#### FORM CMS-2552-10

4090 (Cont.)

This report is requ	ired by law (42 USC 139	5g; 42 CFR 413.20(b)). Fa	ailure to report can result in all interim	1			FORM APPROVED
payments made sir	ce the beginning of the c	ost reporting period being	deemed overpayments (42 USC 1395)	g).			OMB NO. 0938-0050
HOSPITAL AN	D HOSPITAL HEAI	LTH CARE	PROVIDER CCN:		PERIOD		WORKSHEET S
COMPLEX CC	ST REPORT CERTI	FICATION			FROM		PARTS I, II & III
AND SETTLEN	MENT SUMMARY				то		
PART I - COS	T REPORT STATU	JS					
Provider use on	у	1. [] Electronical	ly filed cost report			Date:	Time:
		2. [] Manually su	bmitted cost report				
		3. [] If this is an	amended report enter the number	er of times the	e provider resubmit	ted this cost report	t
		4 [] Medicare U	tilization. Enter "F" for full or "	L" for low.			
Contractor	5. [ ] Cost Repo	rt Status	6. Date Received:			10. NPR Date	2:
use only	(1) As Submitte	ed	7. Contractor No.:			11. Contracto	r's Vendor Code:
	(2) Settled with	out audit	8. [ ] Initial Report for this P	rovider CCN		12. [ ] If line	5, column 1 is 4: Enter number of
	(3) Settled with	audit	9. [ ] Final Report for this Pr	ovider CCN		times	reopened $= 0-9$ .
	(4) Reopened		-				
	(5) Amended						

#### PART II - CERTIFICATION

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

#### CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by \_\_\_\_\_\_\_ {Provider Name(s) and Number(s)} for the cost reporting period beginning \_\_\_\_\_\_ and ending \_\_\_\_\_\_ and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Provider(s)

Title

Date

			TITLE	XVIII			
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1 HOS	SPITAL						
2 SUB	BPROVIDER - IPF						
3 SUB	BPROVIDER - IRF						
4 SUB	BPROVIDER (OTHER)						
5 SWI	NG BED - SNF						
6 SWI	NG BED - NF						
7 SKII	LLED NURSING FACILITY						
8 NUR	RSING FACILITY						
9 HOM	ME HEALTH AGENCY						
0 HEA	ALTH CLINIC - RHC						
	ALTH CLINIC - FQHC						
	IPATIENT REHABILITATION WIDER (Specify)						
00 TOT	`AI.						

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,

search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4003.1-4003.3)

OSPIT	(Cont.)		FORM CMS-2552	-10						09-
OMPL	TAL AND HOSPITAL HEALTH CARE LEX IDENTIFICATION DATA				PROVIDER CCN:	PERIOD FROM		WORKSHEET S-2 PART I		
ospita	and Hospital Health Care Complex Address:					то				
	Street:	P.O. Box:								
2	City:	State:	Zip Code:	County:						
ospita	l and Hospital-Based Component Identification:	•	-							
		Component	CCN	CBSA	Provider	Date	Pa	yment System (P, T, O,	or N)	
	Component	Name	Number	Number	Туре	Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
-	Hospital									
	Subprovider- IPF									
	Subprovider- IRF									
	Subprovider- (Other)									
	Swing Beds-SNF									_
	Swing Beds-NF									
	Hospital-Based SNF								_	_
	Hospital-Based NF Hospital-Based OLTC									_
	Hospital-Based HHA									_
	Separately Certified ASC								-	
	Hospital-Based Hospice									
	Hospital-Based Health Clinic-RHC									
	Hospital-Based Health Clinic-FOHC									-
	Hospital-Based (CMHC, CORF and OPT)									
	Renal Dialysis									
_	Other									
			ł							
20	Cost Reporting Period (mm/dd/yyyy)	From:	To:							
		From:	10:							
	Type of control (see instructions)	From:	10:							
21	Type of control (see instructions) nt PPS Information	From:	10:					1	2	
21 patier				ze with 42 CFR §412.106?				1	2	
21 patien 22	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this	g payments for disproportionate sha facility subject to 42 CFR §412.10	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita	l)? In column 2, enter "Y	for yes or "N" for no.			1	2	
21 patier 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	<ol> <li>In column 2, enter "Y 2 if census days, or 3 if da</li> </ol>	for yes or "N" for no. te of discharge.			1	2	
21 patier 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	<ol> <li>In column 2, enter "Y 2 if census days, or 3 if da</li> </ol>	for yes or "N" for no. te of discharge.				2	
21 patier 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	<ol> <li>In column 2, enter "Y"</li> <li>2 if census days, or 3 if da period? In column 2, enter</li> </ol>	for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no.				2	
21 patien 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	1)? In column 2, enter "Y" 2 if census days, or 3 if da period? In column 2, ent In-State	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State	Out-of State	Out-of State	1 Medicaid	2 Other	
21 patien 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible	Out-of State Medicaid	Medicaid eligible	HMO	Medicaid	
21 patien 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission,	1)? In column 2, enter "Y" 2 if census days, or 3 if da period? In column 2, ent In-State	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col orting period different from the me	re hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission, thod used in the prior cost reporting	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible	Out-of State Medicaid	Medicaid eligible	HMO	Medicaid	
21 patien 22 23 24	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In coi orting period different from the me	are hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days on Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid F	payments for disproportionate shi facility subject to 42 CFR §412.10 nı lines 24 and/or 25 below? In col orting period different from the me e Medicaid paid days in col. 1, in-s paid days in col. 3, out-of-state Me	are hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23 23	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "X" for yes or "N" for no. Is this: Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo the method of identifying the days in this cost repo fit this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid	g payments for disproportionate sha facility subject to 42 CFR §412.10 nı lines 24 and/or 25 below? In col orting period different from the me e Medicaid paid days in col. 1, in-s- paid days in col. 3, out-of-state Me id days in col. 5, and other Medica	tate Medicaid dicaid eligible unpaid days id days in col. 6.	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patier 22 23 23 24 25	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid in col. 4, Medicaid HMO paid and eligible but unpain If this provider is an IRF, enter the in-state Medicaid	g payments for disproportionate shi facility subject to 42 CFR §412.10 m lines 24 and/or 25 below? In coi orting period different from the me e Medicaid paid days in col. 1, in-s paid days in col. 3, out-of-state Me id days in col. 3, and other Medica J paid days in col. 1, in-state Medi	are hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6.	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 aatier 22 23 23 24 24	If PPS Information Does this facility qualify and is it currently receiving In column I, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days on Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid paid days in col.	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In coi orting period different from the me experied days in col. 1, in-s- paid days in col. 3, out-of-state Medi id days in col. 5, and other Medica d paid days in col. 1, in-state Medi a), out-of state Medicaid eligible u	are hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6.	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 aatier 22 23 23 24 24	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid in col. 4, Medicaid HMO paid and eligible but unpain If this provider is an IRF, enter the in-state Medicaid	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In coi orting period different from the me experied days in col. 1, in-s- paid days in col. 3, out-of-state Medi id days in col. 5, and other Medica d paid days in col. 1, in-state Medi a), out-of state Medicaid eligible u	are hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6.	1)? In column 2, enter "Y' 2 if census days, or 3 if da period? In column 2, ent In-State Medicaid	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 22 23 24 25	If PPS Information Does this facility qualify and is it currently receiving In column I, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days on Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid paid days in col.	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col- orting period different from the me period different from the me e Medicaid paid days in col. 1, in-s- paid days in col. 3, out-of-state Medi d days in col. 5, and other Medica d paid days in col. 1, in-state Medi .3, out-of state Medicaid eligible u d days in col. 5.	re hospital adjustment, in accordanc 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6. caid eligible unpaid mpaid days	I)? In column 2, enter "Y" 2 if census days, or 3 if de period? In column 2, ent In-State Medicaid paid days 1	" for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23 24 25 26	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid days in col. in col. 4 Medicaid HMO paid and eligible but unpaid	payments for disproportionate shi facility subject to 42 CFR §412.10 nı lines 24 and/or 25 below? In col orting period different from the me e Medicaid paid days in col. 1, in-s paid days in col. 3, out-of-state Me di days in col. 3, out-of-state Me di days in col. 3, out-of-state Me di days in col. 1, in-state Medica d paid days in col. 1, in-state Medica d paid days in col. 2, and other Medica d paid days in col. 5.	tate Medicaid digible unpaid days id days in col. 6. caid eligible unpaid days id days in col. 6. caid eligible unpaid npaid days cost reporting period. Enter "1" for	1)? In column 2, enter "Y' 2 if census days, or 3 if de period? In column 2, ent Medicaid paid days 1 1 urban or "2" for rural.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23 23 24 24 25 26 27	the PS Information     Does this facility qualify and is it currently receiving     In column 1, enter "Y" for yes or "N" for no. Is this:     Which method is used to determine Medicaid days on     Is the method of identifying the days in this cost report     If this provider is an IPPS hospital, enter the in-state     eligible unpaid days in col. 2, out-of-state Medicaid     fus provider is an IRPS, enter the in-state Medicaid     days in col. 2, out-of-state Medicaid paid days in col.     in col. 4. Medicaid HMO paid and eligible but unpaid     Enter your standard geographic classification (not we	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col orting period different from the me e Medicaid paid days in col. 1, in-s- paid days in col. 3, out-of-state Me id days in col. 5, and other Medica I paid tays in col. 5.	tate Medicaid digible unpaid days id days in col. 6. caid eligible unpaid days id days in col. 6. caid eligible unpaid npaid days cost reporting period. Enter "1" for	1)? In column 2, enter "Y' 2 if census days, or 3 if de period? In column 2, ent Medicaid paid days 1 1 urban or "2" for rural.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patien 22 23 23 24 24 25 26 27	th PPS Information Does this facility qualify and is it currently receiving In column I, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days on Is the method of identifying the days in this cost report if this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid paid days in col. in col. 4, Medicaid HMO paid and eligible but unpaid Enter your standard geographic classification (not we Enter your standard geographic classification (not we Enter your standard geographic classification (not we Enter your standard geographic classification (not we	g payments for disproportionate sha facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col- orting period different from the me end of the state of the state of the state of the state of the state of the state of the id days in col. 3, out-of-state Medic and days in col. 5, and other Medica d paid days in col. 5, and other Medica d paid days in col. 5, and other Medica d paid days in col. 5, and other Medica d days in col. 5, and other Medica d paid days in col. 5, and other Medica d days in col. 5, and the state of the cost re- age) status at the beginning of the cost re- age) status at the end of the cost re- is reclassification in column 2.	re hospital adjustment, in accordance 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6. caid eligible unpaid npaid days cost reporting period. Enter "1" for porting period. Enter in column 1,	1)? In column 2, enter "Y' 2 if census days, or 3 if de period? In column 2, ent Medicaid paid days 1 1 urban or "2" for rural.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21 patier 22 23 23 24 24 25 26 27 35	nt PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repo If this provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid days in col. 4, Medicaid HMO paid and eligible but unpaid In col. 4, Medicaid HMO paid and eligible but unpaid Enter your standard geographic classification (not we Tenter your standard geographic classification (not we I applicable enter the effective date of the geographi	g payments for disproportionate shi facility subject to 42 CFR §412.10 m lines 24 and/or 25 below? In coi orting period different from the me e Medicaid paid days in col. 1, in-s paid days in col. 3, out-of-state Me di days in col. 3, out-of-state Medi days in col. 5, and other Medica d paid days in col. 1, in-state Medi ad days in col. 5, and other Medica d ad state Medicaid eligible to d days in col. 5. age) status at the beginning of the age) status at the end of the cost re ic reclassification in column 2. number of periods SCH status in el	re hospital adjustment, in accordan 6 (c )(2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6. caid eligible unpaid inpaid days cost reporting period. Enter "1" for porting period. Enter in column 1, " ffect in the cost reporting period.	1)? In column 2, enter "Y" 2 if census days, or 3 if de period? In column 2, enter In-State Medicaid paid days 1 1 urban or "2" for rural. "1" for urban or "2" for rural.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
21         patier           22         23           23         24           25         26           27         35           36         36	It PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repor- list the method of identifying the days in this cost repor- list the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in col. 2, out-of-state Medicaid days in col. 2, out-of-state Medicaid paid days in col. in col. 4 Medicaid HMO paid and eligible but unpaid Enter your standard geographic classification (not we Enter your standard geographic classification (not we fapplicable enter the effective date of the geographing of this is sole community hospital (SCH), enter the the the sole community hospital (SCH), enter the the sole community hospital (SCH), enter the the sole community hospital (SCH) and the so	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col orting period different from the me estimation of the state of the state Medical paid days in col. 3, out-of-state Medical paid days in col. 5, and other Medical days in col. 5, and other Medical age) status at the beginning of the age) status at the beginning of the status. Subscript line 36 for num	tate Medicaid digital adjustment, in accordance 6 (c )(2) (Pickle amendment hospita lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6. caid eligible unpaid inpaid days cost reporting period. Enter "1" for porting period. Enter in column 1, iffect in the cost reporting period.	1)? In column 2, enter "Y" 2 if census days, or 3 if de period? In column 2, ent Medicaid paid days 1 1 urban or "2" for rural. "1" for urban or "2" for rural. "1" for urban or "2" for rural.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days 3	Medicaid eligible unpaid days	HMO days 5	Medicaid days	
21 patier 22 23 24 25 26 27 35 36 37 38	It PPS Information Does this facility qualify and is it currently receiving In column I, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost repor- list the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in this cost repor- list of the method of identifying the days in col. In col. 4, Medicaid HMO paid and eligible but unpaid Enter your standard geographic classification (not we Tenter your standard geographic classification (not we Tenter your standard geographic classification (not we Tenter your standard geographic dassification (not we Tenter applicable beginning and ending dates of SCH If this is a Medicare dependent hospital (MDH), enter Enter applicable beginning and ending dates of MDF	g payments for disproportionate shi facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col orting period different from the me period different from the me paid days in col. 3, out-of-state Me di days in col. 3, out-of-state Me di days in col. 5, and other Medica d paid days in col. 1, in-state Medi a, out-of state Medicaid eligible to d days in col. 5. age) status at the beginning of the age) status at the beginning of the age) status at the deginning of the rage) status at the deginning 0. number of periods SCH status in c I status. Subscript line 36 for num H status. Subscript line 36 for num	re hospital adjustment, in accordance (c) (2) (Pickle amendment hospital lumn 1, enter 1 if date of admission, thod used in the prior cost reporting tate Medicaid dicaid eligible unpaid days id days in col. 6. caid eligible unpaid mpaid days cost reporting period. Enter "1" for porting period. Enter in column 1, effect in the cost reporting period. For of periods in excess of one and effect in the cost reporting period.	I)? In column 2, enter "Y'  i (census days, or 3 if de period? In column 2, ent  In-State  Medicaid paid days  1  urban or "2" for rural.  "1" for urban or "2" for rural.  "1" for urban or "2" for rural. "1" net subsequent dates. od.	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2 al.	Out-of State Medicaid paid days 3 3 Beginning: Beginning:	Medicaid eligible unpaid days	HMO days 5	Medicaid days	
21 patier 22 23 24 25 26 27 35 36 37 38	It PPS Information Does this facility qualify and is it currently receiving In column 1, enter "Y" for yes or "N" for no. Is this Which method is used to determine Medicaid days or Is the method of identifying the days in this cost report of the provider is an IPPS hospital, enter the in-state eligible unpaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid If this provider is an IRF, enter the in-state Medicaid days in col. 2, out-of-state Medicaid p in col. 4, Medicaid HMO paid and eligible but unpaid in col. 4, Medicaid HMO paid and eligible but unpaid enter your standard geographic classification (not wi Enter your standard geographic classification (not wi If applicable enter the effective date of the geographi If this is a sole community hospital (SCH), enter the Enter applicable beginning and ending dates of SCH If this is a Medicare dependent hospital (MDH), entet	payments for disproportionate shr facility subject to 42 CFR §412.10 on lines 24 and/or 25 below? In col orting period different from the me e Medicaid paid days in col. 1, in-s- paid days in col. 3, out-of-state Me di days in col. 5, and other Medica I paid days in col. 5, and other M	tate Medicaid tate Medicaid dicaid eligible unpaid days id days in col. 6. cost reporting period. Enter "1" for porting period. Enter "1" for porting period. Enter "1" for porting period. Enter "1" for porting period. Enter olumn 1, effect in the cost reporting period. the cost reporting period. the cost reporting period. Enter in excess of one and e us in effect in the cost reporting period.	1)? In column 2, enter "Y" 2 if census days, or 3 if de period? In column 2, ent Medicaid paid days 1 1 urban or "2" for rural. "1" for urban or "2" for rural. "1" for urban or "2" for rural. enter subsequent dates. enter subsequent dates. Re §412.101(b)(2)(ii)? Ent	' for yes or "N" for no. te of discharge. er "Y" for yes or "N" for no. In-State Medicaid eligible unpaid days 2 al. er in column 1 "Y" for yes s	Out-of State Medicaid paid days 3 3 Beginning: Beginning:	Medicaid eligible unpaid days	HMO days 5	Medicaid days	

