				23		
24		nbursable amount (see instructions)					24		
25		djustments (see instructions) (specify)					25		
25.50		ACO demonstration payment adjustment (see instruction					25.50		
25.99		stration payment adjustment amount before sequestration	1				25.99		
26		st (see instructions)					26		
		ration adjustment (see instructions)					26.01		
26.02	Demons	stration payment adjustment amount after sequestration				1	26.02		

27 Interim payments (see instructions)

Interim payments (see instructions)
 Tentative settlement (for contractor use only)
 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)
 Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)

11-10		FORM CMS-2	.332-10			4090) (Cont.)
	YMENTS TO HOSPITAL-BASED COMMU		PROVIDER	CCN:	PERIOD:	WORKSHEET J-4	
CENTER FOR SEI	RVICES RENDERED TO PROGRAM BENE	EFICIARIES			FROM	_	
			COMPONE	NT CCN:	ТО	_	
Check							
applicable	[] Title XVIII						
boxes:					Т т	Part B	
DESC	RIPTION				1	2 2	_
DESC	KIFTION				mm/dd/yyyy	Amount	-
1 Total inter	rim payments paid to providers				IIIII/dd/yyyy	Amount	1
2 Interim pa	syments payable on individual bills, either						2
	or to be submitted to the intermediary, for						_
	endered in the cost reporting periods. If						
	e "NONE", or enter zero.						
	ately each retroactive			.01			3.01
	adjustment amount		Program	.02			3.02
	subsequent revision of		to	.03			3.03
	1 rate for the		Provider	.04			3.04
	ting period. Also show		11011461	.05			3.05
	ch payment.			.50			3.50
	rite "NONE",		Provider	.51			3.51
or enter ze			to	.52			3.52
or enter 20	20 (1).		Program	.53			3.53
			110514111	.54			3.54
Subtotal (sum of lines 3.01-3.49						3.0 .
	n of lines 3.50-3.98)			.99			3.99
	rim payments (sum of lines 1, 2, and 3.99)						4
	Worksheet J-3, line 27)						
	, , ,						
TO BE CO	MPLETED BY INTERMEDIARY						
5 List separa	ately each tentative		Program	.01			5.01
settlement	payment after desk review.		to	.02			5.02
Also show	date of each payment.		Provider	.03			5.03
If none, w	rite "NONE,"		Provider	.50			5.50
or enter ze	ero (1).		to	.51			5.51
			Program	.52			5.52
Subtotal (sum of lines 5.01-5.49 minus						
sum of lin	es 5.50-5.98)			.99			5.99
6 Determine	e net settlement amount		Program				
(balance d	lue) based on the cost		to				
report (see	e instructions). (1)		Provider	.01			6.01
			Provider				
			to				
			Program	.02			6.02
	licare liability						7
(see instru	,						
8 Name of 0	Contractor	Contractor Number		NPR I	Date (Month, Day, Year	r)	8
				I			

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

	SIS OF HOSPITAL-BASED DE COSTS								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K	-
COS	T CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER 5	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	3	0	,	0	9	10	+-
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance											3
4	Transportation - Staff											4
5	*											5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care									1		7
- 8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services									1		9
10	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
12												12
13	Occupational Therapy											13
14	1 17											14
15	Medical Social Services											15
16	Spiritual Counseling											16
17												17
18												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									1		22
23												23
24	Sedatives / Hypnotics											25
	Other - Specify			1			1					25
26	Durable Medical Equipment/Oxygen											26
27	Patient Transportation											27
28												28
	Labs and Diagnostics											29
30	Medical Supplies											30
31												31
32												32
33												33
	Other											34
	HOSPICE NONREIMBURSABLE SERVICE											
35												35
36	Volunteer Program Costs											36
37												37
38	Other Program Costs											38
39												39

11-16			FC)KM CMS-2552	-10				4090	(Cont.
HOSPICE COMPENSATION ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-1	
SALARIES AND WAGES								FROM	_	
							COMPONENT CCN:	ТО		
			MEDICAL							
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	1
GENERAL SERVICE COST CENTERS										
 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	İ									34
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										35
36 Volunteer Program Costs		 			 					36
37 Fundraising		 			 					37
38 Other Program Costs		†		 	†					38
39 Total (sum of lines 1 thru 38)		†			t					39
5) Total (sum of mics I und 50)					l	I				37

40-633

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

	TE COMPENSATION ANALYSIS EMPLOYEE							PROVIDER CCN:	PERIOD:	WORKSHEET K-2	
BENEF.	ITS (PAYROLL RELATED)								FROM	=	
								COMPONENT CCN:	10	-	
		1	1	MEDICAL	l	1				+	
COS	T CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
	(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	(onit cons)	1	2	3	4	5	6	7	8	9	1
	GENERAL SERVICE COST CENTERS					-		·	, and the second		
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance		1								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
	Medical Social Services									+	15
16	Spiritual Counseling									+	16
	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
	Analgesics										23
24	Sedatives / Hypnotics										24
	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services		†			 				†	28
	Labs and Diagnostics		†			 				†	29
30	Medical Supplies		†			 				†	30
31	Outpatient Services (including E/R Dept.)		†			 				†	31
32	Radiation Therapy		†			 				†	32
33	Chemotherapy		†			 				†	33
	Other		t			t				+	34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs		t			t				+	36
37	Fundraising		t			t				+	37
38	Other Program Costs		t			t				+	38
39	Total (sum of lines 1 thru 38)									+	39
37	Town (June of filles I till a 30)	1	I .	1		I .		1	1		

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

09-13				FC	DRM CMS-2552	:-10				4090	(Cont.
HOSPICE COMPENSATION	ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-3	
CONTRACTED SERVICES/F	PURCHASED SERVICES								FROM	_[
								HOSPICE CCN:	TO	_	
				MEDICAL							
COST CENTER DESCRIP	TIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)		TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
GENERAL SERVIC											-
1 Capital Related Costs											1
2 Capital Related Costs											2
3 Plant Operation and !								_			3
4 Transportation - Staff								_			4
5 Volunteer Service Co								_			5
6 Administrative and G											6
INPATIENT CARE											
7 Inpatient - General C 8 Inpatient - Respite Ca										+	7
VISITING SERVICE											
9 Physician Services	23										9
10 Nursing Care											10
11 Nursing Care-Contin	II C										11
12 Physical Therapy	ious Home Care									+	12
13 Occupational Therap											13
14 Speech/ Language Pa											14
15 Medical Social Service										+	15
16 Spiritual Counseling	cs	+								+	16
17 Dietary Counseling										-	17
18 Counseling - Other										+	18
19 Home Health Aide at	nd Homemaker									+	19
20 HH Aide & Homema										+	20
21 Other	kei - Cont. Home Care									+	21
OTHER HOSPICE S	FRVICE COSTS										- 21
22 Drugs, Biological and											22
23 Analgesics	i initasion Therapy										23
24 Sedatives / Hypnotics											24
25 Other - Specify											25
26 Durable Medical Equ	ipment/Oxygen										26
27 Patient Transportation											27
28 Imaging Services									İ	1	28
29 Labs and Diagnostics										1	29
30 Medical Supplies										1	30
31 Outpatient Services (including E/R Dept.)									1	31
32 Radiation Therapy	* * /									1	32
33 Chemotherapy											33
34 Other										1	34
	MBURSABLE SERVICE										
35 Bereavement Program											35
36 Volunteer Program C	osts										36
37 Fundraising											37
38 Other Program Costs											38
39 Total (sum of lines 1	thru 38)										39

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

COST A	LLOCATION - HOSPICE GENERAL SERVICE	COST						PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET K-4, PART I	
COS	T CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION 0	CAPITAL RE BUILDINGS & FIXTURES	ELATED COST MOVABLE EQUIPMENT 2	PLANT OPERATION & MAINT.	TRANS- PORTATION 4	VOLUNTEER SERVICES COORDI- NATOR 5	SUBTOTAL (cols. 0 - 5) 5A	ADMINIS- TRATIVE & GENERAL 6	TOTAL (col. 5 ± col. 6)	
	GENERAL SERVICE COST CENTERS	Ü	1	2	J		3	311	Ü	,	
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
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify							1			25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services										28
	Labs and Diagnostics										29
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy			1				1			32
	Chemotherapy										33
	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
	Fundraising										37
38	Other Program Costs	•		1				1			38
39	Total (sum of lines 1 thru 38)										39

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

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

(1) Colu (2) Colu

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

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

FORM CMS-2552-10 4090 (Cont.)

ATION OF GENERAL SERVICE								PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
TO HOSPICE COST CENTERS									FROM	PART I (Cont.)	
								HOSPICE CCN:	TO	_	
- ALLOCATION OF GENERAL SERVICE COS	TS TO HOSPICE C	OST CENTERS									
- Industrial of Server Beautiful Service Cos	To not not not o	l certens									$\overline{}$
HOSPICE COST CENTER	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
(omit cents)	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
	SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
	8	9	10	11	12	13	14	15	16	17	1
Administrative and General											1
Inpatient - General Care											2
Inpatient - Respite Care											3
Physician Services											4
Nursing Care											5
Nursing Care-Continuous Home Care											6
Physical Therapy											7
Occupational Therapy											8
Speech/ Language Pathology											9
Medical Social Services											10
Spiritual Counseling											11
Dietary Counseling											12
Counseling - Other											13
Home Health Aide and Homemaker											14
HH Aide & Homemaker - Cont. Home Care											15
Other											16
Drugs, Biological and Infusion Therapy											17
Analgesics											18
Sedatives / Hypnotics											19
Other - Specify											20
Durable Medical Equipment/Oxygen											21
Patient Transportation											22
Imaging Services											23
Labs and Diagnostics											24
Medical Supplies											25
Outpatient Services (including E/R Dept.)											26
Radiation Therapy											27
Chemotherapy											28
Other											29
Bereavement Program Costs											30
Volunteer Program Costs											31
Fundraising											32
Other Program Costs											33
Totals (sum of lines 1-33) (2)											34
Unit Cost Multiplier (see instructions)											35

mn 0, line 34 must agree with Wkst. A, column 7, line 116.

mns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

4090	(Cont.)				FORM CN	AS-2552-10							10-12
	CATION OF GENERAL SERVICE TO HOSPICE COST CENTERS									PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART I (Cont.)	
PART I	- ALLOCATION OF GENERAL SERVICE COS	STS TO HOSPICE	E COST CENTER	S							_	•	
	HOSPICE COST CENTER (omit cents)	OTHER GENERAL SERVICE `8	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL 20	INTERNS & SALARY & FRINGES 21	PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (cols. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUST. 25	SUBTOTAL (cols. 24 ± 25) 26	ALLOCATED HOSPICE A&G (see Part II) 27	TOTAL HOSPICE COSTS (cols. 26 ± 27) 28	
	Administrative and General												1
2	Inpatient - General Care												2
	Inpatient - Respite Care												3
	Physician Services												4
5	Nursing Care												5
6	Nursing Care-Continuous Home Care												6
7	Physical Therapy												7
8	Occupational Therapy											1	8
9	Speech/ Language Pathology												9
10	Medical Social Services												10
11	Spiritual Counseling												11
12	Dietary Counseling												12
13	Counseling - Other										1		13
14	Home Health Aide and Homemaker										1		14
15	HH Aide & Homemaker - Cont. Home Care												15
16	Other												16
17	Drugs, Biological and Infusion Therapy												17
18	Analgesics										1		18
19	Sedatives / Hypnotics												19
20	Other - Specify												20
21	Durable Medical Equipment/Oxygen										1		21
22	Patient Transportation										1		22
23	Imaging Services										1	1	23
24	Labs and Diagnostics										1		24
25	Medical Supplies										1		25
	Outpatient Services (including E/R Dept.)										†	1	26
	Radiation Therapy										1	1	27
	Chemotherapy	İ			1		1		1		1	1	28
	Other										1	1	29
	Bereavement Program Costs										†	†	30
	Volunteer Program Costs										+		31
	Fundraising	1	1		1	i		i			+	+	32