09-13 FORM CMS-2552-10					4090 (	Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE	PROVIDER CCN:	PERIOD		WORKSHEET S-2		
COMPLEX IDENTIFICATION DATA		FROM TO		PART I (CONT.)		
		10	V	XVIII	XIX	Т
Prospective Payment System (PPS)-Capital			1	2	3	
45 Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)						45
46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete 47 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	3 Worksheet L, Part III and L-1, Parts I	through III.			-	46
<ul> <li>48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.</li> </ul>						48
Teaching Hospitals			1	2	3	
<ul> <li>56 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.</li> <li>57 If line 56 is ves, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y</li> </ul>	X711 C					56
57 If line 56 is yes, is this the first cost reporting period during which residents in approved GMB programs trained at this facility? Enter "V If column 1 is "V" did residents start training in the first month of this cost reporting period? Enter "V" for yes or "N" for no in column 2 If column 2 is "N", complete Worksheet D, Parts III & IV and D-2, Part II, if applicable.		heet E-4.				57
58 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148?						58
If yes, complete Worksheet D-5.						
59 Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.						59
60 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter		tions)			Di cutt	60
	Y/N	2	3	IME 4	Direct GME	-
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		-		7		61
	L			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 N					-	61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5 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%						61.02 61.03
61.04 Enter the base time FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see ins	orean (see man nerrons)					61.04
51.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery.		51.03). (see instructions)				61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see in	nstructions)					61.06
				Unweighted	Unweighted	
			<b>D</b>	IME	Direct GME	
		Program Name	Program Code 2	FTE Count 3	FTE Count 4	4
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 instru	uctions)	1	2	5	+	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 and enter in						
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						61.20
Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in GME FTE unweighted count.	n column 4 direct					
GME FIE unweignea count.				I		4
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE fi	unding (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		uctions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings           63         Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, com	aplete lines 64-67 (see instructions)					63
	reaction of the second definition of the secon		Unweighted	Unweighted	Ratio	0.5
			FTEs	FTEs	(col. 1/	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settingsThis base year is your cost reporting period that begins on or after J			Nonprovider Site	in Hospital	(col. 1 + col. 2))	
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 i	resident FTEs attributable to rotations of	occurring				64
in all non-provider settings. 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)						
Earce in commit 5 the ratio of (commit 1 divided by (commit 1 7 conditin 2)). (see instructions)			Unweighted	Unweighted	Ratio	
			FTEs	FTEs	(col. 3/	
				1	(col. 3 + col. 4))	1
	Program Name	Program Code	Nonprovider Site	in Hospital	(1111)	_
	Program Name 1	Program Code	Nonprovider Site 3	in Hospital 4	(coi. 3 + coi. 4)) 5	1
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name	0	č			(1111)	65
associated with primary care FTEs for each primary care program in which you trained residents.	0	č			(1111)	65
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 care FTE residents attributable to	0	č			(1111)	65
associated with primary care FTEs for each primary care program in which you trained residents.	0	č			(1111)	65

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.14

4090 (Cont.) FORM CMS-2552-10						09-13
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN	PERIOD FROM		WORKSHEET S-2 PART I (CONT.)		
COMI LEA IDENTITICATION DATA		то		TAKI I (CONT.)		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings Effective for cost reporting periods beginning on or after Ju	uly 1, 2010		1	2	3	-
66 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provide	r settings. Enter in column 2 the numb	er of				66
unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (colu	umn 1 + column 2)). (see instructions)					_
			Unweighted	Unweighted	Ratio (col. 3/	
F	Program Name	Program Code	FTEs Nonprovider Site	FTEs in Hospital	(col. 3/ (col. 3 + col. 4))	
	Fiogram Name	2	Nonprovider Site	iii Hospitai 4	(coi. 5 + coi. 4)) 5	
67 Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1			*		67
Inpatient Psychiatric Facility PPS				2	3	7
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.			1	2	3	70
71 If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter " Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beg in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	"Y" for yes or "N" for no.					71
Inpatient Rehabilitation Facility PPS			1	2	3	٦
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.						75
76 If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 20 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beg in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	"Y" for yes or "N" for no.					76
				•		
Long Term Care Hospital PPS					1	
80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						80
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.						05
<ul> <li>85 Is this a new nospital under 42 CFK §413.40(f)(1)(1) TEFKA? Enter Y for yes of N for ho.</li> <li>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 new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(i)?</li> </ul>						85
80 Did this facility establish a new Other subprovider (excluded unit) under 42 CFK §415.40(f)(1)(1)? Enter Y for yes or N for ne	0.			V	XIX	80
Title V and XIX Services				1	2	
90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.					-	90
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	n the applicable column.					91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no i						92
93 Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable col						93
94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.						94
95 If line 94 is "Y", enter the reduction percentage in the applicable column.						95
96 Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.						96
97 If line 96 is "Y", enter the reduction percentage in the applicable column.						97

09-1	3 FORM CMS-2552-	10				4090 (	(Cont.)
	ITAL AND HOSPITAL HEALTH CARE 'LEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
Rural	Providers				1	2	<u> </u>
105	Does this hospital qualify as a Critical Access Hospital (CAH)?					_	105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructi	ions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "						107
	If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed.	If yes complete Worksheet D-2, Part II.					
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for ye						108
			Physical	Occupational	Speech	Respiratory	
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
Misce	Ilaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or	r 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 (include	des psychiatric, rehabilitation and long term hospita	ıls				
	providers) based on the definition in CMS 15-1 §2208.1.						
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.						116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.						117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the poli	icy is occurrence.					118
118.01	List amounts of malpractice premiums and paid losses:			Premiums	Paid losses	Self insurance	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, su	bmit supporting schedule listing cost centers and a	mounts contained therein.				118.02
119	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter	in column 2 the monetary limit per policy year.					119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendme	ents? (see instructions) Enter in column 1 "Y" for	yes or "N" for no. Is this a				120
	rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable am	endments? (see instructions) Enter in column 2 "Y	" for yes or "N" for no.				
121	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.						121
-							
Trans	plant Center Information						
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/y	yyy) below.					125
126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if app	plicable, in column 2.					126
127	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if appl	licable, in column 2.					127
128	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if appli	icable, in column 2.					128
	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if appli						129
130	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if a						130
131	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if						131
132	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applied						132
100	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if appl				1		133
133		incable, in column 2.					

4090	) (Cont.)	FORM CMS-2552-10	)						09-13
HOSP	ITAL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD		WORKSHEET S-2	-	
COMF	PLEX IDENTIFICATION DATA				FROM		PART I (CONT.)		
					то				
All Pr	roviders								
							1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chap		for no in column 1.						140
	If yes, and home office costs are claimed, enter in column 2 the home office chain number.	(see instructions)							
	facility is part of a chain organization, enter on lines 141 through 143 the name and address	s of the home office and enter the				-			
	Name:		Contractor's Name:			Contractor's Number:			141
142	Street:	P. O. Box:		1					142
		State:	Zip Code:						143
	Are provider based physicians' costs included in Worksheet A?								144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient s								145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter	"Y" for yes or "N" for no in colum	in 1. (See CMS Pub. 15-	2, section 4020)					146
	If yes, enter the approval date (mm/dd/yyyy) in column 2.								
									_
	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147
	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						_		148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no	).							149
<b>D</b>	aren						<u> </u>		-
	this facility contain a provider that qualifies for an exemption from the application of the low				Title XV				
Enter	"Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)				Part A	Part B	Title V	Title XIX	
					1	2	3	4	1.5.5
	Hospital								155
	Subprovider - IPF								156
	Subprovider - IRF								157
									158
159 160	SNF HHA								159
	СМНС								160
101	CMHC								161
Make									
	campus Is this hospital part of a multicampus hospital that has one or more campuses in different (	DCAs2 Enter "V" for use or "N"	6	T					165
105	is this hospital part of a multicampus hospital that has one of more campuses in uniferent of	BSAS? Enter 1 for yes of in	IOF IIO.						105
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	n column 2 ZIP in column 2 CPS	A in column 4 ETE/Co	mpus in column 5					166
100	In the 105 is yes, for each campus enter the name in column 0, county in column 1, state in Name	ii columni 2, Zir in columni 3, CB3	3A in column 4, 1112/Ca	County	State	Zip Code	CBSA	FTE/Campus	100
	0			County	2	3	4	5	-
	0				2	5			-
				1	1	1			
Health	h Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
	by ( ) and reminent rec								

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 reasonable cost incurred for the HIT assets. (see instructions)			168
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			169
170	If line 167 is "Y", enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period, respectively. (nm/dd/yyyy) (see instructions)	•		170

10-12	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2
REIMBURSEMENT QUESTIONNAIRE		FROM	Part II
		ТО	

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

## COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2	-	
1 Has the provider changed ownership immediately prior to the beginning of the cost reporting period?					1
If yes, enter the date of the change in column 2. (see instructions)					
		Y/N	Date	V/I	
		1	2	3	
2 Has the provider terminated participation in the Medicare Program?		•	-	5	2
If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.					-
3 Is the provider involved in business transactions, including management contracts, with individuals or entities	25				3
(e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, i					5
staff, management personnel, or members of the board of directors through ownership, control, or family an					
other similar relationships? (see instructions)	-				
		Y/N	Туре	Date	
Financial Data and Reports		1	2	3	-
4 Column 1: Were the financial statements prepared by a Certified Public Accountant?				5	4
Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy o	r enter				-
date available in column 3. (see instructions) If no, see instructions.	renter				
5 Are the cost report total expenses and total revenues different from those on the filed financial statements?					5
If yes, submit reconciliation.					5
ii yes, subilit feolicination.					
			Y/N	Y/N	
Approved Educational Activities			1	2	-
6 Column 1: Are costs claimed for nursing school?			1	2	6
Column 2: If yes, is the provider is the legal operator of the program?					0
7 Are costs claimed for allied health programs? If yes, see instructions.					7
<ul> <li>8 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period</li> </ul>	49				8
If yes, see instructions.	u :				0
<ul><li>9 Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.</li></ul>					9
<ul> <li>Are costs claimed for intern-Resident program initiated or renewed in the current cost report; if yes, see instructions.</li> <li>Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.</li> </ul>					10
					10
11 Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Wor If yes, see instructions.	KSHEEL A?				11
i yes, see instructions.					
Rad Dahts				V/N	1
Bad Debts				Y/N	12
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.	s submit conv			Y/N	12
<ol> <li>Is the provider seeking reimbursement for bad debts? If yes, see instructions.</li> <li>If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes</li> </ol>	s, submit copy.			Y/N	13
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.	s, submit copy.			Y/N	
<ul> <li>12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.</li> <li>13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes</li> <li>14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.</li> </ul>	s, submit copy.			Y/N	13
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	s, submit copy.			Y/N	13 14
<ul> <li>12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.</li> <li>13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes</li> <li>14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.</li> </ul>	s, submit copy.			Y/N	13
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement			Port		13 14
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par	t A	Part V/N	B	13 14
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.	Par Y/N	t A Date	Y/N	B Date	13 14
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data	Par	t A		B	13       14       15
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data       16         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Par Y/N	t A Date	Y/N	B Date	13 14
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data       16         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data       16         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Par Y/N	t A Date	Y/N	B Date	13       14       15
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par Y/N	t A Date	Y/N	B Date	13           14           15           16           17
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the 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?         18       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If either column 1 or 3 is yes, were adjustments made to PS&R Report data for additional claims that have been	Par Y/N	t A Date	Y/N	B Date	13           14           15           16
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the 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?         18       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.	Par Y/N	t A Date	Y/N	B Date	13         14         15         16         17         18
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the 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?         18       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.         19       If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other	Par Y/N	t A Date	Y/N	B Date	13           14           15           16           17
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par Y/N	t A Date	Y/N	B Date	13           14           15           16           17           18           19
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par Y/N	t A Date	Y/N	B Date	13         14         15         16         17         18
12       Is the provider seeking reimbursement for bad debts? If yes, see instructions.         13       If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye         14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement	Par Y/N	t A Date	Y/N	B Date	13           14           15           16           17           18           19

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4004.2) Rev. 3

4090 (Cont.)	FORM CMS-2552-10			10-12
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2	
REIMBURSEMENT QUESTIONNAIRE		FROM TO	Part II (CONT.)	
General Instruction: Enter Y for all YES responses. Enter	N for all NO responses.			

Enter all dates in the mm/dd/yyyy format.

## COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

22	Have assets been relifed for Medicare purposes? If yes, see instructions.			2
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period?			2
	If yes, see instructions.			
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.			24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			27
Intere	st Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.			29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31
	ased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	?		32
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	?		32
	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services?	?		32 33
32 33	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?	?		
32 33	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	?		
32 33 Provi	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians	?		33
32 33 Provi 34	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost		Date	33
32 33 Provi 34 35	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	? Y/N 1	Date	33
32 33 Provi 34 35 Home	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Date 2	33 34 35
32 33 Provi 34 35 Home 36	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			33 34 35 36
32 33 Provi 34 35 Home	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Coffice Costs Are home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			33 32 35
32 33 Provi 34 35 Home <u>36</u> 37	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			32 32 35 36 30
32 33 Provi 34 35 Home <u>36</u> 37	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. Office Costs Are home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes , was the fiscal year end of the home office different from that of the provider?			3: 3: 3: 3: 3:

Cost R	Cost Report Preparer Contact Information										
41	First name:	Last name:	name:								
42	42 Employer:										
43	Phone number:		E-mail Address:		43						

09-1	3					FORM	I CMS-2	552-10								4090 (C	ont.)
	ITAL AND HOSPITAL HEALTH CARE COMI ISTICAL DATA	PLEX								PROVIDER CCN:		PERIOD FROM TO		WORKSHEET S-3 PART I			
						Inpatie	nt Days / Ou	tpatient Visit	ts / Trips	Full	Time Equiva	alents	10	Disc	harges	arges	
	Component	Worksheet A Line No.	No. of Beds 2	Bed Days Available	CAH Hours 4	Title V	Title XVIII 6	Title XIX 7	Total All Patients	Total Interns & Residents 9	Employees On Payroll 10	Nonpaid Workers 11	Title V	Title XVIII 13	Title XIX 14	Total All Patients 15	
	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) ( <i>see instructions for col.</i> 2 for the portion of LDP room available beds)		2	3	4		0	,	0	9	10	11	12	15	14	15	1
2																	2
3																	3
	HMO IRF Subprovider																4
	Hospital Adults & Peds. Swing Bed SNF																5
6 7	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude																6 7
	observation beds) (see instructions)																
8																	8
	Coronary Care Unit																9
	Burn Intensive Care Unit																10
	Surgical Intensive Care Unit																11
	Other Special Care																12
	Nursery																13
	Total (see instructions)																14
	CAH visits																15
	Subprovider - IPF																16
	Subprovider - IRF																17
	Subprovider - Other																18
	Skilled Nursing Facility																19
	Nursing Facility																20
	Other Long Term Care																21
22																	22
	ASC (Distinct Part)																23
24	Hospice (Distinct Part)																24
	Hospice (non-distinct part)								ļ								24.10
25						L											25
	RHC/FQHC (specify)																26
	Total (sum of lines 14-26)																27
	Observation Bed Days																28
29																	29
	Employee discount days (see instructions)																30
	Employee discount days -IRF																31
32																	32
32.01	Total ancillary labor & delivery room																32.01
22	outpatient days (see instructions)																22
53	LTCH non-covered days																33

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4005.1) Rev. 4

40-511

4090	(Cont.)	FOR	M CMS-25	552-10			09-13		
HOSPIT	AL WAGE INDEX INFORMATION		PROVIDER C	CCN:	PERIOD FROM TO		WORKSHEET PART II	S-3	
Part II - Y	Wage Data								
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 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-Part B							5	
6	Non-physician-Part B							6	
7	Interns & residents (in an approved program)							7	
7.01	Contracted interns & residents (in an approved program)							7.01	
8	Home office personnel							8	
9	SNF							9	
10	Excluded area salaries (see instructions)							10	
	OTHER WAGES AND RELATED COSTS								
11	Contract labor (see instructions)							11	
12	Contract management and administrative services							12	
13	Contract labor: Physician-Part A - Administrative							13	
14	Home office salaries & wage-related costs							14	
15	Home office: Physician Part A - Administrative							15	
16	Home office & Contract Physicians Part A - Teaching							16	
	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	