33 Other Program Costs

34 Totals (sum of lines 1-33) (2)

35 Unit Cost Multiplier (see instructions)

33

34

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

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

ALLOC	ATION OF GENERAL SERVICE COSTS TO					PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	ALLO
HOSPIG	E COST CENTERS STATISTICAL BASIS						FROM	PART II	HOSPI
						HOSPICE CCN:	ТО		
PART I	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STA	TISTICAL BASIS							PART
		CAP	ITAL						
		RELATI	ED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
I	IOSPICE COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
		(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
1	Administrative and General								1 1
2	Inpatient - General Care								2 2
3	Inpatient - Respite Care								3 3
4	Physician Services								4 4
5	Nursing Care								5 5
6	Nursing Care-Continuous Home Care								6 6
7	Physical Therapy								7 7
8	Occupational Therapy								8 8
9	Speech/ Language Pathology								9 9
10	Medical Social Services								10 10
11	Spiritual Counseling								11 11
12	Dietary Counseling								12 12
13	Counseling - Other								13 13
14	Home Health Aide and Homemaker								14 14
15	HH Aide & Homemaker - Cont. Home Care								15 15
16	Other								16 16
17	Drugs, Biological and Infusion Therapy								17 17
18	Analgesics								18 18
19	Sedatives / Hypnotics								19 19
20	Other - Specify								20 20
21	Durable Medical Equipment/Oxygen								21 21
22	Patient Transportation								22 22
23	Imaging Services								23 23
24	Labs and Diagnostics								24 24
25	Medical Supplies								25 25
26	Outpatient Services (including E/R Dept.)								26 26
27	Radiation Therapy								27 27
28	Chemotherapy								28 28
29	Other								29 29
30	Bereavement Program Costs								30 30
31	Volunteer Program Costs								31 31
32	Fundraising								32 32
33	Other Program Costs								33 33
34	Totals (sum of lines 1-33) (2)								34 34
35	Total cost to be allocated								35 35
36	Unit Cost Multiplier (see instructions)								36 36

Cont.)			101	CIVI CIVID-255	72-10					07-13
ATION OF GENERAL SERVICE COSTS TO							PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
E COST CENTERS STATISTICAL BASIS								FROM	PART II	
							HOSPICE CCN:	TO		
- ALLOCATION OF GENERAL SERVICE COSTS TO H	IOSPICE COST CENTERS - S	STATISTICAL BA	SIS							
	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL	
	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	
HOSPICE COST CENTER	SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	
	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	
	LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	
	8	9	10	11	12	13	14	15	16	1
Administrative and General										1
Inpatient - General Care										2
Inpatient - Respite Care										3
Physician Services										4
Nursing Care										5
Nursing Care-Continuous Home Care										6
Physical Therapy										7
Occupational Therapy										8
Speech/ Language Pathology										9
Medical Social Services										10
Spiritual Counseling										11
Dietary Counseling										12
Counseling - Other										13
Home Health Aide and Homemaker										14
HH Aide & Homemaker - Cont. Home Care										15
Other										16
Drugs, Biological and Infusion Therapy										17
Analgesics										18
Sedatives / Hypnotics										19
Other - Specify										20
Durable Medical Equipment/Oxygen										21
Patient Transportation										22
Imaging Services										23
Labs and Diagnostics										24
Medical Supplies										25
Outpatient Services (including E/R Dept.)										26
Radiation Therapy										27
Chemotherapy										28
Other										29
Bereavement Program Costs										30
Volunteer Program Costs										31
Fundraising										32
Other Program Costs										33
Totals (sum of lines 1-33) (2)										34
Total cost to be allocated										35
Unit Cost Multiplier (see instructions)										36

	ATION OF GENERAL SERVICE COSTS TO					PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
HOSPIC	E COST CENTERS STATISTICAL BASIS						FROM	PART II	
						HOSPICE CCN:	то	_	
PARTI	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS			1				I	
				NON-				PARA-	I
				PHYSICIAN		INTERNS &	& RESIDENTS	MEDICAL	
		SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
	HOSPICE COST CENTER	SERVICE	GENERAL	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	
		(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
		SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	
		17	18	19	20	21	22	23	1
1	Administrative and General			-				-	
2	Inpatient - General Care								1 2
3	Inpatient - Respite Care								
4	Physician Services								4
5	Nursing Care								
6	Nursing Care-Continuous Home Care								(
7	Physical Therapy								1
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services								10
11	Spiritual Counseling								1
12	Dietary Counseling								12
13	Counseling - Other								1.
14	Home Health Aide and Homemaker								14
15	HH Aide & Homemaker - Cont. Home Care								1.5
16	Other								10
17	Drugs, Biological and Infusion Therapy								11
18	Analgesics								18
19	Sedatives / Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								2
	Patient Transportation								22
23	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								2:
26	Outpatient Services (including E/R Dept.)								20
	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1-33) (2)								34
	Total cost to be allocated								35
36	Unit Cost Multiplier (see instructions)								30

4090 ((Cont.)	FORM CMS-2332-10				10-12
APPOR	TIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-5, PART III	
			HOSPICE CCN:	TO		
				-	_	
PART I	II - COMPUTATION OF TOTAL HOSPICE SHARED COSTS	S		•	•	
		Wkst. C, Part I,	Cost to	Total Hospice Charges	Hospice Shared Ancillary	
		col. 9,	Charge	(Provider	Costs	
	COST CENTER	line	Ratio	Records)	(cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	66				1
2	Occupational Therapy	67				2
3	Speech/ Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73				4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60				6
7	Medical Supplies	71				7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	76				10
11	Totals (sum of lines 1-10)					11

40-644 Rev. 3

07-23		FORM CMS-2552-10		4090 (
CALCU	JLATION OF HOSPICE PER DIEM COST		PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET K-6			
	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL			
		1	2	3	4			
1	Total cost (see instructions)					1		
2	Total unduplicated days (Worksheet S-9, column 6, line 5)					2		
3	Average cost per diem (line 1 divided by line 2)					3		
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)					4		
5	Aggregate Medicare cost (line 3 times line 4)					5		
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)					6		
7	Aggregate Medicaid cost (line 3 times line 6)					7		
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8		
9	Aggregate SNF cost (line 3 times line 8)					9		
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10		
11	Aggregate NF cost (line 3 times line 10)					11		
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)					12		
13	Aggregate cost for other days (line 3 times line 12)					13		

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

Rev. 21 40-645

1070	(COII	·· <i>)</i>	1 OIUI	CIVID 2332 10	•			01 23
CALCU	ULATI	ON OF CAPITAL PAYMENT			PROVIDER CCN:	PERIOD:	WORKSHEET L	
						FROM		
					COMPONENT CCN:	то		
Cl. I		[] Title V	[[]] []	[] PPS				
Check applicable	1.	Title V	[] Hospital [] PARHM Demonstration	Cost Met	had			
boxes:	ie	Title XIX	[] FARHW Demonstration	[] Cost Met	nou			
	I - EIII	LY PROSPECTIVE METHOD						
TAKT		TAL FEDERAL AMOUNT						
	_	tal DRG other than outlier						1 1
1.01	_	el 4 BPCI Capital DRG other than ou	tlier					1.01
2		tal DRG outlier payments	and a					2
2.01	_	el 4 BPCI Capital DRG outlier paymo	ents					2.01
3			days in the cost reporting period (see in	structions)				3
4		ber of interns & residents (see instru		,				4
- 5		ect medical education percentage (se						5
6		ect medical education adjustment (se						6
7	Perce	entage of SSI recipient patient days to	Medicare Part A patient days (Worksho	eet E, Part A line 30)	(see instructions)			7
- 8	Perce	entage of Medicaid patient days to tot	al days (see instructions)					8
9	Sum	of lines 7 and 8						9
10	Allov	wable disproportionate share percenta	age (see instructions)					10
11	Disp	roportionate share adjustment (see in	structions)					11
12	Total	prospective capital payments (see in	structions)					12
PART I	II - PA	YMENT UNDER REASONABLE C	OST					
1	Prog	ram inpatient routine capital cost (see	e instructions)					1
2		ram inpatient ancillary capital cost (s	,					2
3		inpatient program capital cost (line l	1					3
4	_	tal cost payment factor (see instruction						4
5		inpatient program capital cost (line 3						5
PART I	_	MPUTATION OF EXCEPTION PA						
1		ram inpatient capital costs (see instru						1
2			dinary circumstances (see instructions)					2
3	_	program inpatient capital costs (line 1						3
4		icable exception percentage (see inst						4
5	•	tal cost for comparison to payments (,					5
- 0		entage adjustment for extraordinary c	· · · · · · · · · · · · · · · · · · ·	2 v lina 6)				7
- 8		tal minimum payment level (line 5 pl	evel for extraordinary circumstances (line 7)	ie 2 x iiiie 0)				8
9		ent year capital payments (from Part I						9
10			um payment level to capital payments (l	ine & less line (1)				10
11		• • •	n payment level over capital payment	ine o iess inie)				11
		n prior year Worksheet L, Part III, lir	1 7 1 1 7					- 11
12	_		ent level to capital payments (line 10 pl	us line 11)				12
13	_		is positive, enter the amount on this lin					13
14	_		n payment level over capital payment	-/				14
• •		ne following period (if line 12 is nega						1
15	_	ent year allowable operating and cap						15
16		ent year operating and capital costs (16
		ent year exception offset amount (see						17

40-646 Rev. 21

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

Rev. 18

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		ITAL D COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	U	1	2	ZA	4	3	6	/	
	Operating Room									50
	Recovery Room							+		51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
										59
60	Laboratory									60
61	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
	Physical Therapy									66
67	Occupational Therapy									67
	Speech Pathology									68
69	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
	Other Outpatient (specify)								<u> </u>	93
93.99	Partial Hospitalization Program									93.99

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I	
EATRA	ORDINARY CIRCUMSTANCES							TO	PARTI	
		EXTRA-	CAP	ITAI.				10		$\overline{}$
		ORDINARY		D COSTS						
		CAPITAL			SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION	
	cost content postripuons	COSTS	FIXTURES	EQUIPMENT	cols. 0-4)	DEPARTMENT	GENERAL	REPAIRS	OF PLANT	
		0	1	2	2A	4	5	6	7	-
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
102	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
	Negative Cost Centers									201
202	Total (sum of line 118 and lines 190 through 201)									202
203	Total Statistical Basis									203
204	Unit Cost Multiplier									204

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROM TO _	WORKSHEET L-1, PART I (Cont.)	
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	0	,	10	11	12	13	14	13	10	17	+-
Capital Related Costs-Buildings and Fixtures											1
Capital Related Costs-Movable Equipment	1										2
4 Employee Benefits Department	1										4
5 Administrative and General	1										5
6 Maintenance and Repairs	1										6
7 Operation of Plant	1										7
8 Laundry and Linen Service		1									8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria					1						11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply								Ī			14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing Program											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Ed. Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											3(
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											4(
41 Subprovider IRF											41
42 Subprovider											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care		I								1	40

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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
,	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS	Ü		10		.2	13		10	10	• /	
_	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
102	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
	Gift, Flower, Coffee Shop, & Canteen											190
	Research											191
	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
	Cross Foot Adjustments											200
	Negative Cost Centers											201
	Total (sum of line 118 and lines 190 through 201)											202
	Total Statistical Basis											203
204	Unit Cost Multiplier											204

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES	_						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
ANCILLARY SERVICE COST CENTERS	10	17	20	21	22	23	27	23	20	
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catherization										59
60 Laboratory										60
61 PBP Clinical Laboratory Service-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
77 Allogeneic HSCT Acquisition										77
78 CAR T-Cell Immunotherapy										78
OUTPATIENT SERVICE COST CENTERS										00
88 Rural Health Clinic (RHC)										88 89
89 Federally Qualified Health Center (FQHC)										
90 Clinic										90 91
91 Emergency 92 Observation Beds										91
										92
93 Other Outpatient (specify)										93.99
93.99 Partial Hospitalization Program	1									93.99