FORM CMS-2552-10 (0-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4005.2 - 4005.3) 40-512

09-13			FO	RM CMS-255	52-10		4090 (Cont.)		
	AL WAGE INDEX INFORMATION		PROVIDER C	CN:	PERIOD FROM TO		WORKSHEET S-3 PART II & III		
Part II - V	Vage Data								
		Worksheet A Line Number 1	Amount Reported 2	Reclassification of Salaries (from Worksheet A-6) 3	Adjusted Salaries (column 2 ± column 3) 4	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5) 6		
	OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits <i>Department</i>	4						26	
27	Administrative & General	5						27	
28	Administrative & General under contract (see instructions)	-						28	
29	Maintenance & Repairs	6						29	
30	Operation of Plant	7					1	30	
31	Laundry & Linen Service	8					1	31	
32	Housekeeping	9						32	
33	Housekeeping under contract (see instructions)							33	
34	Dietary	10						34	
35	Dietary under contract (see instructions)							35	
36	Cafeteria	11						36	
37	Maintenance of Personnel	12						37	
38	Nursing Administration	13						38	
39	Central Services and Supply	14						39	
40	Pharmacy	15						40	
41	Medical Records & Medical Records Library	16						41	
42	Social Service	17						42	
43	Other General Service	18						43	
Part III -	Hospital Wage Index Summary								
1	Net salaries (see instructions)							1	
2	Excluded area salaries (see instructions)							2	
3	Subtotal salaries (line 1 minus line 2)							3	
4	Subtotal other wages and related costs (see instructions)							4	
5	Subtotal wage-related costs (see instructions)							5	
6	Total (sum of lines 3 through 5)							6	
7	Total overhead cost (see instructions)							7	

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4005.2 - 4005.3) Rev. 4

40-513

4090 (Cont.)		09-13	
HOSPITAL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD	WORKSHEET S-3,
		FROM	PART IV
		то	
Part IV - Wage Related Cost			

Part A - Core List

		Amount Reported	
R	ETIREMENT COST		
1 4	01k Employer Contributions		1
2 T	ax Sheltered Annuity (TSA) Employer Contribution		2
3 N	onqualified Defined Benefit Plan Cost (see instructions)		3
4 Q	ualified Defined Benefit Plan Cost (see instructions)		4
Р	LAN ADMINISTRATIVE COSTS (Paid to External Organization):	·	
5 4	01k/TSA Plan Administration fees		5
6 L	egal/Accounting/Management Fees-Pension Plan		6
7 E	mployee Managed Care Program Administration Fees		7
Н	IEALTH AND INSURANCE COST		
8 H	lealth Insurance (Purchased or Self Funded)		8
9 P	rescription Drug Plan		9
10 D	Dental, Hearing and Vision Plan		10
11 L	ife Insurance (If employee is owner or beneficiary)		11
12 A	ccident Insurance (If employee is owner or beneficiary)		12
13 D	visability Insurance (If employee is owner or beneficiary)		13
14 L	ong-Term Care Insurance (If employee is owner or beneficiary)		14
15 W	Vorkers' Compensation Insurance		15
16 R	etirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
Т	AXES		
17 F	ICA-Employers Portion Only		17
18 N	Medicare Taxes - Employers Portion Only		18
19 U	Inemployment Insurance		19
20 S	tate or Federal Unemployment Taxes		20
C	VTHER		
21 E	xecutive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22 D	Day Care Cost and Allowances		22
	uition Reimbursement		23
24 T	otal Wage Related cost (Sum of lines 1 -23)		24

Part B	- Other than Core Related Cost	
25	Other Wage Related Costs (specify)	25

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4005.4) 40-514

10-12	FORM CMS-2552-10			4090 (Cont.)
HOSPITAL CONTRACT LABOR AND BENEFIT COST		PROVIDER CCN:	PERIOD:	WORKSHEET S-3,
			FROM	PART V
			то	

Part V - Contract Labor and Benefit Cost

		Contract	Benefit	
	Component	Labor	Cost	
	0	1	2	
1 T	otal facility contract labor and benefit cost			1
2 H	lospital			2
3 S1	ubprovider- IPF			3
4 Su	ubprovider- IRF			4
5 Si	ubprovider- (Other)			5
6 S	wing Beds-SNF			6
7 S	wing Beds-NF			7
8 H	ospital-Based SNF			8
9 H	ospital-Based NF			9
10 H	ospital-Based OLTC			10
11 H	ospital-Based HHA			11
12 Se	eparately Certified ASC			12
13 H	ospital-Based Hospice			13
14 H	ospital-Based Health Clinic RHC			14
15 H	ospital-Based Health Clinic FQHC			15
16 H	ospital-Based-CMHC			16
17 R	enal Dialysis			17
18 O	ther			18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA		PROVIDE 		PERIOD: FROM TO		WORKSHE	ET S-4	
HOME HEALTH AGENCY STATISTICA	L DATA	<b> </b>		County	:			
			Title V	Title XVIII	Title XIX	Other	Total	Г
Description			1	2	3	4	5	
1 Home Health Aide Hours								
2 Unduplicated Census Count (see instruction	ons)							
HOME HEALTH AGENCY - NUMBER O	F EMPLOYEES							
						nber of Emplo		
Enter the number of hours in						1 Time Equiva		-
your normal work week					Staff 1	Contract	Total	-
2 Administrator and Assistant Administrator	e(c)				1	2	3	╀
<ul> <li>3 Administrator and Assistant Administrator</li> <li>4 Director(s) and Assistant Director(s)</li> </ul>	(5)							╋
4 Director(s) and Assistant Director(s) 5 Other Administrative Personnel								╉
6 Direct Nursing Service								$^{+}$
7 Nursing Supervisor								$^{+}$
8 Physical Therapy Service								$^{+}$
9 Physical Therapy Supervisor								$^{+}$
10 Occupational Therapy Supervisor								t
11 Occupational Therapy Service								╈
12 Speech Pathology Service								t
13 Speech Pathology Supervisor								t
14 Medical Social Service								t
15 Medical Social Service Supervisor								t
16 Home Health Aide								t
17 Home Health Aide Supervisor								t
18 Other (specify)								t
								-
HOME HEALTH AGENCY CBSA CODES	S							
19 Enter the number of CBSAs where you pro		reporting period.						Т
20 List those CBSA code(s) serviced during th	his cost reporting period (line 2	20 contains the first cod	le).					Т
PPS ACTIVITY								
IISACIIVIII			Full E	pisodes			Total	Т
			Without	With	LUPA	PEP only	(columns 1	
			Outliers	Outliers	Episodes	Episodes	through 4)	
			1	2	3	4	5	1
21 Skilled Nursing Visits								Ţ
22 Skilled Nursing Visit Charges								Т
23 Physical Therapy Visits								Т
24 Physical Therapy Visit Charges								Ι
25 Occupational Therapy Visits								Γ
26 Occupational Therapy Visit Charges								Γ
27 Speech Pathology Visits								I
28 Speech Pathology Visit Charges								Γ
29 Medical Social Service Visits								
30 Medical Social Service Visit Charges								ſ
2.5								Ţ
31 Home Health Aide Visits								Ţ
31       Home Health Aide Visits         32       Home Health Aide Visit Charges								ſ
31 Home Health Aide Visits	9, and 31)							
31       Home Health Aide Visits         32       Home Health Aide Visit Charges	9, and 31)							
<ol> <li>Home Health Aide Visits</li> <li>Home Health Aide Visit Charges</li> <li>Total visits (sum of lines 21, 23, 25, 27, 29</li> <li>Other Charges</li> <li>Total Charges (sum of lines 22, 24, 26, 28, 28, 28, 28, 28, 28, 28, 28, 28, 28</li></ol>	, 30, 32, and 34)							t
<ul> <li>31 Home Health Aide Visits</li> <li>32 Home Health Aide Visit Charges</li> <li>33 Total visits (sum of lines 21, 23, 25, 27, 29</li> <li>34 Other Charges</li> <li>35 Total Charges (sum of lines 22, 24, 26, 28, 36</li> <li>36 Total Number of Episodes (standard/non-or-</li> </ul>	, 30, 32, and 34)							ł
<ol> <li>Home Health Aide Visits</li> <li>Home Health Aide Visit Charges</li> <li>Total visits (sum of lines 21, 23, 25, 27, 29</li> <li>Other Charges</li> <li>Total Charges (sum of lines 22, 24, 26, 28, 28, 28, 28, 28, 28, 28, 28, 28, 28</li></ol>	, 30, 32, and 34) butlier)							

09-13 FORM CMS-2552-10				4090 (Cont.)			
HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		PROVIDER O	CCN:	PERIOD: FROM		WORKSHEE	T S-5
			TO				
RENAL DIALYSIS STATISTICS							-
	Outpati	ient	Train		Hom		_
DESCRIPTION	D1	TT-1 Thurs	Hemo-	CAPD	Hemo-	CAPD	
DESCRIPTION	Regular 1	High Flux 2	dialysis 3	CCPD 4	dialysis 5	CCPD 6	
1 Number of patients in program at	1		5		5	0	1
end of cost reporting period							
2 Number of times per week patient							2
receives dialysis							
3 Average patient dialysis time including setup							3
4 CAPD exchanges per day							4
5 Number of days in year dialysis furnished							5
6 Number of stations							6
7 Treatment capacity per day per station							7
8 Utilization (see instructions)							8
9 Average times dialyzers re-used							9
10 Percentage of patients re-using dialyzers							10
ESRD PPS         10.01       Is the dialysis facility approved as a low-volume facility f Enter "Y" for yes or "N" for no. (see instructions)         10.02       Did your facility elect 100% PPS effective January 1, 201 (See instructions for "new" providers.)	1? Enter "Y" for yes or "	N" for no.				2	10.0. 10.0
0.03 If you responded "N" to line 10.02, enter in column 1 the enter in column 2 the year of transition for periods after 1			uary 1 and				10.0.
TRANSPLANT INFORMATION							
11 Number of patients on transplant list							11
12 Number of patients transplanted during the cost reporting	period						12
EPOETIN							
13 Net costs of Epoetin furnished to all maintenance dialysis							13
14 Epoetin amount from Worksheet A for home dialysis prog							14
15 Number of EPO units furnished relating to the renal dialys	•						15
16 Number of EPO units furnished relating to the home dialy	sis department						16
ARANESP							
17 Net costs of ARANESP furnished to all maintenance dialy		er					17
18 ARANESP amount from Worksheet A for home dialysis p	0						18
19 Number of ARANESP units furnished relating to the renal	× 1						19
20 Number of ARANESP units furnished relating to the home							20

# PHYSICIAN PAYMENT METHOD (Enter "X" for applicable method(s))

21	MCP	INITIAL METHOD					21
			Net Cost of	Net Cost of	Number of ESA	Number of ESA	
		ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
		Description	Renal Patients	Home Patients	Dialysis Dept.	Dialysis Dept.	
	Erythropoiesis-Stimulating Agents (ESA) Statistics:	1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net						22
	costs of ESAs furnished to all renal dialysis patients.						
	Enter in column 3 the net cost of ESAs furnished to all home						
	dialysis program patients. Enter in column 4 the number of						
	ESA units furnished to patients in the renal dialysis department.						
	Enter in column 5 the number of units furnished						
	to patients in the home dialysis program. (see instructions)						

4090 (Cont.)	FORM CMS-2552-10				09-13
HOSPITAL-BASED COMMUNITY MENTAL HEALTH CEN	ITER AND	PROVIDER CCN:	PERIOD:	WORKSHEET S-6	
OTHER OUTPATIENT REHABILITATION			FROM		
PROVIDER STATISTICAL DATA		COMPONENT CCN:	то		

## 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 \_\_\_\_\_

		Staff	Contract	Total (column 1 + column 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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4008) 40-518

10-12	2 FOR	M CMS-2552-10		4090 (C	Cont.)
	PECTIVE PAYMENT FOR SNF ISTICAL DATA	PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-7	
			то	-	
			X/AI	Dut	1
			Y/N 1	Date 2	-
1	If this facility contains a hospital-based SNF, were all patients under manage	ged care or was there no Medicare		-	1
	utilization? Enter "Y" for yes and do not complete the rest of this workshe	et.			
	Does this hospital have an agreement under either section 1883 or section 2				2
	yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yy	yy) in column 2.			
		SNF	Swing Bed SNF	TOTAL	T
	Group	Days	Days	(sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL RVX				4
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11 12	RLX RUC			+	11 12
12	RUB			1	12
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA		-		17
18 19	RHC			1	18 19
20	RHB RHA				20
20	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25 26	RLA ES3				25 26
20	ES2				20
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32 33	HD1 HC2				32 33
33 34	HC2 HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LEI				38
39 40	LD2 LD1				39 40
40	LDI LC2				40
42	LC1	1			42
43	LB2				43
44	LB1				44
45	CE2				45
46 47	CE1 CD2				46 47
47	CD2 CD1				47
40	CC2			1	40
50	CC1				50
51	CB2				51
52 53	CB1				52
	CA2		1	1	53

4090	) (Cont.)	FORM CMS-2552-10	<b>IS-2552-10</b>				
	PECTIVE PAYMENT FOR SNF ISTICAL DATA		PERIOD: FROM TO	WORKSHEET S-7 (CONT.)			
	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)			
	1	2	3	4			
55	SE3				55		
56	SE2				56		
57	SE1				57		
58	SSC				58		
59	SSB				59		
60	SSA				60		
61	IB2				61		
62	IB1				62		
63	IA2				63		
64	IA1				64		
65	BB2				65		
66	BB1				66		
67	BA2				67		
68	BA1				68		
69	PE2 PE1				69		
70	PE1 PD2				70 71		
72	PD2 PD1				71		
73	PD1 PC2				72		
73	PC2 PC1				73		
74	PB2				74		
76	PB1				76		
77	PA2				77		
78	PA1				78		
199	AAA				199		
200	TOTAL				200		

## SNF SERVICES

	ERTICLE			
		CBSA at	CBSA on/after	
		Beginning of	October 1 of the	
		Cost Reporting	Cost Reporting	
		Period	Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning			201
	of the cost reporting period.			
	Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			

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

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

09-13 FORM CMS-2552-10							4	090 (C	ont.)							
FEDE	ITAL-BASED RURAL H RALLY QUALIFIED HE. ISTICAL DATA							DER CCN				):		WORKSHEET S-8		-8
Check applic		RHC FQHC														
Clinic	Address and Identification	n:														
1	Street:															1
2	City:	State:			Zip Coc	le:			County:					r		2
3	FQHCs ONLY: Designation	ation - Enter "R"	for rural	or "U" fo	r urban											3
Source	e of Federal Funds:															
												Award		-	ate	
		(0 : 220)										1		1	2	4
4	Community Health Center Migrant Health Center (S			Act)												4
6	Health Services for the F			DUS Act												5
7	Appalachian Regional Co		II 340(u),	THS Act												7
8	Look-alikes	011111351011														8
9	Other (specify)															9
	••••••(*F••••))															
-														1	2	
10	Does this facility operate	e as other than ar	RHC or	FQHC?	Enter "Y	" for yes o	r "N" for	no in colu	mn 1.							10
	If yes, indicate the numb	er of other opera	tions in c	column 2.												
Facilit	y hours of operations (1)									T						-
			nday		nday	_	esday		nesday		rsday		iday		ırday	
	Type Operation	from 1	to 2	from 3	to 4	from 5	to	from 7	to	from 9	to	from	to	from	to	
11	0 Clinic	1	2	3	4	5	6	/	8	9	10	11	12	13	14	11
	Enter clinic hours of oper	ration on line 11	and other	type oper	rations of	subscript	ts of line	11 (both t	vne and b	ours of or	veration)					11
(1)	List hours of operation ba															
														1	2	
12	Have you received an ap	proval for an exc	ception to	the produ	ctivity s	tandard?										12
13	Is this a consolidated cos	st report as define	ed in CM	S Pub. 10	0-04, ch	apter 9, se	ction 30.8	? Enter	"Y" for y	es or "N"	for no in	column 1				13
	If yes, enter in column 2															
14	Provider name:								CCN nu	mber:						14
													1	I	I	
															Total	
											Y/N	v	XVIII	XIX	Visits	
	1										1	2	3	4	5	
15	Have you provided all or												1			15
	If yes, enter in columns 2		-	-	-	-							1			
	XVIII, and XIX, as appli	cable. Enter in	column 5	the numb	er of tota	l visits for	this prov	uder. (see	instructio	ons)				1	1	

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4010) Rev. 4

40-521

4090 (Cont.)	FORM CMS-2552-10		09-13
HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-9 PARTS I & II
	HOSPICE NO.:	то	