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	<u> </u>
	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										0.4
	Home Program Dialysis										94 95
	Ambulance Services										95
	Durable Medical Equipment-Rented Durable Medical Equipment-Sold										96
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	Opioid Treatment Program										102
	SPECIAL PURPOSE COST CENTERS										
	Kidney Acquisition										105
	Heart Acquisition										106
	Liver Acquisition										107
	Lung Acquisition										108
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers										193
	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
	Negative Cost Centers										201
	Total (sum of line 118 and lines 190 through 201)										202
	Total Statistical Basis										203
204	Unit Cost Multiplier										204

4090 ((Cont.)	FC	JRM CMS-2552-	-10					12-22
COMPU	UTATION OF PROGRAM INPATIENT ROUTINE SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
	AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						FROM	PART II	
							ТО	-	
Check	[] Title V					1		-1	
applicable									
box:	Title XIX								
		Capital Cost		Reduced					
		for Extraordinary		Capital Cost				ļ	ĺ
		Circumstances		for Extraordinary				Inpatient Program	l
		(from Wkst. L-1,	Swing Bed	Circumstances	Total	Per Diem	Inpatient	Capital Cost	ĺ
	Cost Center Description	Part I, col. 26)	Adjustment	(col. 1 - col. 2)	Patient Days	(col. 3 ÷ col. 4)	Program Days	(col. 5 x col. 6)	l
(A)	Cost Center Description	1 art 1, cor. 20)	Aujustinent 2	3	4	(coi. 3 · coi. 4)	6	7	l
(A)	INPATIENT ROUTINE SERVICE	1		3	7	,	0		
	COST CENTERS								i
	COST CENTERS								-
30	Adults & Pediatrics (General Routine Care)								30
	1								2.1
31	Intensive Care Unit								31
32	Coronary Care Unit								32
	colonialy care onic						+	+	- 32
33	Burn Intensive Care Unit								33
24	Surgical Intensive Care Unit								24
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
	• • • • • • • • • • • • • • • • • • • •						1		
40	Subprovider IPF								40
41	Subprovider IRF								41
	Supported Ita						+	+	
42	Subprovider (Other)								42
- 12	Norman								42
43	Nursery								43
200	Total (sum of lines 30-199)						A		200

⁽A) Worksheet A line numbers

07-20				I OIGNI CIVID-2332-	10				T070 ((Cont.)
	ATION OF PROGRAM INPATI		E				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
CAPITAL C	COSTS FOR EXTRAORDINAR	RY CIRCUMSTANCES					GOV MOVENIM GOV	FROM	PART III	
							COMPONENT CCN:	то	-	
Check	[] Hospital		[] Title V							
applicable			[] Title XVIII, Part A							
boxes:			[] Title XIX							
	•				Capital Cost for				I	
					Extraordinary				Program	
					Circumstances	Total Charges	Ratio of Cost		Extraordinary	
Co	ost Center Description				(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
	1				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)					1	2	3	4	5	1
	NCILLARY SERVICE COST C	ENTERS								
50 O	perating Room									50
51 R	ecovery Room									51
52 La	abor Room and Delivery Room									52
	nesthesiology									53
54 Ra	adiology-Diagnostic									54
55 Ra	adiology-Therapeutic									55
56 Ra	adioisotope									56
57 C	omputed Tomography (CT) Scan	1								57
	Iagnetic Resonance Imaging (MF	RI)								58
59 Ca	ardiac Catherization									59
	aboratory									60
	BP Clinical Laboratory Service-P									61
	hole Blood & Packed Red Blood									62
	lood Storing, Processing, & Tran	IS.								63
	travenous Therapy									64
	espiratory Therapy									65
66 Ph	hysical Therapy									66
	ccupational Therapy									67
	peech Pathology									68
	lectrocardiology									69
	lectroencephalography									70
	ledical Supplies Charged to Patie									71
	nplantable Devices Charged to Pa	atients								72
	rugs Charged to Patients									73
	enal Dialysis									74
	SC (Non-Distinct Part)									75
	ther Ancillary (specify)									76
77 A	llogeneic Stem Cell Acquisition	·								77

⁽A) Worksheet A line numbers

.0,0 (0.	01111)		1 014.1 01	.10 2002 10					·
	ATION OF PROGRAM INPA COSTS FOR EXTRAORDIN	ATIENT ANCILLARY SERVICE				PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART III (CONT.)	
						COMPONENT CCN:		Truct in (convin)	
Check applicable boxes:	[] Hospital	[] Title V [] Title XVIII, Part A [] Title XIX						l	
Co	ost Center Description			Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)	
(A)				1	2	3	4	5	
	UTPATIENT SERVICE COS	ST CENTERS							
	ural Health Clinic (RHC)								88
	ederally Qualified Health Cen	ter (FQHC)							89
90 Cl									90
	mergency								91
	bservation Beds								92
	ther Outpatient (specify)								93
	artial Hospitalization Program								93.99
	THER REIMBURSABLE CO	OST CENTERS							
94 H	ome Program Dialysis								94
95 A	mbulance Services								95
	urable Medical Equipment-Re								96
	urable Medical Equipment-Sc	old							97
98 O	ther Reimbursable (specify)	_							98
200 To	otal (sum of lines 50 through	199)							200

40-658 Rev. 16

⁽A) Worksheet A line numbers

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

32 Total facility costs (sum of lines 22, 28 and 31)

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

	ATION OF OVERHEAD			PROVIDER CCN:	PERIOD:	WORKSHEET M-2	
10 ноз	SPTIAL-BASED RHC/FQHC SERVICES			COMPONENT CCN:	FROM TO	_	
						_	
		ospital-based FQHC			•	•	
VISITS	AND PRODUCTIVITY						
		Number			Minimum	Greater of	
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
		Personnel	Visits	Standard (1)	x col. 3)	col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1 through 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)						8
9	Physician Services Under Agreements						9
DETER	MINATION OF ALLOWABLE COST APPLICABLE TO I	HOSPITAL-BASED F	RHC/FQHC SERVI	CES			
10	Total costs of health care services (from Worksheet M-1, co	lumn 7, line 22)					10
11	Total nonreimbursable costs (from Worksheet M-1, column	7, line 28)					11
12	Cost of all services (excluding overhead) (sum of lines 10 at						12
13	Ratio of hospital-based RHC/FQHC services (line 10 divide						13
14	Total hospital-based RHC/FQHC overhead (from Workshe		: 31)				14
15	Parent provider overhead allocated to facility (see instruction	ons)					15
16	Total overhead (sum of lines 14 and 15)						16
17	Allowable Direct GME overhead (see instructions)						17
18	Enter the amount from line 16						18
19	Overhead applicable to hospital-based RHC/FQHC services	(line 13 x line 18)					19
20	Total allowable cost of hospital-based RHC/FQHC services	(sum of lines 10 and	19)				20

40-660 Rev. 10

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

03 23		I OIGH CIVID 2.	752 10		1070(Cont.
CALCULATIO	ON OF REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET M-3	
SETTLEMEN'	T FOR HOSPITAL-BASED RHC/FQHC SERV	ICES		FROM		
			COMPONENT CCN:	TO		
Check	[] Hospital-based RHC	[] Title V				
applicable	[] Hospital-based FQHC	[] Title XVIII				
boxes:		[] Title XI				
DETERMINA	TION OF RATE FOR HOSPITAL-BASED RH	C/FQHC SERVICES				
1 Total	allowable cost of hospital-based RHC/FQHC se	rvices (from Worksheet M-2, line 20)				1
2 Cost	of injections/infusions and their administration (f	rom Worksheet M-4, line 15)				2
3 Total	allowable cost excluding injections/infusions (lin	ne 1 minus line 2)				3
4 Total	visits (from Worksheet M-2, column 5, line 8)					4
5 Physi	icians visits under agreement (from Worksheet M	-2, column 5, line 9)				5
6 Total	adjusted visits (line 4 plus line 5)					6
7 Adjus	sted cost per visit (line 3 divided by line 6)					7

			Calculation of Limit (1)		7
		Payment Limit Period 1	Payment Limit Period 2	Payment Limit Period 3	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6, or your contractor)				8
9	Rate for Program covered visits (see instructions)				9
	LATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)				10
11	Program cost excluding costs for mental health services (line 9 x line 10)				11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)				16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)				16.04
16.05	Total program cost (see instructions)				16.05
17	Primary payer amounts				17
18	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19
20	Net Medicare cost excluding injections/infusions (see instructions)				20
21	Program cost of injections/infusions and their administration (from Worksheet M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)				22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				25.50
25.99	Demonstration payment adjustment amount before sequestration				25.99
26	Net reimbursable amount (see instructions)				26
26.01	Sequestration adjustment (see instructions)				26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments				27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program line 26 minus lines 26.01, 26.02, 27, and 28				29
30	Protested amounts (nonallowable cost report items) in accordance with CMS				30
	Pub. 15-2, chapter 1, section 115.2				

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

4090 (Con			RM CMS-2552-10)			03-23
COMPUTAT	TION OF HOSPITAL-BASED RHC/FQHC	VACCINE COST		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET M-4	
Check applicable boxes:	[] Hospital-based RHC [] Hospital-based FQHC	[] Title V [] Title XVIII [] Title XI				•	
			PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
1 Hee	alth care staff cost (from Worksheet M-1, colu	ımn 7 line 10)	1	2	2.01	2.02	1
	io of injection/infusion staff time to total	min 7, mic 10)					2
	lth care staff time						_
3 Inje	ection/infusion health care staff cost (line 1 x	line 2)					3
	ections/infusions and related medical supplies	costs					4
	m your records)						
	ect cost of injections/infusions (line 3 plus lin						5
	al direct cost of the hospital-based RHC/FQH rksheet M-1, column 7, line 22)	IC (Irom					6
	al overhead (from Worksheet M-2, line 19)						7
	io of injection/infusion direct cost to total dire	ect					8
	t (line 5 divided by line 6)						
	erhead cost - injection/infusion (line 7 x line 8	3)					9
	al injection/infusion costs and their						10
	ninistration costs (sum of lines 5 and 9)						
	al number of injections/infusions						11
	om your records) st per injection/infusion (line 10/line 11)						12
	mber of injection/infusion administered						13
	Program beneficiaries						15
	mber of COVID-19 vaccine injections/infusio	ons					13.01
	ninistered to MA enrollees						
	gram cost of injections/infusions and their ad						14
cost	ts (line 12 times the sum of lines 13 and 13.0)	l, as applicable)					
			1	COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION			
15 Tota	al cost of injections/infusions and their		1				15
adn	ninistration costs (sum of columns 1, 2, 2.01, nsfer this amount to Worksheet M-3, line 2)	and 2.02, line 10)					13
adn	al Program cost of injections/infusions and th ninistration costs (sum of columns 1, 2, 2.01, nsfer this amount to Worksheet M-3, line 21)	and 2.02, line 14)					16

11-10	FORM	CMS-2332-10		4090	(Cont.)
	SIS OF PAYMENTS TO HOSPITAL-BASED OHC FOR SERVICES RENDERED	PROVIDER CC	N: PERIOD: FROM	WORKSHEET M-5	
TO PRO	OGRAM BENEFICIARIES	COMPONENT	CCN: TO	-	
Check a	pplicable box: [] Hospital-based RHC [] Hospital-based FQF	HC			
				Part B	
	DESCRIPTION		1	2	
			mm/did/iv	y Amount	
1	Total interim payments paid to hospital-based RHC/FQHC				1
2	Interim payments payable on individual bills, either				2
	submitted or to be submitted to the intermediary, for				
	services rendered in the cost reporting periods. If				
	none, write "NONE", or enter zero.				
3	List separately each retroactive		.01		3.01
	lump sum adjustment amount	Program	.02		3.02
	based on subsequent revision of	to	.03		3.03
	the interim rate for the	Provider	.04		3.04
	cost reporting period. Also show		.05		3.05
	date of each payment.		.50		3.50
	If none, write "NONE",	Provider	.51		3.51
	or enter zero (1).	to	.52		3.52
		Program	.53		3.53
	G 1 - 1 / GP - 2 01 2 40 - 1 - GP - 2 50 2 00)		.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)				4
	(transfer to Worksheet M-3, line 27)				
	TO BE COMPLETED BY CONTRACTOR				
- 5	List separately each tentative	Program	.01		5.01
3	settlement payment after desk review.	to	.02		5.02
	Also show date of each payment.	Provider	.02		5.03
	If none, write "NONE,"	Provider	.50		5.50
	or enter zero (1).	to	.51		5.51
	of effici zero (1).	Program	.52		5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	Hogiani	.99		5.99
6	Determine net settlement amount	Program	.99		3.99
Ü	(balance due) based on the cost	to			
	report (see instructions). (1)	Provider	.01		6.01
	report (see instructions). (1)	Provider	.01		0.01
		to			
		Program	.02		6.02
7	Total Medicare liability (see instructions)	11061			7
- 8	Name of Contractor		Contractor Number	NPR Date	8
Ü				(Month/Day/Year)	
				(
			1	1	1