## PART I - ENROLLMENT DAYS

				Undupli	cated Days			
				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

# PART II - CENSUS DATA

				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous							7
	Care Hours Billable to Medicare							
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4011) 40-522

09-1	3 FORM CMS-2552-1	0	4090 (Cont.)		
	ITAL UNCOMPENSATED AND INDIGENT DATA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-10	
Unco	mpensated and indigent care cost computation				
1	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column	8)			1
		*)			
Media	caid (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 or supplemental payments from Medicaid?				4
5	If line 4 is no, enter DSH 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 (line 7 minus lines 2 and	id 5).			8
	If line 7 is less than the sum of lines 2 and 5, then enter zero.				
State	Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9	Net revenue from stand-alone SCHIP				9
10	Stand-alone SCHIP charges				10
11	Stand-alone SCHIP cost (line 1 times line 10)				11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9).				12
	If line 11 is less than line 9, then enter zero.				
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	lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)				15
16	Difference between net revenue and costs for state or local indigent care program (line 1	5 minus line 13)			16
	If line 15 is less than line 13, then enter zero.				
17	mpensated care (see instructions for each line)				17
17	Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations				17
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care program	s (sum of lines 8, 12 and	16)		19
19	Total unreinbursed cost for Medicald, SCIII and state and local indigent care program	s (sum of times 8, 12 and	10)		19
		Uninsured	Insured	Total	
		patients	patients	(col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding				20
	non-reimbursable cost centers) for the entire facility				
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)				23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of by Medicaid or other indigent care program?	of stay limit imposed on p	atients covered		24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length	of stay limit (see instructi	ons)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	ar any mile (see instruct	,		26
27	Medicare bad debts for the entire hospital complex (see instructions)				20
28	Non-Medicare and non-reimbursable <i>Medicare</i> bad debt expense (line 26 minus line 27	)			28
29	Cost of non-Medicare and <i>non-reimbursable Medicare</i> bad debt expense (line 1 times li	,			29
30	Cost of uncompensated care (line 23 column 3 plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4012) Rev. 4

40-523

4090	) (Cor	nt.)		FORM CM	MS-2552-10				0	9-13	
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES		PROVIDER CCN:	_	PERIOD: FROM TO	_	WORKSHEET A		
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm col. 6$ ) 7		
		GENERAL SERVICE COST CENTERS	-	_	-	· ·	-				
1	00100	Capital Related Costs-Buildings and Fixtures								1	
		Capital Related Costs-Movable Equipment								2	
		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	
		Nursing School								20	
21		Intern & Res. Service-Salary & Fringes (Approved)								21	
		Intern & Res. Other Program Costs (Approved)								22	
23	02300	Paramedical Ed. Program (specify)								23	
		INPATIENT ROUTINE SERVICE COST CENTERS									
		Adults and Pediatrics (General Routine Care)								30	
_		Intensive Care Unit								31	
_		Coronary Care Unit								32	
_		Burn Intensive Care Unit								33	
	03400	Surgical Intensive Care Unit								34	
35		Other Special Care (specify)								35	
		Subprovider - IPF								40	
	04100	Subprovider - IRF								41	
		Subprovider (specify)								42	
		Nursery								43	
		Skilled Nursing Facility								44	
		Nursing Facility								45	
46	04600	Other Long Term Care								46	

10-1	2			FORM CM	AS-2552-10				4090 (C	ont.)
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE (	OF EXPENSES		PROVIDER CCN:		PERIOD: FROM TO	WORKSHE		
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. $3 \pm$ col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
		ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	<u> </u>
50	05000	Operating Room								50
51		Recovery Room								51
52		Labor Room and Delivery Room								52
53		Anesthesiology								53
		Radiology-Diagnostic								54
55		Radiology-Therapeutic								55
56		Radioisotope								56
57		Computed Tomography (CT) Scan								57
58		Magnetic Resonance Imaging (MRI)								58
59										59
60		Cardiac Catheterization Laboratory								60
61		PBP Clinical Laboratory Services-Program Only								61
62										62
62		Whole Blood & Packed Red Blood Cells								62
		Blood Storing, Processing, & Trans.								64
64 65		Intravenous Therapy								64
		Respiratory Therapy								65
66		Physical Therapy								
67		Occupational Therapy								67
68		Speech Pathology								68
69		Electrocardiology								69
70		Electroencephalography								70
71		Medical Supplies Charged to Patients								71
		Implantable Devices Charged to Patients								72
73		Drugs Charged to Patients								73
74		Renal Dialysis					+			74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
	0000-	OUTPATIENT SERVICE COST CENTERS								<u> </u>
88		Rural Health Clinic (RHC)					+			88
89		Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91		Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

4090	) (Coi	nt.)		FORM CM	AS-2552-10				1	0-12	
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE	OF EXPENSES		PROVIDER CCN:		PERIOD: FROM TO	-	WORKSHEET A		
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. $3 \pm col. 4$ )	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)		
	r	OTHER REIMBURSABLE COST CENTERS	1	2	3	4	5	6	7		
0.4	00400									0.1	
94 95	09400 09500	Home Program Dialysis Ambulance Services								94 95	
										95 96	
96		Durable Medical Equipment-Rented Durable Medical Equipment-Sold								96 97	
97 98	09700	Other Reimbursable (specify)								97	
98		Outpatient Rehabilitation Provider (specify)	-							98 99	
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100	
100		Home Health Agency								100	
101	10100	SPECIAL PURPOSE COST CENTERS								101	
105	10500	Kidney Acquisition								105	
105	10600	Heart Acquisition								105	
107		Liver Acquisition								107	
107		Lung Acquisition								108	
109		Pancreas Acquisition								100	
110		Intestinal Acquisition								110	
111		Islet Acquisition								111	
112		Other Organ Acquisition (specify)								112	
113	11300	Interest Expense							- 0 -	113	
		Utilization Review-SNF							- 0 -	114	
		Ambulatory Surgical Center (Distinct Part)								115	
116		Hospice								116	
117		Other Special Purpose (specify)								117	
118		SUBTOTALS (sum of lines 1-117)								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 118-199)				- 0 -				200	

RECLASSIFICATIONS		TIONS						): 	WORKSHEET A-6		
			INCRE/	ASES			DECREA	ASES		Wkst.	Т
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #		OTHER	A-7 Ref.	
	1	2	3	4	5	6	7	8	9	10	
											Т
2											Τ
3											Τ
L.											
;											
5											
1											_
											_
											_
									-	<u> </u>	4
											4
											+
											+
			-				+ +			+	+
j											┽
							+ +			-	+
										-	╡
										-	+
											1
											1
											1
											1
					1						T
1											
											_
											_
							+			┿	4
							+			4	4
							+			┿	4
							+			┿	4
Total reclassifications (sum of columns 4 and 5										4	+

(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.

4090 (Cont.)		FO	RM CMS-2552	2-10				1	0-12
RECONCILIATION OF CAPITAL COSTS CENTERS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET A-7, PARTS I, II & III	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	SET BALANCES			+				•	
				Acquisitions		Disposals		Fully	
Description		Beginning Balances	Purchases	Donation	Total	and Retirements	Ending Balance	Depreciated Assets	L
		1	2	3	4	5	6	7	
1 Land			<u> </u>		L				1
2 Land Improvements			L		ļ				2
3 Buildings and Fixtures					ļ				3
4 Building Improvements			L		ļ				4
5 Fixed Equipment					L				5
6 Movable Equipment					L				6
7 HIT-designated Assets									7
8 Subtotal (sum of lines 1-7)			L		ļ				8
9 Reconciling Items					L				9
10 Total (line 7 minus line 9)		L			L				10
PART II - RECONCILIATION OF AMOUNTS FROM	PROVIDER CCN:     PROVIDER CCN:     PROV     PRO								
				<u> </u>	SUMMARY OF CAP	PITAL			
	l						· · ·		
		I			Insurance				
Description								×	
*		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures					L				1
2 Capital Related Costs-Movable Equipment			L		ļ				2
3 Total (sum of lines 1-2)		. <u> </u>	<u> </u>		L				3
<ul> <li>(1) The amount in columns 9 through 14 must equal the a column 2, lines 1 and 2.</li> <li>* All lines numbers are to be consistent with Workshee</li> </ul>			2. Enter in each colur	nn the appropriate am	ounts including any d	lirectly assigned cost t	hat may have been incl	luded in Worksheet A,	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS								
		COMPUTAT	ION OF RATIOS			ALLOCATION O	F OTHER CAPITAL		
			Gross Assets					Total	
		Capitalized	for Ratio	Ratio			Other Capital-	(sum of	
Description	Gross Assets	-	(col. 1 - col. 2)	(see instructions)	Insurance	Taxes	-	cols. 5 through 7)	
*									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1-2)				1.000000					3
	I			J					
				S	UMMARY OF CA	PITAL			
							Other Capital-	Total (2)	
		I			Insurance	Taxes	-		
Description		Depreciation	Lease	Interest				· ·	
*		-						<b>U</b>	
1 Capital Related Costs-Buildings and Fixtures			1	1		-		-	1
2 Capital Related Costs-Movable Equipment			1	1					2
3 Total (sum of lines 1-2)			†	1					3

Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.) FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4015)

09-1	3 FO	RM CMS-2552	-10			)90 (C		
ADJU	STMENTS TO EXPENSES	PROVIDER CCN:		PERIOD: FROM TO	WORKSHEET A-			
				10				
DESCRIPTION (1)				EXPENSE CLASSIFICAT WORKSHEET A TO/FROM THE AMOUNT IS TO BE A	M WHICH	Wkst. A-7		
		BASIS/CODE (2)	AMOUNT	COST CENTER	LINE #	Ref.		
		BASIS/CODE (2)	2	3	4	5		
1	Investment income - buildings and fixtures (chapter 2)	1	2	Buildings and Fixtures	1	5	1	
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2			
3								
4	•						4	
5							4	
6							(	
7	Telephone services (pay stations excluded) (chapter 21)							
8					1		8	
9						1	9	
10		Worksheet A-8-2				l	10	
11	Sale of scrap, waste, etc. (chapter 23)	Worksheet IT 0 2			-		11	
12		Worksheet A-8-1					12	
	Laundry and linen service	worksheet n-0-1			-		13	
14							14	
14					-		1:	
16	1 1 2				_		10	
10	supplies to other than patients						10	
17	Sale of drugs to other than patients				_		17	
17							18	
18					_		10	
20	Vending machines						2	
20	Income from imposition of interest,				_		2	
21	· ·						2	
22	finance or penalty charges (chapter 21)						2	
22	Interest expense on Medicare overpayments and						Ζ.	
22	borrowings to repay Medicare overpayments				_		~	
23	5 1 5 15	W 11 02			67		23	
24	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65			
24							24	
25	in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66			
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		2	
26	1 0			Buildings and Fixtures	1		20	
27	Depreciation - movable equipment			Movable Equipment	2		27	
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28	
29	Physicians' assistant				_		29	
30	Adjustment for occupational therapy costs			0			30	
	in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		20.0	
30.99	Hospice (non-distinct) (see instructions)			Adults and Pediatrics	30		30.9	
31	Adjustment for speech pathology costs			0 1011			31	
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		<u> </u>	
32					_	ļ	32	
33	Other adjustments (specify) <sup>(3)</sup>						33	
50	TOTAL (sum of lines 1 thru 49)						50	
	(Transfer to Worksheet A, column 6, line 200)							

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

(2) Basis for adjustment (see instructions)

- A. Costs if cost, including applicable overhead, can be determined B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Rev. 4

4090 (Cont.)	FORM CMS-2552-10			09-13
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:

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

\* 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.

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

(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 \_\_\_\_\_

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4017) 40-530

Rev. 4

ROV	IDER-BASED PHY	SICIANS ADJUSTMENTS			PROVIDER CCN:		PERIOD:	WORKSHEET A-	8-2	
							FROM	_		
							то	_		
		Cost Center/					Physician/		5 Percent of	
	Wkst. A	Physician	Total	Professional	Provider	RCE	Provider	Unadjusted	Unadjusted	
	Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
00	TOTAL									200

			Cost of	Provider	Physician	Provider				
		Cost Center/	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line #	Identifier	Education	col. 12	Insurance	col. 14	RCE Limit	Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

4090 (Cont.)			FOF	RM CMS-2552	-10				10-12
REASONABLE COST DETERMINA FURNISHED BY OUTSIDE SUPPLI		RVICES				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8 PARTS I & II	-3,
Check applicable box:	[] Occupational	[] Physical	[] Respiratory	[] Speech Path	hology				
DADEL OFNEDAL INFORMATI	ON								
PART I - GENERAL INFORMATI		uctions)							1
2 Line 1 multiplied by 15 hours	τ υ ,τ	iettolis)							2
3 Number of unduplicated days i		ist was on provid	ler site (see instru	ctions)					3
4 Number of unduplicated days i	1 1	1			as on provider site (see	instructions)			4
5 Number of unduplicated offsite		1	1	1	1	,			5
6 Number of unduplicated offsite	e visits - therapy assistants (i	nclude only visits	s made by therapy	assistant and on whi	ch				6
supervisor and/or therapist wa	s not present during the visit	(s)) (see instruction	ons)						
7 Standard travel expense rate									7
8 Optional travel expense rate pe	r mile								8
				Supervisors	Therapists	Assistants	Aides	Trainees	
				1	2	3	4	5	
9 Total hours worked									9
10 AHSEA (see instructions)									10
11 Standard travel allowance (colu	,	lumn 2,							11
line 10; column 3, one-half of	, ,								
12 Number of travel hours (see in	,								12
13 Number of miles driven (see in	structions)								13
PART II - SALARY EQUIVALEN	V COMPUTATION								
14 Supervisors (column 1, line 9 t									14
15 Therapists (column 2, line 9 tir									14
16 Assistants (column 3, line 9 tin	, ,								16
17 Subtotal allowance amount (su	, ,	piratory therapy of	r lines 14-16 for	all others)					17
18 Aides (column 4, line 9 times c									18
19 Trainees (column 5, line 9 time	es column 9, line 10)								19
20 Total allowance amount (sum o	of lines 17-19 for respiratory	therapy or lines	17 and 18 for all	others)					20
If the sum of columns 1 and 2 f					y or occupational therap	py, line 9, is greater than	line 2,		
make no entries on lines 21 and	22 and enter on line 23 the	amount from line	20. Otherwise c	omplete lines 21 thro	ugh 23.				
21 Weighted average rate excludin	ng aides and trainees (line 17	divided by sum	of columns 1 and	2, line 9 for respirate	ory therapy or columns	1 through 3, line 9 for all	others)		21
22 Weighted allowance excluding		nes line 21)							22
23 Total salary equivalency (see in	structions)								23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES       PROVIDER CCN:       PERIOD:         FURNISHED BY OUTSIDE SUPPLIERS       [] Occupational [] Physical [] Respiratory       [] Speech Pathology         Check applicable box:       [] Occupational [] Physical [] Respiratory       [] Speech Pathology         PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE         Standard Travel Allowance	WORKSHEET A-8-3, PARTS III & IV
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance	
Standard Travel Allowance	
Standard Travel Allowance	
24 Therapists (line 3 times column 2, line 11)	25
25 Assistants (line 4 times column 3, line 11)	23
26 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	26
27 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	27
28 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	28
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 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
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE	
Standard Travel Expense	
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 9 times column 2, line 10)	40
41 Assistants (column 3, line 9 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)	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

4090 (Cont.)		FORM CMS-255	52-10				10-12
REASONABLE COST DETERMINA FURNISHED BY OUTSIDE SUPPLIE				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8 PARTS V-VI	3-3,
Check applicable box:	[] Occupational [] Physical [] Respirate	ory [] Speech Path	ology	•			
PART V - OVERTIME COMPUTA	TION						
		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47 Overtime hours worked during a							47
· · · ·	eater than 2,080, do not complete						
lines 48-55 and enter zero in each	ch column of line 56)						_
48 Overtime rate (see instructions)							48
	and overtime allowance) (multiply						49
line 47 times line 48)							
CALCULATION OF LIMIT							
50 Percentage of overtime hours by							50
	vertime worked in column 5, line 47)						
51 Allocation of provider's standar							51
employee times the percentages							
DETERMINATION OF OVERTIN				-			
52 Adjusted hourly salary equivale							52
53 Overtime cost limitation (line 5	· · · · · · · · · · · · · · · · · · ·						53
54 Maximum overtime cost (enter	,						54
-	uded in hourly computation at the AHSEA (multiply						55
line 47 times line 52)							
	nus line 55 - if negative enter zero) (Enter in column 5 the						56
sum of columns 1, 3, and 4 for	respiratory therapy and columns 1 through 3 for all others.)						
PART VI - COMPUTATION OF TH	IERAPY LIMITATION AND EXCESS COST ADJUS	IMENT					
57 Salary equivalency amount (from	m 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 colu	mn 5, line 56)						60
61 Equipment cost (see instructions	, ,						61
62 Supplies (see instructions)							62
63 Total allowance (sum of lines 5	7-62)						63
64 Total cost of outside supplier se	,						64
	ninus line 63; if negative, enter zero)						65