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENFOR HOSPITAL-BASED FQHC							WORKSHEET N-1	
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
REIMBURSABLE PASS THROUGH COSTS	1	2	,	-	J	Ü	,	
47 Pneumococcal Vaccines & Med Supplies								47
48 Influenza Vaccines & Med Supplies			 				 	48
48.10 COVID-19 Vaccine & Med Supplies								48.10
48.11 Monoclonal Antibody Products								48.11
49 Subtotal - Reimbursable Pass through Costs								49
OTHER FOHC SERVICES								
60 Medicare Excluded Services								60
61 Diagnostic & Screening Lab Tests								61
62 Radiology - Diagnostic								62
63 Prosthetic Devices								63
64 Durable Medical Equipment								64
65 Ambulance Services								65
66 Telehealth								66
67 Drugs Charged to Patients								67
68 Chronic Care Management								68
69 Other								69
70 Subtotal - Other FQHC Services								70
NONREIMBURSABLE COST CENTERS								
77 Retail Pharmacy								77
78 Other Nonreimbursable								78
79 Subtotal - Non-Reimbursable Costs								79
100 TOTAL (sum of lines 13, 37, 49, 70, and 79)								100

4000 (Cont.)	1 ORWI CIVIS-2552-10		01-22
CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT	PROVIDER CCN:	PERIOD:	WORKSHEET N-2
		FROM:	
	COMPONENT CCN:	TO:	

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

01-22	FOR	RM CMS-2552-10		4090 (Cont.			
COMPU	TATION OF HOSPITAL-BASED FQHC VACCINE COST		PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-3		
			COMPONENT CCN:	TO:	-		
			l		_ _		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS		
		1	2	2.01	2.02		
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)					1	
2	Ratio of injection/infusion staff time to total health care staff time					2	
3	Injection/infusion health care staff cost (line 1 x line 2)					3	
4	Injections/infusions and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, 48.10, and 48.11, respectively)					4	
5	Direct cost of injections/infusions (line 3 + line 4)					5	
6	Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8)					6	
7	Total administrative overhead (from Worksheet N-1, column 7, line 8)					7	
8	Ratio of injection/infusion direct cost to total direct cost (line 5 / line 6)					8	
9	Overhead cost - injections/infusions (line 7 x line 8)					9	
10	Total cost of injections/infusions and their administration (sum of lines 5 and 9)					10	
11	Total number of injections/infusions (from your records)					11	
12	Cost per injection/infusion (line 10 / line 11)					12	
13	Number of injections/infusions administered to Medicare beneficiaries					13	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees					13.01	
14	Cost of injections/infusions and their administration costs furnished to Medicare/MA beneficiaries					14	
	(line 12 times the sum of lines 13 and 13.01, as applicable)						
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10)					15	
16	Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Worksheet N-4, line 2)					16	

CALCU	CLATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-4	
		COMPONENT CCN:	TO:	_	
1	FQHC PPS Amount (see instructions)				1
2	Medicare cost of injections/infusions and administration (From Worksheet N-3, line 16)				2
3	Medicare advantage supplemental payments (for information only)				3
4	Total (sum of lines 1 through 2)				4
5	Primary payer payments				5
6	Total amount payable for program beneficiaries (line 4 minus line 5)				6
7	Coinsurance billed to program beneficiaries				7
8	Net Medicare reimbursement excluding bad debts (line 6 minus line 7)				8
9	Allowable bad debts (see instructions)				9
10	Adjusted reimbursable bad debts (see instructions)				10
11	Allowable bad debts for dual eligible beneficiaries (see instructions)				11
12	Subtotal (line 8 plus line 10)				12
13	Other adjustments (specify) (see instructions)				13
13.99	Demonstration payment adjustment amount before sequestration				13.99
14	Amount due hospital-based FQHC prior to the sequestration adjustment (see instructions)				14
15	Sequestration adjustment (see instructions)				15
15.25	Sequestration for non-claims based amounts (see instructions)				15.25
16	Amount due hospital-based FQHC after sequestration adjustment (see instructions)				16
16.01	Demonstration payment adjustment amount after sequestration				16.01
17	Interim payments (from Worksheet N-5, col. 2, line 4)				17
18	Tentative settlement (for contractor use only)				18
19	Balance due hospital-based FQHC/program (line 16 minus lines 16.01, 17 and 18)				19
20	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chap	oter 1, §115.2			20

40-668 Rev. 17

ANAL	YSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENI	DERED PROVIDER CC	N:	PERIOD:	WORKSHEET N-5	
		COMPONENT	CCN:	FROM: TO:	_	
				T	Part B	1
				mm/dd/yyyy	Amount	
	Description			1	2	
1	Total interim payments paid to hospital-based FQHC					1
2	Interim payments payable on individual bills, either submitted or to be submitted	ed to the contractor				2
	for services rendered in the cost reporting period. If none, write "NONE" or er	nter a zero				
3	List separately each retroactive		.01			3.01
	lump sum adjustment amount based		.02			3.02
	on subsequent revision of the	Program to	.03			3.03
	interim rate for the cost reporting period.	Provider	.04			3.04
	Also show date of each payment.		.05			3.05
	If none, write "NONE" or enter a zero. (1)		.50			3.5
			.51			3.51
		Provider to	.52			3.52
		Program	.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01 through 3.49 minus sum of lines 3.50 through 3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)					4
	(transfer to Wkst. N-4, line 17)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement	Program to	.01			5.01
	payment after desk review. Also show	Provider	.02			5.02
	date of each payment.		.03			5.03
	If none, write "NONE" or enter a zero. (1)		.50			5.5
		Provider to	.51			5.51
		Program	.52			5.52
	Subtotal (sum of lines 5.01 through 5.49 minus sum of lines 5.50 through 5.98)	,	.99			5.99
6	Determine net settlement amount (balance	Program to 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