09-13	RM CMS-255	2-10	4090 (Cont.)						
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART I	
	NET EXPENSES FOR COST ALLOCATION		TTAL D COSTS			TOADMINIS-	MAIN-		Γ
COST CENTER DESCRIPTIONS	(from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	TRATIVE & GENERAL 5	TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS		•				0		,	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment				1					2
4 Employee Benefits <i>Department</i>									4
5 Administrative and General									5
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary	_			-				-	10
11 Cafeteria									11
12 Maintenance of Personnel									12
13         Nursing Administration           14         Central Services and Supply								+	13 14
15 Pharmacy									14
16 Medical Records & Medical Records Library									16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									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									<u> </u>
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
35         Other Special Care Unit (specify)           40         Subprovider IPF	+ +			+				+	40
40 Subprovider IRF	+ +			1			<u> </u>		40
42 Subprovider (specify)	+ +			1			1	1	42
43 Nursery	1 1			1			1	1	43
44 Skilled Nursing Facility									44
45 Nursing Facility							1	1	45
46 Other Long Term Care									46

4090	4090 (Cont.) FORM CMS-2:				2-10	(	09-13			
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART I	
		NET EXPENSES FOR COST		PITAL ED COSTS						
	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7) 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	ANCILLARY SERVICE COST CENTERS	0	1	2	4	44	5	0	1	
50	Operating Room									50
_	Recovery Room									51
										52
53									1	53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization			1				1		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
	Implantable Devices Charged to Patients									72
_	Drugs Charged to Patients								ļ	73
	Renal Dialysis									74
_	ASC (Non-Distinct Part)								ļ	75
	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
90										90
91										91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

09-13	P-13 FORM CMS					552-10				
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		WORKSHEET B, PART I				
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)		TTAL ED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT		
	0	1	2	4	4A	5	6	7		
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	
SPECIAL PURPOSE COST CENTERS									<u> </u>	
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 1-117)									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 118-201)									202	

## FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) Rev. 4

409	0 (Cont.)			FOF	RM CMS-25	52-10					(	09-13
COST	ALLOCATION - 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 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS	0	,	10		12	15	14	15	10	17	
1	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
	Employee Benefits <i>Department</i>											4
	Administrative and General											5
	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
	Nursing Administration											13
	Central Services and Supply									4		14
	Pharmacy											15
	Medical Records & Medical Records Library	-						-				16
	Social Service											17
	Other General Service (specify)			4								18
	Nonphysician Anesthetists											19 20
	Nursing School Intern & Res. Service-Salary & Fringes (Approved)				+							20
	Intern & Res. Service-Salary & Fringes (Approved)											21
	Paramedical Education Program (specify)											22
23	INPATIENT ROUTINE SERVICE COST CENTERS											23
30	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit											31
_	Coronary Care Unit											32
	Burn Intensive Care Unit		l		1	l		1		l		33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											35
	Subprovider IPF											40
41	Subprovider IRF											41
42	Subprovider (specify)											42
	Nursery											43
	Skilled Nursing Facility				<u> </u>							44
	Nursing Facility			ļ	<b> </b>			ļ			I	45
46	Other Long Term Care											46

10-1	2		FOR	M CMS-25	52-10		4090 (Cont.					
COST	ALLOCATION - GENERAL SERVICE COSTS		I	I	PROVIDER CO	CN:		PERIOD: FROM TO		ſ	WORKSHEET PART I	В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	-
	ANCILLARY SERVICE COST CENTERS		· · ·									
50	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
53	Anesthesiology											53
	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
	Laboratory											60
61	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
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients				ļ			ļ				73
	Renal Dialysis											74
	ASC (Non-Distinct Part)				ļ			ļ				75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											<u> </u>
	Rural Health Clinic (RHC)				<b> </b>			<b> </b>				88
	Federally Qualified Health Center (FQHC)	-	[	l	ł			ł			[	89
_	Clinic	-	[	l	ł			ł			[	90
	Emergency				L			-				91
	Observation Beds											92
93	Other Outpatient Service (specify)											93

4090	) (Cont.)	FOR	FORM CMS-2552-10 PROVIDER CCN: PERIOD:							10-12		
COST	ALLOCATION - GENERAL SERVICE COSTS		1			CN:		PERIOD: FROM TO		1	WORKSHEET PART I	ЗΒ,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold										1	97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)										1	99
	Intern-Resident Service (not appvd. tchng. prgm.)										1	100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
	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)			1	1							112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice			1	1							116
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1-117)											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 118-201)											202

09-	13			FO	RM CMS-255	2-10				4090 (0	Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD: FROM TO		WORKSHEET B PART I	,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2											2
	Employee Benefits <i>Department</i>										4
-	Administrative and General										5
-	Maintenance and Repairs										6
7	· · · · · · · · · · · · · · · · · · ·										7
8	Laundry and Linen Service										8
9	· · ·										9
10	Dietary										10
	Cafeteria										11
-	Maintenance of Personnel										12
	Nursing Administration										13
14											14
	Pharmacy										15
-	Medical Records & Medical Records Library										16
	Social Service										17
18	Other General Service (specify)										18
	Nonphysician Anesthetists										19
	Nursing School				1						20
21	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										
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
41	Subprovider IRF										41
42	Subprovider (specify)										42
	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

4090	(Cont.)			FO	RM CMS-255	2-10					09-13
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	-	PERIOD: FROM TO		WORKSHEET B PART I	\$,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room										50
_	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology						1				53
	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
	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	1							1	ļ	72
_	Drugs Charged to Patients	1							1	ļ	73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										<b>_</b>
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)		ļ								89
	Clinic		ļ			ļ				ļ	90
	Emergency										91
92	Observation Beds										92
93	Other Outpatient Service (specify)										93

DR	AFT	RM CMS-255	2-10				4090 (Cont.)				
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD: FROM TO		WORKSHEET B, PART I	,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	ž į										95
96	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition				1			1			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 1-117)										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 118-201)										202

ALLOC.	ATION OF CAPITAL-RELATED COSTS									
			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART II			
						-	то			
		DIRECTLY ASSIGNED		ITAL D COSTS						
	COST 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 7	
6	ENERAL SERVICE COST CENTERS	0	1	2	2A	4	5	6	/	<u> </u>
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs Dunuings and Extenses									2
	Employee Benefits <i>Department</i>									4
	Administrative and General									5
6 N	Maintenance and Repairs									6
	Deperation of Plant									7
8 L	Laundry and Linen Service									8
9 E	Iousekeeping									9
10 E	Dietary									10
11 C	Cafeteria									11
12 N	Maintenance of Personnel									12
13 N	Jursing Administration									13
14 C	Central Services and Supply									14
	Pharmacy									15
16 N	Medical Records & Medical Records Library									16
17 S	locial Service									17
	Other General Service (specify)									18
-	Vonphysician Anesthetists									19
	Nursing School									20
	ntern & Res. Service-Salary & Fringes (Approved)									21
	ntern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
	NPATIENT ROUTINE SERVICE COST CENTERS									<u> </u>
	Adults and Pediatrics (General Routine Care)									30
	ntensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33 34
	Surgical Intensive Care Unit	┨────┤								34
	Other Special Care Unit (specify)	+				}				40
	Subprovider IPF	+				<del> </del>	+		+	40
	Subprovider (specify)	-								41
	Jursery									42
	Skilled Nursing Facility									43
	Jursing Facility	1			1	1	1		1	45
	Other Long Term Care	1			1	1	1		1	46

DRA	AFT	RM CMS-255	2-10				4090 (Cont.)			
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:	-	PERIOD: FROM TO		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		PITAL ED COSTS						
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT 7	
	ANCILLARY SERVICE COST CENTERS	0	1	2	2A	4	5	6	/	
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology				1	1	1	1	1	53
	Radiology-Diagnostic									54
	Radiology-Therapeutic			1		1				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
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
	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
	Other Ancillary (specify)									76
-	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

4090	(Cont.)		RM CMS-255	2-10			DRAFT			
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART II	
	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS		PITAL ED COSTS MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	7	<u> </u>
	Home Program Dialysis									94
	Ambulance Services									94
95	Durable Medical Equipment-Rented									95
_	Durable Medical Equipment-Sold			-				-	-	90
	Other Reimbursable (specify)									97
98	Outpatient Rehabilitation Provider (specify)									98
_										100
	Intern-Resident Service (not appvd. tchng. prgm.)									
	Home Health Agency SPECIAL PURPOSE COST CENTERS									101
										105
-	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
	Islet Acquisition									111
_	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)								-	117
_	SUBTOTALS (sum of lines 1-117)	_								118
	NONREIMBURSABLE COST CENTERS									
	Gift, Flower, Coffee Shop, & Canteen									190
191	Research				+					191
192	Physicians' Private Offices									192
-	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross Foot Adjustments									200
201	Negative Cost Centers				+					201
202	TOTAL (sum lines 118-201)									202

09-13			FOR	RM CMS-25	52-10					4090 (C	Cont.)
ALLOCATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM			WORKSHEET I PART II	В,
							то			17ii(1 ii	
					1						Т
	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
COST CENTER DESCRIPTIONS	& LINEN	HOUSE-	DIDELDU		TENANCE OF	ADMINIS-	SERVICES &		RECORDS &		
	SERVICE 8	KEEPING 9	DIETARY 10	CAFETERIA 11		TRATION 13	SUPPLY 14	PHARMACY 15	LIBRARY	SERVICE 17	-
GENERAL SERVICE COST CENTERS	8	9	10	11	12	15	14	13	16	17	
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment	-										2
4 Employee Benefits <i>Department</i>	-										4
5 Administrative and General											5
6 Maintenance and Repairs				1			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	_			-					4		14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16 17
17         Social Service           18         Other General Service (specify)	-			-			-				17
19 Nonphysician Anesthetists	-										18
20 Nursing School											20
21 Intern & Res. Service-Salary & Fringes (Approved)	-										20
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Education Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
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			ļ								40
41 Subprovider IRF				ļ			ļ				41
42 Subprovider (specify)											42
43 Nursery	+		ł	+	<b> </b>	<b> </b>	ł		<b> </b>	ł	43
44 Skilled Nursing Facility	_										44
45 Nursing Facility					<u> </u>		<u> </u>				45
46 Other Long Term Care					I	I	I				46

4090	0 (Cont.)	FOR	M CMS-25	52-10					0	)9-13		
ALLC	OCATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM TO			WORKSHEET I PART II	В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	,	10		12	15	14	15	10	17	
50	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology					1				1		53
	Radiology-Diagnostic											54
	Radiology-Therapeutic	1		1		i i		1		1		55
	Radioisotope			1				1				56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
	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
	OUTPATIENT SERVICE COST CENTERS											
-	Rural Health Clinic (RHC)			ł	1			ł				88
89				ł	1			ł				89
-				ł	1			ł				90
	Emergency			L	l			L				91
92												92
93	Other Outpatient Service (specify)							I				93

DR	AFT	FOR	FORM CMS-2552-10						4090 (Cont.)			
ALLO	DCATION OF CAPITAL-RELATED COSTS			-	PROVIDER C	CN:		PERIOD: FROM TO		-	WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
	Durable Medical Equipment-Rented				1	1		1			1	96
97	Durable Medical Equipment-Sold										1	97
98	Other Reimbursable (specify)											98
99											1	99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency										1	101
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
	Heart Acquisition											106
	Liver Acquisition										1	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			1						1		116
117	Other Special Purpose (specify)			1						1		117
118	SUBTOTALS (sum of lines 1-117)			1						1		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 118-201)											202

409	0 (Cont.)		FOR	RM CMS-255	52-10						09-13
ALLO	DCATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department	1									4
5	Administrative and General										5 6
6	Maintenance and Repairs										
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping	_									9
10	Dietary										10
11		-									11
12		-									12
13		-									13 14
14	Central Services and Supply Pharmacy	-									14
16	Medical Records & Medical Records Library										16
17	Social Service	-									17
18	Other General Service (specify)		1								18
19	Nonphysician Anesthetists										19
20											20
21						1					21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
30											30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit	+						<b> </b>	<b> </b>	<b> </b>	33
34	Surgical Intensive Care Unit	+								<u> </u>	34
35		+									35 40
40	Subprovider IPF Subprovider IRF	+						ł	ł	<del> </del>	40
41	Subprovider (specify)	+								<u> </u>	41
42	Nursery	1							<u> </u>	1	42
44	Skilled Nursing Facility										44
45	Nursing Facility				1		1			1	45
46										1	46

10-12	2		FOR	M CMS-25	52-10					4090 (	Cont.)
ALLOC	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	
	Operating Room				-	1	-				50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology	-								1	53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan					1					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					1					65
	Physical Therapy					1					66
	Occupational Therapy					1					67
68	Speech Pathology										68
	Electrocardiology										69
70	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	DUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
_	Clinic										90
91	Emergency										91
	Observation Beds										92
93	Other Outpatient Service (specify)										93

409	0 (Cont.)		FOR	M CMS-255	52-10						10-12
ALLO	DCATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAI EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98											98
99	Outpatient Rehabilitation Provider (specify)										- 99
100	Intern-Resident Service (not appvd. tchng. prgm.)				1		1				100
	Home Health Agency										101
	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 1-117)										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 118-201)										202

09-1	3	FO	RM CMS-255	2-10				4090 (C	Cont.)
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	1
						то			
		CAPITAL RE	ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
	COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	GENERAL SERVICE COST CENTERS								
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							7	6
	Operation of Plant								7
	Laundry and Linen Service								8
-	Housekeeping			1			l	1	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 School								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								2.5
30	Adults and Pediatrics (General Routine Care)							1	30
	Intensive Care Unit			1			1	1	31
-	Coronary Care Unit		1			1	1	1	32
	Burn Intensive Care Unit		1			1	1	1	33
	Surgical Intensive Care Unit			1		1	1	1	34
_	Other Special Care Unit (specify)						1	1	35
	Subprovider IPF						1	1	40
	Subprovider IRF						1	1	40
	Subprovider (specify)					1	<u> </u>	1	42
	Nursery						<u> </u>	1	42
	Skilled Nursing Facility								43
	Nursing Facility								44
						+	ł	+	45
40	Other Long Term Care		1	I		1	I	1	40

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

409	0 (Cont.)	FO	RM CMS-255	2-10				(	09-13
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B-1	1
						FROM			
						то			
		CAPITAL RE	LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
	COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
	Recovery Room								51
-	Labor Room and Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic	ļ		l		ļ			54
	Radiology-Therapeutic								55
	Radioisotope								56
57	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
	Laboratory								60
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
	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
73	Drugs Charged to Patients								73
	Renal Dialysis								74
	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	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

09-1	3	FO	RM CMS-255	2-10				4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B-	1
		CAPITAL RE BLDGS. & FIXTURES	ELATED COST MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT		ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	COST CENTER DESCRIPTIONS	(SQUARE FEET)	(DOLLAR VALUE)	(GROSS SALARIES) 4	RECONCIL- IATION 5A	(ACCUM. COST) 5	(SQUARE FEET) 6	(SQUARE FEET) 7	_
	OTHER REIMBURSABLE COST CENTERS	1	2	+	JA	5	0	1	
	Home Program Dialysis								94
_	<u> </u>								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
	SPECIAL PURPOSE COST CENTERS								101
	Kidney Acquisition								105
106	Heart Acquisition								106
107	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
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)								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
205	Unit cost multiplier (Worksheet B, Part II)								205

4090	) (Cont.)			FOR	M CMS-25	52-10					(	09-13
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	Г В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 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
	Laundry and Linen Service											8
	Housekeeping				4							9
	Dietary											10
	Cafeteria											11
12	Maintenance of Personnel											12
	Nursing Administration											13 14
	Central Services and Supply Pharmacy											14
	Medical Records & Medical Records Library											15
	Social Service											10
	Other General Service (specify)											18
	Nonphysician Anesthetists											19
	Nursing School											20
	Intern & Res. Service-Salary & Fringes (Approved)											21
22	Intern & Res. Other Program Costs (Approved)											22
23	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit											31
	Coronary Care Unit											32
	Burn Intensive Care Unit	4			<b> </b>			l				33
	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											35
40	Subprovider IPF Subprovider IRF	1										40 41
	*											41
	Subprovider (specify) Nursery											42
	Skilled Nursing Facility				1							43
	Nursing Facility											44
	Other Long Term Care				1			1		1		46

10-1	2			FOR	M CMS-25	52-10					4090 (C	Cont.)
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	Г В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	-
	ANCILLARY SERVICE COST CENTERS		-									
50	Operating Room											50
	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic				1		1			1		55
56	Radioisotope											56
57	Computed Tomography (CT) Scan				1		1			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	· · · · · · · · · · · · · · · · · · ·											68
69	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
73	Drugs Charged to Patients											73
74	ž											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											<u> </u>
	Rural Health Clinic (RHC)				ļ		ļ			ļ		88
89	Federally Qualified Health Center (FQHC)				ļ		ļ			ļ		89
	Clinic											90
91	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93

4090	) (Cont.)			FOR	M CMS-25	52-10					1	10-12
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	Г В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
	OTHER REIMBURSABLE COST CENTERS	8	9	10	11	12	15	14	15	10	17	
94	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
-	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)				1	1	1	1	1	1	1	98
99												99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											101
_	Kidney Acquisition											105
_	Heart Acquisition											106
	Liver Acquisition											107
	Lung Acquisition										1	108
109	Pancreas Acquisition											109
_	Intestinal Acquisition											110
	Islet Acquisition											111
	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
117	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1-117)										1	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
205	Unit cost multiplier (Worksheet B, Part II)											205

09-13	3		FOR	M CMS-255	52-10					4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET	B-1
			NON-			RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
	COST CENTER DESCRIPTIONS	GENERAL SERVICE	ANES- THETISTS	SCHOOL (ASSIGNED	FRINGES (ASSIGNED	COSTS (ASSIGNED	EDUCATION (ASSIGNED		COST & POST STEPDOWN		
	COST CENTER DESCRIPTIONS	(SPECIFY)	(ASGND TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	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	4									6
	Operation of Plant	_									7 8
	Laundry and Linen Service	_									8
	Housekeeping Dietary	_									10
	Cafeteria	-									10
_	Maintenance of Personnel										12
	Nursing Administration										13
	Central Services and Supply										14
	Pharmacy										15
16	Medical Records & Medical Records Library	1									16
17	Social Service										17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
	Nursing School										20
	Intern & Res. Service-Salary & Fringes (Approved)						4				21
	Intern & Res. Other Program Costs (Approved)							ł			22
	Paramedical Education Program (specify)										23
	NPATIENT ROUTINE SERVICE COST CENTERS Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit										30
_	Coronary Care Unit										32
	Burn Intensive Care Unit						1				33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	Subprovider IPF										40
41	Subprovider IRF										41
	Subprovider (specify)										42
_	Nursery										43
	Skilled Nursing Facility										44
	Nursing Facility				ļ		ļ				45
46	Other Long Term Care										46

4090	(Cont.)		FOR	AM CMS-255	52-10					(	09-13
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10		20			20	2.	20	20	
_	Operating Room										50
	Recovery Room										51
52	Labor Room and Delivery Room										52
	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
	Occupational Therapy										67
68	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients				ļ	ļ	ļ				71
	Implantable Devices Charged to Patients										72
-	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										<b>_</b>
	Rural Health Clinic (RHC)		ļ								88
	Federally Qualified Health Center (FQHC)	-									89
90	Clinic	-									90
	Emergency										91
92	Observation Beds							-			92
93	Other Outpatient Service (specify)										93

DRA	<b>NFT</b>		FOR	M CMS-255	52-10					4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	10	17	20	21		23	24	25	20	
94	Home Program Dialysis										94
-	Ambulance Services										95
-	Durable Medical Equipment-Rented						1				96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)						1				98
	Outpatient Rehabilitation Provider (specify)						1				99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	SPECIAL PURPOSE COST CENTERS										101
105	Kidney Acquisition										105
-	Heart Acquisition						1				106
107	Liver Acquisition										107
108	Lung Acquisition										108
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
112	Other Organ Acquisition (specify)								1		112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
117	Other Special Purpose (specify)						1				117
118	SUBTOTALS (sum of lines 1-117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen						1				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
205	Unit cost multiplier (Worksheet B, Part II)										205

-		FORM CMS-2552				09-13
POST	STEPDOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD:		WORKSHEET B-2	
			FROM			
			ТО			-
			WORKS		4	
	DESCRIPTION		PART	LINE NO.	AMOUNT	_
	1		2	3	4	+
-	Adjustment for EPO costs in Renal Dialysis cost center		1	74		1
	Adjustment for EPO costs in Home Program Dialysis cost center		1	94		2
	Adjustment for ARANESP costs in Renal Dialysis cost center		1	74		3
	Adjustment for ARANESP costs in Home Program Dialysis cost		1	94		4
	Adjustment for ESA costs in Renal Dialysis cost center (see instru		1	74		5
6		(see instructions)	1	94		6 7
7						8
9						9
						_
10						10
11						11
13			+	1	<u> </u>	13 14
14						14
15						15
17				1	1	17
17						18
19						19
20						20
20						20
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50			+	+	ł	50
51			+	+	<b> </b>	51
52			+	+	<b> </b>	52
53			+	+	ł	53
54			+	+	<b> </b>	54
55						55
56						56
57						57
58						58
59					1	59

10-12		FORM CMS-2552-10										4090 (Cont.)	
COM	UTATION OF RATIO OF COSTS TO CHARGES							PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET C PART I	
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Dis- allowance	Total Costs	Inpatient	Charges Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	-
	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 (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
	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												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory												60
61	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.												63
64	Intravenous Therapy												64
65	Respiratory Therapy												65
66	Physical Therapy												66
67	Occupational Therapy												67
68	Speech Pathology												68

4090 (Cont.) FORM CMS-2552-10					1	10-12						
COMPUTATION OF RATIO OF COSTS TO CHARGES			-				PROVIDER	CCN:	PERIOD: FROM TO		WORKSHE PART I	ET C
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj. 2	Total Costs 3	Costs RCE Dis- allowance 4	Total Costs 5	Inpatient 6	Charges Outpatient 7	Total (column 6 + column 7) 8	Cost or Other Ratio 9	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio 11	
69 Electrocardiology	1		5		5	0	,	0	,	10	11	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)				1		1	1		1			76
OUTPATIENT SERVICE COST CENTERS			-									
88 Rural Health Clinic (RHC)												88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency												91
92 Observation Beds (see instructions)												92
93 Other Outpatient Service (specify)												93
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
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
200 Subtotal (see instructions)												200
201 Less Observation Beds												201
202 Total (see instructions)		I										202

10-12 FORM CMS-2552-10												
	EULATION OF OUTPATIENT SERVICE COST TO RGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title V [ ] Title XIX			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET C, PART II			
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26) 2	Operating Cost Net of Capital Cost (col. 1 - col. 2) 3	Capital Reduction 4	Operating Cost Reduction Amount 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8) 7	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7) 8			
	ANCILLARY SERVICE COST CENTERS	-	_	-		-			-			
50										50		
51	Recovery Room									51		
52	Labor Room and Delivery Room									52		
53	Anesthesiology									53		
54	Radiology-Diagnostic									54		
55	Radiology-Therapeutic									55		
56	Radioisotope									56		
57	Computed Tomography (CT) Scan									57		
58	Magnetic Resonance Imaging (MRI)						1			58		
59	Cardiac Catherization						1			59		
60	Laboratory									60		
61	PBP Clinical Laboratory Services-Prgm. Only						1			61		
62	Whole Blood & Packed Red Blood Cells						1			62		
63	Blood Storing, Processing, & Trans.									63		
64	Intravenous Therapy						1			64		
65	Respiratory Therapy						1			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		

4090 (Cont.)	FOF	RM CMS-25	52-10						0-12
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title V [ ] Title XIX			PROVIDER CO	CN:	PERIOD: FROM TO		WORKSHEET C PART II (CONT.	
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 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8) 7	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7) 8	
OUTPATIENT SERVICE COST CENTERS	1	2	5		5	0	,	0	
88 Rural Health Clinic (RHC)									88
89 Federally Qualified Health Center (FQHC)									89
90 Clinic									90
91 Emergency			1						91
92 Observation Beds (see instructions)									92
93 Other Outpatient Service (specify)									93
OTHER REIMBURSABLE COST CENTERS									
94 Home Program Dialysis									94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold							1		97
98 Other Reimbursable (specify)							1		- 98
99 Outpatient Rehabilitation Provider (specify)							1		- 99
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
101 Home Health Agency									101
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
200 Subtotal (sum of lines 50 thru 199)									200
201 Less Observation Beds									201
202 Total (line 200 minus line 201)									202

10-1	2	M CMS-25	52-10	4090 (Cont.)					
	RTIONMENT OF INPATIENT ROUTINE ICE CAPITAL COSTS			PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET D, PART I	
Check applica boxes:	able [] Title XVIII, Part A	[ ] 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	1	2	3	4	5	6	7	
30	INPATIENT ROUTNE SERVICE COST CENTERS Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)								200

4090	0 (Cont.)	F	FORM CMS-255	2-10				10-12
APPO	ORTIONMENT OF INPATIENT ANC	ILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	,
SERV	/ICE CAPITAL COSTS				FROM		PART II	
			COMPONENT CO	CN:	ТО			
Check	2	[] Title V		[] Hospital	[] Subprovider (O	Other)	[] PPS	
applic	cable	[] Title XVIII	, Part A	[] IPF			[] TEFRA	
boxes:	:	[] Title XIX		[] IRF				
			Capital					
			Related Cost		Ratio of Cost		Capital	
			(from Wkst.	Total Charges	to Charges	Inpatient	Costs	
			B, Part II,	(from Wkst. C,	(col .1 ÷	Program	(column 3 x	
			col. 26)	Part I, col. 8)	col. 2)	Charges	column 4)	
(A)	Cost Center Description		1	2	3	4	5	
	ANCILLARY SERVICE COST CEN	ITERS						
50	Operating Room							50
51	Recovery Room							51
52	Labor Room and Delivery Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55				1	1			55
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI)							58
59	Cardiac Catheterization						-	60
60	Laboratory							60
61	PBP Clinical Laboratory Services-Pr	am Only						61
62	Whole Blood & Packed Red Blood	č ,						62
63	Blood Storing, Processing, & Transf							63
64	Intravenous Therapy	using						64
65	Respiratory Therapy							65
66	Physical Therapy							66
67								67
68	Occupational Therapy Speech Pathology							68
	A 81							_
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patient							71
72	Implantable Devices Charged to Pati	ents						72
73	Drugs Charged to Patients				╂────┤			73
74	Renal Dialysis				+			74
75	ASC (Non-Distinct Part)				+			75
76	Other Ancillary (specify)				+			76
88	Rural Health Clinic (RHC)							88
89	Federally Qualified Health Center (F	QHC)						89
90	Clinic				┨─────┤			90
91	Emergency				┨─────┤			91
92	Observation Beds				┨─────┤			92
93	Other Outpatient Service (specify)		_				1	93
	OTHER REIMBURSABLE COST C	ENTERS						
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented				<u> </u>			96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
200	Total (sum of lines 50 through 199)							200

09-13	3			FOR	M CMS-255	52-10					4090 (C	Cont.)
	TIONMENT OF INPATIENT ROUTINE CE OTHER PASS THROUGH COSTS						PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET D, PART III	
Check applicab boxes:	le	[] Title V [] Title XVIII, ] [] Title XIX	Part A	[ ] PPS [ ] TEFRA								
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 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 Description		1	2	3	4	5	6	7	8	9	$\square$
1	INPATIENT ROUTINE SERVICE COST CENT Adults & Pediatrics (General Routine Care)	ERS										30
31 I	Intensive Care Unit											31
32 0	Coronary Care Unit											32
33 1	Burn Intensive Care Unit											33
34 5	Surgical Intensive Care Unit											34
35 0	Other Special Care Unit (specify)											35
	Subprovider IPF											40
41 5	Subprovider IRF											41
42 5	Subprovider (Other)											42
43 1	Nursery											43
44 5	Skilled Nursing Facility											44
45 1	Nursing Facility											45
	Total (sum of lines 30-199)											200

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.3) Rev. 4

4090	090 (Cont.)		FORM CM	IS-2552-10				09-13	
APPO	RTIONMENT OF INPAT	ENT/OUTPATIENT ANCILLA	RY	PROVIDER CC	N:	PERIOD:		WORKSHEET D	D,
SERV	ICE OTHER PASS THRO	UGH COSTS				FROM		PART IV	
				COMPONENT	CCN:	то			
Check		[] Title V	[] Hospital	[] Subpro	vider (Other)	[] ICF/MR	[] PPS		
applica	able	[] Title XVIII, Part A	[] IPF	[ ] SNF			[] TEFRA		
boxes:		[] Title XIX	[] IRF	[] NF					
						All		Total	
			Non			Other		Outpatient	
			Physician			Medical	Total cost	Cost	
			Anesthetist	Nursing	Allied	Education	(sum of col 1	(sum of col. 2,	
			Cost	School	Health	Cost	through col. 4)	3 and 4)	
(A)	Cost Center Descrip		1	2	3	4	5	6	<u> </u>
	ANCILLARY SERVICE	COST CENTERS							
50	Operating Room								50
51	Recovery Room								51
52	Labor room and Delivery	Room				<b> </b>	ł	ļ	52
53	Anesthesiology					+			53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope	CTD C							56
57	Computed Tomography (								57
58 59	Magnetic Resonance Imag Cardiac Catheterization	ging (MRI)							58 59
60	Laboratory					-			60
61	PBP Clinical Laboratory	Same Brann Only							60
62	Whole Blood & Packed F								62
63	Blood Storing, Processing								63
64	Intravenous Therapy	g, & Transfusing							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 Charge	d To Patients							71
72	Implantable Devices Char								72
73	Drugs Charged to Patient								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE	E COST CENTERS							
88	Rural Health Clinic (RHC					<u> </u>			88
89	Federally Qualified Healt	h Center (FQHC)				<b>_</b>	ļ		89
90	Clinic								90
91	Emergency								91
92				l		<b> </b>			92
93	Other Outpatient Service								93
	OTHER REIMBURSABI	LE COST CENTERS							
94	Home Program Dialysis						1		94
95	Ambulance Services	· D · 1				+	ł		95
96	Durable Medical Equipm					+			96
97	Durable Medical Equipm					+			97
98	Other Reimbursable (spec					<u> </u>			98
200	Total (sum of lines 50 thr	ougii 199)		I	I	1	1		200

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4) 40-570

Rev. 4

10-1	2			FORM CM	S-2552-10			4090 (Cor		
APPO	RTIONMENT OF INPAT	IENT/OUTPATIEN	T ANCILLARY		PROVIDER CCN	N:	PERIOD:		WORKSHEET D	,
SERV	ICE OTHER PASS THRO	UGH COSTS					FROM		PART IV (Cont.)	
					COMPONENT C	CN:	то		. ,	
Check		[] Title V		[] Hospital		rider (Other)	[] ICF/MR	[] PPS	•	
applica	able	[] Title XVIII, Pa	art A	[] IPF	[] SNF			[] TEFRA		
boxes:		[] Title XIX		[] IRF	[] NF					
							Inpatient		Outpatient	
					Outpatient		Program		Program	l l
			Total	Ratio	Ratio		Pass-		Pass-	
			Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	l l
			(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
			Part I, col. 8)	$(col.\ 5 \div col.\ 7)$	$(col. 6 \div col. 7)$	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A)	Cost Center Descrip		7	8	9	10	11	12	13	
	ANCILLARY SERVICE	COST CENTERS								<b>—</b>
50	Operating Room									50
51	Recovery Room	_								51
52	Delivery Room and Labo	r Room								52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55 56	Radiology-Therapeutic Radioisotope									55 56
57	Computed Tomography (	CT) Scan								57
58	Magnetic Resonance Imag									58
59	Cardiac Catheterization	ging (wiki)								59
60	Laboratory									60
61	PBP Clinical Laboratory	Serv -Prom Only								61
62	Whole Blood & Packed F									62
63	Blood Storing, Processing									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 Chargee	d To Patients								71
72	Implantable Devices Char	rged to Patients								72
73	Drugs Charged to Patients	S								73
74	Renal Dialysis						<b>_</b>			74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE									
88	Rural Health Clinic (RHC									88
89	Federally Qualified Healt	h Center (FQHC)								89
90 91	Clinic									90 91
	Emergency Observation Reds									
92	Observation Beds Other Outpatient Service	(specify)	1				+		1	92 93
	OTHER REIMBURSABI		S							75
94	Home Program Dialysis	L CODI CLIVILA	l							94
95	Ambulance Services									95
96	Durable Medical Equipm	ent-Rented								96
97	Durable Medical Equipm									97
98	Other Reimbursable (spec									98
200	Total (sum of lines 50 thr									200
					-	-	-		•	