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

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

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

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

ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O	
						HOSPICE CCN:	то		
				SUBTOTAL (col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	(col. 5 ± col. 6)	_
		1	2	3	4	5	6	7	
	PATIENT CARE SERVICE COST CENTERS (Cont.)								
	Imaging Services**								40
	Labs and Diagnostics**								41
	Medical Supplies-Non-routine**								42
	Drugs Charged to Patients**								42.50
	Outpatient Services**								43
	Palliative Radiation Therapy**								44
	Palliative Chemotherapy**								45
	Other Patient Care Services**								46
	EIMBURSABLE COST CENTERS								
	Bereavement Program *								60
	Volunteer Program *								61
	Fundraising*								62
63	Hospice/Palliative Medicine Fellows*								63
	Palliative Care Program*								64
	Other Physician Services*								65
66	Residential Care *								66
67	Advertising*								67
68	Telehealth/Telemonitoring*								68
	Thrift Store*								69
	Nursing Facility Room & Board*								70
71	Other Nonreimbursable*								71
100	Total								100

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

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

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

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

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

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

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

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

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

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

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

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

	ALLOCATION - HOSPITAL-BASED HOSPICE	E GENERAL SERVICE	COSTS		1401 01018 230		PROVIDER CCN:		PERIOD: FROM		WORKSHEET O	D-6
							HOSPICE CCN:	_	ТО	 -		
		NURSING ADMINIS- TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS- PORTATION	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT / RESIDENT CARE SVCS	TOTAL	
	Descriptions	9	10	11	12	13	14	15	16	17	18	-
GENER	AL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance											5
	*											6
7	Housekeeping											7
												8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation					1						12
13	Volunteer Service Coordination						1					13
14	Pharmacy							1				14
15	Physician Administrative Services								1			15
16	Other General Service (specify)									1		16
17	Patient/Residential Care Services										1	17
LEVEL	OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
NONRE	EIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
65	Other Physician Services											65
												66
	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
	Nursing Facility Room & Board											70
71	Other Nonreimbursable (specify)											71
99	Negative Cost Center											99
100	Total											100

COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS					PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM TO		WORKSHEET O-6 PART II	
		CAP REL BLDG & FIX (Square Feet)	CAP REL MVBLE EQUIP (Dollar Value)	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT (Square Feet)	LAUNDRY & LINEN (In-Facil- ity Days)	HOUSE- KEEPING (Square Feet)	OIETARY (In-Facility Days)	
C	ost Center Descriptions	1	2	3	4A	4	5	6	7	8	1
	AL SERVICE COST CENTERS	1	-	3	12.1		J	Ů	,	-	
	Cap Rel Costs-Bldg & Fixt										1
	Cap Rel Costs-Myble Equip										2
	Employee Benefits										3
	Administrative & General										4
5	Plant Operation and Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping									1	7
8	Dietary									1	8
9	Nursing Administration										9
10	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation										12
13	Volunteer Service Coordination										13
14	Pharmacy										14
15	Physician Administrative Services										15
16	Other General Service										16
	Patient/Residential Care Services										17
	OF CARE										
	Hospice Continuous Home Care										50
	Hospice Routine Home Care										51
	Hospice Inpatient Respite Care										52
	Hospice General Inpatient Care										53
	IMBURSABLE COST CENTERS										
	Bereavement Program										60
	Volunteer Program										61
	Fundraising										62
	Hospice/Palliative Medicine Fellows										63
	Palliative Care Program										64
	Other Physician Services										65
	Residential Care	_									66
	Advertising										67
	Telehealth/Telemonitoring										68
	Thrift Store		_								69
	Nursing Facility Room & Board										70
	Other Nonreimbursable							_			71
	Negative Cost Center										99
	Cost to be allocated (per Wkst. O-6, Part I)							ļ			100
101	Unit cost multiplier										101

COST	ALLOCATION - HOSPITAL-BASED HOSPICE G	ENERAL SERVICE	COSTS STATISTIC		Idvi Ovid 2001		PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM TO	_	WORKSHEET O- PART II	1-6
		NURSING ADMINIS- TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS- PORTATION (Mileage)	VOLUNTEER SVC COOR- DINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMIN SERVICES (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENT CARE SVCS (In-Facil- ity Days)	TOTAL	
	ost Center Descriptions	9	10	11	12	13	14	15	16	17	18	1
GENER	AL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services										1	17
LEVEL	OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
	General Inpatient Care											53
NONRE	EIMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
66								-				66
	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
	Nursing Facility Room & Board											70
71												71
99	Negative Cost Center											99
100	Cost to be allocated (per Wkst. O-6, Part I)											100
101	Unit cost multiplier											101

APPOR	TIONMENT OF HOSPITAL-BASED HOSPICE	SHARED SERVICE	COSTS BY LEV	VEL OF CARE					HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET 0-7	
		Wkst. C,	Cost to	C	harges by LOC (fr	om Provider Recor	ds)	1	Shared Service	e Costs by LOC		
		Pt. I, col. 9,	Charge					HCHC	HRHC	HIRC	HGIP	
		line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
	Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS											
1	Physical Therapy	66										1
2	Occupational Therapy	67										2
3	Speech/ Language Pathology	68										3
4	Drugs, Biological and Infusion Therapy	73										4
5	Durable Medical Equipment/Oxygen	96										5
6	Labs and Diagnostics	60										6
7	Medical Supplies	71										7
8	Outpatient Services (including E/R Dept.)	93										8
	Radiation Therapy	55										ç
10	Other	76										10
11	Totals (sum of lines 1 through 10)											11

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