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4) Rev. 3

	) (Cont.)			PORM CIV	IS-2552-10	NY.	DEDIOD			0-12
		EDICAL AND OTHER			PROVIDER CC	N:	PERIOD:		WORKSHEET I	),
HEAL	TH SERVICES COS	15			COMPONENT O	CN	FROM TO		PART V	
Check		] Title V - O/P		[] Hospital		vider (Other)	[] Swing Be	d SNF		
applica		[] Title XVIII, Part B		[] IPF	[] SNF	ider (ouler)	[] Swing Be			
boxes:		] Title XIX - O/P		[] IRF	[] NF		[] ICF/MR			
		IENT OF MEDICAL A	AND OTHER I							Т
					Program Charge	s		Program Cos	t	1
			Cost		Cost	Cost		Cost	Cost	
			to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
			Charge	PPS	Services	Services Not	PPS	Services	Services Not	
			Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
			Worksheet C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
			Part I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Cent	er Description	1	2	3	4	5	6	7	
	ANCILLARY SERV	ICE COST CENTERS								
50	Operating Room									50
51	Recovery Room									51
52	Labor & Delivery Ro	oom								52
53	Anesthesiology									53
54	Radiology-Diagnosti	ic								54
55	Radiology-Therapeu	tic								55
56	Radioisotope									56
57	Computed Tomograp	phy (CT) Scan								57
58	Magnetic Resonance	e Imaging (MRI)								58
59	Cardiac Catheterizat	ion								59
60	Laboratory									60
61	PBP Clinical Laborat	tory ServPrgm. Only								61
62	Whole Blood & Pacl	ked Red Blood Cells								62
63	Blood Storing, Proce	essing, & Transfusing								63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therap	у								67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalogra									70
71	Medical Supplies Ch	0								71
72	Implantable Devices	-								72
73	Drugs Charged to Pa	tients								73
74	Renal Dialysis									74
75	ASC (Non-Distinct H	,								75
76	Other Ancillary (spe									76
		VICE COST CENTERS				-				
88	Rural Health Clinic (		ļ			<b> </b>			ł	88
89		Health Center (FQHC)								89
90	Clinic						1			90
91	Emergency Observation Bed									91
92		zion (spacify)								92 93
93	Other Outpatient Ser	SABLE COST CENTER	c .							93
94	Home Program Dialy		3							94
94	Ambulance	y 515				<u> </u>				94
93	Durable Medical Equ	uinment Pented				<del> </del>				93
96	Durable Medical Eq	upment-Sold				<del> </del>			1	96
97	Other Reimbursable	Cost Center				<del> </del>			1	97
200	Subtotal (see instruct					<del> </del>				200
200	Less PBP Clinic Lab					<del> </del>				200
201	Only Charges	. Services i logiani								201
202	Net Charges (line 20	0 - line 201 )								202

10-12		FORM CMS-2552		4090 (0	_ont.	
COMPUTATION OF I	NPATIENT	PROVIDER CCN.: _		PERIOD:	WORKSHEET D-1,	
OPERATING COST				FROM	PART I	
		COMPONENT CCN.		ТО		
Check	[] Title V - I/P	[] Hospital	[] Subprovider (other)	[] ICF/MR	[] PPS	
applicable	[] Title XVIII, Part A	[] IPF	[] SNF		[] TEFRA	
boxes:	[] Title XIX - I/P	[] IRF			[] Other	
PART I - ALL PRO	VIDER COMPONENTS					
		INPATIENT DAYS				-
	ncluding private room days and swing					1
	ncluding private room days, excludin					2
3 Private room da	ys (excluding swing-bed and observat	tion bed days). If you have o	nly private room days, do	not complete this line.		3
4 Semi-private roo	om days (excluding swing-bed and ob	servation bed days)				4
5 Total swing-bed	SNF type inpatient days (including p	rivate room days) through E	December 31 of the cost re	porting period		5
6 Total swing-bed	SNF type inpatient days (including p	rivate room days) after Deco	ember 31 of the cost repor	ting period (if		6
calendar year, ei	nter 0 on this line)					
7 Total swing-bed	NF type inpatient days (including pri	vate room days) through De	ecember 31 of the cost repo	orting period		7
8 Total swing-bed	NF type inpatient days (including pri	vate room days) after Decer	nber 31 of the cost reporti	ng period (if		8
calendar year, er	nter 0 on this line)					
9 Total inpatient d	lays including private room days appl	icable to the Program (exclu	ding swing-bed and newb	orn days)		9
10 Swing-bed SNF	type inpatient days applicable to title	XVIII only (including priva	te room days) through Dee	cember 31 of the		10
cost reporting p	eriod (see instructions).					
11 Swing-bed SNF	type inpatient days applicable to title	XVIII only (including priva	te room days) after Decer	nber 31 of the		11
cost reporting p	eriod (if calendar year, enter 0 on this	line)				
12 Swing-bed NF t	ype inpatient days applicable to titles	V or XIX only (including p	rivate room days) through	December 31 of		12
the cost reportin	ng period.					
13 Swing-bed NF t	ype inpatient days applicable to titles	V or XIX only (including p	rivate room days) after De	cember 31 of the		13
-	eriod (if calendar year, enter 0 on this					
1 61	sary private room days applicable to		ng-bed days)			14
	ys (title V or XIX only)	U X U	0 ,/			15
	tle V or XIX only)					16
		SWING BED ADJUS	IMENT			
17 Medicare rate for	or swing-bed SNF services applicable			period		17
	or swing-bed SNF services applicable	ě.	· · · ·	*		18
	or swing-bed NF services applicable to					19
	or swing-bed NF services applicable to					20
	patient routine service cost (see instru-		f of the cost reporting peri	ou -		21
	applicable to SNF type services throu		t reporting period (line 5 x	line 17)		22
U	applicable to SNF type services after					23
	applicable to NF type services throug					24
U	applicable to NF type services after D					25
	cost (see instructions)	control of the cost repu	and period (line o X line)	20)		26
	t routine service cost net of swing-be	d cost (line 21 minus line 24	5)			20
27 General Inpatien	a fourne service cost net of swing-be		9 FERENTIAL ADJUSTM	ENT		21
28 General inpatien	t routine service charges (excluding s			1111		28
	arges (excluding swing-bed charges)	ming-oca ana observation t	cu charges)			28
	arges (excluding swing-bed charges) om charges (excluding swing-bed cha	rgas)				30
		ě :				31
1	t routine service cost/charge ratio (lin					31
01	room per diem charge (line 29 ÷ line					33
<u> </u>	rivate room per diem charge (line 30		structions)			
	m private room charge differential (lin		structions)			34
<u> </u>	m private room cost differential (line					35
	st differential adjustment (line 3 x line	,				36
37 General inpatien	t routine service cost net of swing-be	a cost and private room cost	uniterential (line 27 minus	s mie 30)		

4090 (Cont.)		FORM	M CMS-2552-10			1	0-12
COMPUTATION OF INPATIE	ENT		PROVIDER CCN:		PERIOD:	WORKSHEET D-1,	
OPERATING COST					FROM	PART II	
			COMPONENT CCN:		то		
Check	[] Title V -	I/P	[] Hospital	[]Subprovider (othe	r)	[] PPS	
applicable	[] Title XV	III, Part A	[] IPF			[] TEFRA	
boxes:	[] Title XIX	- I/P	[] IRF			[] Other	
PART II - HOSPITAL AND	SUBPROVIDERS O	NLY					
	PROGRAM INF	ATIENT OPERATIN	G COST BEFORE				1
	PASS-TH	ROUGH COST ADJU	JSTMENTS			1	
38 Adjusted general inpatie							38
39 Program general inpatie							39
40 Medically necessary pri		· /	14 x line 35)				40
41 Total Program general i							41
11 Total Program general 1	iputent routine servic	le cost (line 55 + line 10)		Average			
		Total	Total	Per Diem	Program	Program Cost	
		Inpatient Cost	Inpatient Days	$(col. 1 \div col. 2)$	Days	(col. 3 x col. 4)	
		1	2	3	4	5	
42 Nursery (title V & XIX	only)	1	2	3	4	5	42
42 Nursery (the V & XIX Intensive Care Type In							42
••	patient						1
43 Intensive Care Unit							43
43 Intensive Care Unit 44 Coronary Care Unit		+	<u> </u>	<del> </del>	1		43
			-				
45 Burn Intensive Care Un							45
46 Surgical Intensive Care							46
47 Other Special Care Unit	(specify)						47
						1	10
48 Program inpatient ancill	•						48
49 Total Program inpatient	costs (sum of lines 4.	through 48) (see instruc	ctions)				49
		ROUGH COST ADJU					r
50 Pass through costs appli							50
51 Pass through costs appli			from Worksheet D, sum	of Parts II and IV)			51
52 Total Program excludat							52
53 Total Program inpatient	operating cost exclud	ing capital related, nonp	hysician anesthetist, and	medical education cos	ts		53
(line 49 minus line 52)							
	TARGET AM	OUNT AND LIMIT C	OMPUTATION				
54 Program discharges							54
55 Target amount per disch	narge						55
56 Target amount (line 54	x line 55)						56
57 Difference between adju	usted inpatient operati	ng cost and target amour	nt (line 56 minus line 53	)			57
58 Bonus payment (see ins	tructions)						58
59 Lesser of line 53 ÷ line	54 or line 55 from the	cost reporting period en	ding 1996, updated and	compounded by the ma	arket basket		59
60 Lesser of line 53 ÷ line	54 or line 55 from pri	or year cost report, upda	ted by the market baske	t			60
61 If line 53 ÷ line 54 is les	ss than the lower of lin	nes 55, 59 or 60 enter the	e lesser of 50% of the ar	nount by which operatir	ng costs		61
(line 53) are less than ex	spected costs (lines 54	x 60), or 1 % of the targ	get amount (line 56), oth	erwise enter zero.			1
(see instructions)			/				1
62 Relief payment (see inst	tructions)						62
63 Allowable Inpatient cos		ent (see instructions)					63
	- 17	,					•
	PROGRAM INP	ATIENT ROUTINE S	WING BED COST				
64 Medicare swing-bed SN				eriod (see instructions)			64
(title XVIII only)		5	1 01				
65 Medicare swing-bed SN	F inpatient routine co	sts after December 31 of	f the cost reporting perio	d (see instructions)			65
(title XVIII only)			Porting perio	(			00
66 Total Medicare swing-b	ed SNF inpatient rout	ine costs (line 64 plus lir	ne 65) (Title XVIII only	For CAH see instruct	ions )		66
67 Title V or XIX swing-b							67
68 Title V or XIX swing-b							68
69 Total title V or XIX swilg-b	*			enou (nne 15 x nne 20	/		69
57 TOTAL LICE V OF ATA SW	ing ocu in inpanelit i	ouune cosis (iiiie 07 + ii	ne (0)			1	09

10-1	2		FORM CMS-2552-	-10		4090 (0	Cont.)
	PUTATION OF ATING COST	INPATIENT	PROVIDER CCN:		PERIOD: FROM	WORKSHEET D-1, PARTS III & IV	
Check applica boxes:	able :	[] Title V - I/P [] Title XVIII, Part A [] Title XIX - I/P ) NURSING FACILITY, OTHER N	COMPONENT CC [] Hospital [] IPF [] IRF	[] Subprovider (othe [] SNF [] NF	er) [] ICF/MR	[] PPS [] TEFRA [] Other	
PARI	I III - SKILLEI	D NUKSING FACILITY, OTHER N	UKSING FACILITY, AND IC	F/MR ONL I			Τ
70	Skilled nursing	facility/other nursing facility/ICF/MR	routine service cost (line 37)				70
71	Adjusted gener	al inpatient routine service cost per die	m (line 70 ÷ line 2)				71
72	Program routin	e service cost (line 9 x line 71)					72
73	Medically nece	essary private room cost applicable to F	rogram (line 14 x line 35)				73
74	Total Program	general inpatient routine service costs	line 72 + line 73)				74
75	Capital-related	cost allocated to inpatient routine serv	ce costs (from Worksheet B, Pa	rts II, column 26, line 45)			75
76	Per diem capita	al-related costs (line 75 ÷ line 2)					76
77	Program capita	ll-related costs (line 9 x line 76)					77
78	Inpatient routin	ne service cost (line 74 minus line 77)					78
79	Aggregate char	rges to beneficiaries for excess costs (fi	om provider records)				79
80	Total Program	routine service costs for comparison to	the cost limitation (line 78 minu	is line 79)			80
81	Inpatient routir	ne service cost per diem limitation					81
82	Inpatient routir	ne service cost limitation (line 9 x line 8	31)				82
83	Reasonable inp	patient routine service costs (see instruc	tions)				83
84	Program inpati	ent ancillary services (see instructions)					84
85	Utilization revi	ew - physician compensation (see instr	uctions)				85
86	Total Program	inpatient operating costs (sum of lines	83 through 85)				86

## PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	88
89	Observation bed cost (line 87 x line 88) (see instructions)	89

#### COMPUTATION OF OBSERVATION BED PASS THROUGH COST

					Total	Observation Bed	
			Routine		Observation	Pass-Through Cost	
			Cost	column 1 ÷	Bed Cost	(col. 3 x col. 4)	
		Cost	(from line 27)	column 2	(from line 89)	(see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School cost						91
92	Allied Health cost						92
93	All other Medical Education						93

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4025.3 - 4025.4) Rev. 3

	RTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
	ICES RENDERED BY		FROM	PARTS I-III	
	RNS AND RESIDENTS		то		
4KI	'I - NOT IN APPROVED TEACHING PROGRAM	Percent of	Expense	Total Inpatient Days	Т
	Cost Centers	Assigned Time	Allocation 2	All Patients	
1	Total cost of services rendered	100.00			Ē
	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care)				_
3	Intensive care unit				+
4	Coronary care unit Burn Intensive Care Unit				+
5	Surgical Intensive Care Unit				t
7	Other Special Care (specify)				t
8	Nursery				T
9	Subtotal (sum of lines 2 through 8)				Г
10	IPF - Inpatient routine service				
11	IRF - Inpatient routine service				
12	Subprovider (Other) - Inpatient routine service				
13	Skilled Nursing Facility				Ļ
14	Nursing Facility				L
15	Other Long Term Care				ŀ
16 17	Home Health Agency Outpatient Rehabilitation Providers				ŀ
17 18	*				ŀ
18	Hospice				t
20	Subtotal (sum of lines 9 through 19)				ľ
				Total Charges	T
				(from Worksheet C,	
				Part I, column 8,	
	Hospital Outpatient Services:			lines 88 through 93)	
21	Rural Health Clinic (RHC)				
22	Federally Qualified Health Center (FQHC)				
23	Clinic				
24	Emergency				
25	Observation beds				╋
26 27	Other Outpatient Service (specify) Subtotal (sum of lines 21 through 26)				t
-	Total (sum of lines 20 and 27)	100.00			÷
20					
			TS ONLY)		
	Total (sum of nines 20 and 27) TII - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR)		TS ONLY)		T
		T B INPATIENT ROUTINE COS	TS ONLY)	Net Cost	I
		T B INPATIENT ROUTINE COS Expenses Allocated	TS ONLY) Swing Bed	Net Cost (column 1 plus	Ī
		T B INPATIENT ROUTINE COS Expenses Allocated to cost centers			I
RT	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services:	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I	Swing Bed	(column 1 plus	
<b>RT</b>	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b>	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR' Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32 33	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 229 30 31 32 33 34	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32 33 34 35	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
29 30 31 32 33 34 35 36	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32 33 34 35 36 37	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32 33 34 35 36 37 38	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 229 30 31 32 33 34 35 36 37 38 39	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 29 30 31 32 33 34 35 36 37 38 38 39 40	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service IRF - Inpatient routine service	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 229 30 31 32 33 34 35 36 37 38 39 40 41	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
<b>RT</b> 229 330 31 32 33 34 35 36 37 38 39 40 41 42	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2	(column 1 plus column 2) 3	
29 30 31 32 33 34 35 36 37 38 39 40 41 42	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 through 36) IPF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED) Not In Approv	(column 1 plus column 2) 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
229 300 31 32 333 34 35 36 37 38 39 40 41 41 42 <b>.RT</b>	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 28, and 29 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) <b>III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF</b>	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED) Not In Approv (from Part I)	ed Teaching Program	
<b>RT</b> 229 30 31 32 33 34 35 36 37 38 39 40 41 42 <b>RT</b>	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 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 Hospital	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED Not In Approv (from Part I) 1	(column 1 plus column 2) 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	
<b>RT</b> 229 330 331 332 333 34 35 36 37 38 39 40 41 42 <b>RT</b> 43	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR         Hospital Inpatient Routine Services:         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 28, and 29 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         Hospital         Inpatient	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED Not In Approv. (from Part I) 1 column 9, line 9	ed Teaching Program	
229 30 31 32 33 34 35 36 37 38 39 40 41 42 <b>RT</b> 43 44	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR'         Hospital Inpatient Routine Services:         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 28, and 29 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         Hospital         Inpatient         Outpatient	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED Not In Approv (from Part I) 1	ed Teaching Program	
229 30 31 32 33 34 35 36 37 38 39 40 41 42 <b>RT</b> 44 45	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 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 Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED Not In Approv (from Part I) 1 column 9, line 9 column 9, line 27	ed Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 42 <b>RT</b> 43 44 45 46	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR         Hospital Inpatient Routine Services:         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)         Subtrotil (sum of lines 28, and 29 through 36)         IPF - 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         Hospital         Inpatient         Outpatient         Total Hospital (sum of lines 43 and 44)         IPF - Inpatient routine service	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED) Not In Approv (from Part I) 1 column 9, line 9 column 9, line 27 column 9, line 10	ed Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 42 41 42 <b>ART</b> 43 44 45	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PAR Hospital Inpatient Routine Services: 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 28, and 29 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 Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	T B INPATIENT ROUTINE COS Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 1 1	Swing Bed Amount 2 SED Not In Approv (from Part I) 1 column 9, line 9 column 9, line 27	ed Teaching Program	

				FORM CMS-2		PERIOR	4090 (0	.on.)
	FIONMENT OF COS				PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
	ES RENDERED BY					FROM	PARTS I-III (Cont.)	
	IS AND RESIDENTS		DOGDAN			ТО	_	
KT I		ED TEACHING PI		( D	T: 1 X	T:4 XX/III	TA VIV	T
	Average Cost		h Care Program Inpatie		Title V	Title XVIII	Title XIX	
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5) 8	(col. 4 x col. 6) 9	(col. 4 x col. 7) 10	-
1	4	5	6	7	8	9	10	1
1								1
2								2
2								3
4								4
5								5
6								6
7								7
8								8
9								9
0								10
1								11
2								12
3								13
4								14
5								15
6								16
17								17
8								18
9								19
20								20
	Ratio of Cost	Title	es V and XIX Outpatier	nt and	Ti	les V and XIX Outpatie		
	to Charges		itle XVIII Part B Charg	ges		Title XVIII Part B Co	st	
	(column 2 ÷	Title	Title XVIII	Title	Title	Title XVIII	Title	
	column 3)	V	Part B	XIX	V	Part B	XIX	
1								21
2								22
3								23
24								24
5								25
26								26
						1		
_								27
28								27
28	I - IN AN APPROV		OGRAM (TITLE XV		ENT ROUTINE COS	TS ONLY)		27
8		Average Cost		Expenses	IENT ROUTINE COS	IS ONLY)		27
8	Total	Average Cost Per Day	Title XVIII	Expenses Applicable	ENT ROUTINE COS	TS ONLY)		27
8	Total Inpatient Days -	Average Cost Per Day (column 3 ÷	Title XVIII Part B	Expenses Applicable to Title XVIII	ENT ROUTINE COS	TS ONLY)		27
8	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27
RT I	Total Inpatient Days -	Average Cost Per Day (column 3 ÷	Title XVIII Part B	Expenses Applicable to Title XVIII	ENT ROUTINE COS	IS ONLY)		27 28
8 RT I	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29
8 <b>RT I</b> 87 1	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 28 29 30
28 <b>RT I</b> RT I 29 80 81	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29 30 31
8 <b>RT I</b> 9 0 1 2	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29 30 31 32
8 <b>RT I</b> 9 1 2 3 3	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29 30 31 32 33
8 <b>RT I</b> 99 0 11 2 33 44	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29 30 31 32 33 34
8 <b>RT</b> I 9 0 1 2 3 4 5	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	TS ONLY)		27 28 29 30 31 32 33 33 34 35
8           RT I           9           9           11           2           3           44           55           66	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	TS ONLY)		27 28 29 30 31 32 33 34 35 36
8       RT I       RT I       9       9       11       12       13       14       155       166       17	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	ENT ROUTINE COS	IS ONLY)		27 28 29 30 31 32 33 33 34 35 36 37
8 <b>RT I</b> <b>RT I</b> 9 0 1 1 2 3 3 4 5 6 7 8	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)		IS ONLY) IS ONLY) I I I I I I I I I I I I I I I I I I I		27 28 29 30 31 32 33 34 35 36 37 38
RT         I           RT         I <tr tr=""></tr>	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)		IS ONLY) IS ONLY) I I I I I I I I I I I I I I I I I I I		27 28 29 30 31 32 33 34 35 36 37 38 39
RT         I	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)		IS ONLY) IS ONLY) IS ONLY		27 28 29 30 31 32 33 34 35 36 37 38 39 40
8       RT I       9       9       11       12       13       14       15       16       17       18       19       10       11       12       13       14       15       16       17       18       19       10       11	Total Inpatient Days - All Patients	Average Cost Per Day (column 3 ÷ column 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)		IS ONLY) IS ONLY) IS ONLY		27 28 29 30 31 32 33 34 35 36 37 38 9 40 41
RT         I           RT         I <tr td=""></tr>	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7	ENT ROUTINE COS			27 28 29 30 31 32 33 34 35 36 37 38 9 40 41
8       RT I       9       9       11       12       13       14       15       16       17       18       19       10       11       12       13       14       15       16       17       12       13       14       15       16       17       12	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 8 8 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7				27 28 29 30 31 32 33 34 35 36 37 38 9 40 41
8     1       RT I     1       1     1       1     1       32     1       33     1       34     1       35     1       364     1       37     88       38     1       39     1       10     1       12     1       RT I     1	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 8 8 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7				27 28 29 30 31 32 33 34 35 36 37 38 9 40 41
8     1       8     1       9     1       10     1       12     1       13     1       14     1       15     1       16     1       17     1       18     1       19     1       10     1       12     1       12     1       12     1       12     1       14     1       15     1       16     1       17     1       18     1       19     1       10     1       10     1       11     1       12     1       14     1       15     1       16     1       17     1       18     1       19     1       10     1       10     1       10     1       11     1       12     1       14     1       15     1       16     1       17     1       18     1       19     1       10	Total Inpatient Days - All Patients 4 	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (To aching Program	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 				27 28 29 30 31 32 33 34 35 36 37 38 9 40 41
8         1           8         1           99         1           10         1           2         2           33         4           55         6           66         1           77         8           99         0           11         2           2         2           33         44           55         3           66         1           77         8           99         0           11         2           2         1           2         1           2         1           12         1           13         1           14         1           15         1           16         1           17         1           18         1           19         1           10         1           11         1           12         1           14         1           15         1           16         1 <td< td=""><td>Total Inpatient Days - All Patients 4</td><td>Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount</td><td>Title XVIII Part B Inpatient Days 6</td><td>Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0</td><td></td><td></td><td></td><td>27 28 29 30 31 31 32 33 34 40 41 42</td></td<>	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 31 32 33 34 40 41 42
28	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 32 33 34 35 35 36 37 38 39 40 41 42
88         -           RT I         -           RT I         -           89         -           33         -           34         -           35         -           36         -           37         -           38         -           39         -           44         -           13         -           13         -           13         -           14         -	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 32 33 34 35 36 36 36 37 38 39 40 41 41 42
229 30 31 32 33 34 35 36 37 38 38 38 38 39 40 41 42 <b>RT I</b>	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6 	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 32 33 34 35 36 36 36 37 37 38 39 40 41 41 42
28	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 32 33 34 35 36 36 36 37 38 39 40 41 41 42
28            RT I         I           RT 3            29            30            31            32            33            34            35            36            37            38            39            40            41            42            43            44            43            44            45            46	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5 5 R TITLE XVIII (TO aching Program Amount	Title XVIII Part B Inpatient Days 6 	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7 7 0 0 0 0 0 1 0 0 0 1 0 0 1 0 0 1 0 0 1 0 0 1 0				27 28 29 30 31 32 33 34 35 36 36 37 37 38 39 40 41 41 42

4090	4090 (Cont.) FORM C			S-2552-10			10-12	
INPA	TIENT ANCILLA	RY SERVICE		PROVIDER CCN:	PERIOD:	WORKSHEET D-3		
COST	APPORTIONME	NT			FROM			
				COMPONENT CCN:	то			
Check	:	[] Title V	[] Hospital	[] Subprovider (other)	[] Swing-Bed SNF	[] PPS		
applica	able	[] Title XVIII, Part A	[] IPF	[] SNF	[] Swing-Bed NF	[] TEFRA		
boxes:		[] Title XIX	[] IRF	[] NF	[] ICF/MR	[] Other		
	COST CENTER	DESCRIPTION		Ratio of Cost	Inpatient Brogrom Charges	Inpatient Program Cos	its	
(A)	COST CENTER	DESCRIPTION		to Charges	Program Charges 2	(col. 1 x col. 2) 3		
(11)	INPATIENT RO	UTINE SERVICE COST CEN	TERS	•	_			
30	Adults and Pedia	trics (General Routine Care)					30	
_	Intensive Care U				_		31	
32	Coronary Care U Burn Intensive C						32 33	
34							33	
35	5						35	
40	Subprovider IPF						40	
41	Subprovider IRF				_		41	
42		ecity)			_		42	
45	ļ	ERVICE COST CENTERS					43	
50	Operating Room						50	
51	Recovery Room						51	
52	Labor Room and	Delivery Room					52	
53							53	
54	Radiology-Diagr Radiology-Thera						54 55	
	Radioisotope	peute					56	
57	Computed Tomo	graphy (CT) Scan					57	
58	ě.	ance Imaging (MRI)					58	
59	Cardiac Catheter	ization					59	
60 61	,	ooratory Services-Prgm. Only					60 61	
62		Packed Red Blood Cells					62	
63	Blood Storing, P	rocessing, & Trans.					63	
64	Intravenous Ther						64	
-	Respiratory Ther						65	
66 67	Physical Therapy Occupational The						66 67	
68	Speech Patholog						68	
69	Electrocardiolog						69	
	Electroencephalo						70	
		s Charged to Patients				-	71	
72	Implantable Devi Drugs Charged to	ices Charged to Patients			1	+	72 73	
	Renal Dialysis	uaomo			1		74	
	ASC (Non-Distin	nct Part)					75	
76	Other Ancillary (						76	
00		ERVICE COST CENTERS						
	Rural Health Clin Federally Qualifi	nic (RHC) ed Health Center (FQHC)					88 89	
-	Clinic	tea rienna center (i Qiic)			1		90	
	Emergency						91	
92		s (see instructions)					92	
93	Other Outpatient						93	
Q/I	OTHER REIMBU Home Program I	URSABLE COST CENTERS					94	
_	Ambulance Servi						94	
		Equipment-Rented					96	
-	Durable Medical	Equipment-Sold					97	
98	Other Reimbursa						98	
200	· · · · · · · · · · · · · · · · · · ·	es 50-94 and 96-98)	only charges (line 61)		_		200	
2471	LESS F DF UIIIIC	Laboratory Services-Program	my charges (lille 01)				201 202	

I	0-12 FORM				-2552-10		4090 (C	Cont.)
	PUTATION OF ORGAN ACQU				PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR H	IOSPITALS WHICH ARE CEI	RTIFIED TRANSPLA	NT CENTERS			FROM	_ PART I	
					OPO CCN:	то	-	
Check		[] HEART	[] LIVER	[]]]]	NCREAS	[] ISLET		
	able box:	[] HEART	[] LUNG		ESTINE	[] OTHER (specify)		
applied	ible box.		[]10110	[][11]	LOTINE	[] OTHER (speen y)		
PART	I - COMPUTATION OF OR	RGAN ACOUISITIO	N COSTS (INPATIEN)	<b>F ROUTINI</b>	E AND ANCILLARY S	ERVICES)		
		· · · · · · · · · · · · · · · · · · ·	Inpatient		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Organ		Г
Cor	nputation of Inpatient		Routine Organ		Per Diem Costs	Acquisition	Cost	
Rou	tine Service Costs		Charges		(from Wkst. D-1, Part II)	Days	(col. 2 x col. 3)	
	plicable to Organ Acquisition		1	D	2	3	4	
	Adults and Pediatrics			38				1
2	Intensive Care			43			_	2
3	Coronary Care Burn Intensive Care Unit			44				4
	Surgical Intensive Care Unit			45				5
6	Other Special Care (specify)			40				6
7	TOTAL (sum of lines 1-6)							7
					Ratio of Cost	Organ	Organ	г
					to Charges	Acquisition	Acquisition	
Con	nputation of Ancillary				(from	Ancillary	Ancillary	
Serv	vice Costs Applicable				Wkst. C)	Charges	Costs	
to O	rgan Acquisition			С	1	2	3	
8	Operating Room			50				8
9	Recovery Room			51				9
10	Labor Room & Delivery Roor	n		52				10
11	Anesthesiology			53				11
12	Radiology-Diagnostic			54				12
13	Radiology-Therapeutic			55				13
14	Radioisotope	_		56				14
15	Computed Tomography (CT)			57				15
16	Magnetic Resonance Imaging	(MRI)		58			_	16
17	Cardiac Catheterization			59 60			_	17 18
18 19	Laboratory PBP Clinical Laboratory Servi	icas Program Only		60				18
20	Whole Blood & Packed Red E			62				20
20	Blood Storage, Processing, &			63				20
_	IV Therapy	Transrasning		64				22
23	Respiratory Therapy			65				23
24	Physical Therapy			66	1	1		24
25	Occupational Therapy			67		1	1	25
26	Speech Pathology			68				26
27	Electrocardiology			69				27
28	Electroencephalography			70				28
	Medical Supplies Charged to H			71				29
	Implantable Devices Charged	to Patients		72				30
	Drugs Charged to Patients			73				31
	Renal Dialysis ASC (non-distinct part)			74 75	<b> </b>	<b> </b>	+	32 33
	Other Ancillary (specify)			75		1		34
35	Rural Health Clinic (RHC)			88	1		+	35
36	Federally Qualified Health Cer	nter (FOHC)		89	<del> </del>	<del> </del>	+	36
37	Clinic	()		90	1	1	1	37
	Emergency Room			91	1	l		38
39	Observation Beds			92	1	1		39
40	Other Outpatient Service (spec	cify)		93		İ		40
41	TOTAL (sum of lines 8-40)							41

C = Worksheet C line numbers

D = Worksheet D-1 line numbers

#### 4090 (Cont.) FORM CMS-2552-10 COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS WORKSHEET D-4, PART II PROVIDER CCN: PERIOD: FROM

		OPO CCN:	то	
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)

#### PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE 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)	
		D	1	2	3	1
42	Adults & Pediatrics (General routine care)	2				42
43	Intensive Care Unit	3				43
44	Coronary Care Unit	4				44
45	Burn Intensive Care Unit	5				45
46	Surgical Intensive Care Unit	6				46
47	Other Special Care (specify)	7				47
48	TOTAL (sum of lines 42 through 47)					48

				Ratio of Cost	Organ	
(	Computation of the Cost of Outpatient	Organ		to Charges	Acquisition	
5	Services of Interns and Residents Not	Charges		from Wkst. D-2,	Costs	
1	In Approved Teaching Program	(see instructions)		Part I, col. 4)	(col. 1 x col. 2)	
		1	D	2	3	
49	Rural Health Clinic (RHC)		21			49
50	Federally Qualified Health Center (FQHC)		22			50
51	Clinic		23			51
52	Emergency		24			52
53	Observation Beds		25			53
54	Other Outpatient Service (specify)		26			54
55	TOTAL (sum of lines 49 through 54)					55

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

09-13		FORM CMS-25:	52-10		4090 (Cont.)
COMPUTATION OF ORGAN ACQUISITION	COSTS AND CHAF	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR HOSPITALS WHICH ARE CERTIFIED	FRANSPLANT CEN		FROM	PARTS III & IV	
			OPO CCN:	то	
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)	

## PART III - SUMMARY OF COSTS AND CHARGES

	C	ost	Cha	rges	
	Part A	Part B	Part A	Part B	
	1	2	3	4	
56 Routine and Ancillary from Part I					56
57 Interns and Residents (inpatient)					57
58 Interns and Residents (outpatient)					58
59 Direct Organ Acquisition (see instructions)					59
60 Cost of Services of Teaching Physicians (Wkst. D-5, Part II)					60
61 Total (sum of lines 56 thru 60)					61
62 Total Usable Organs (see instructions)					62
63 Medicare Usable Organs (see instructions)					63
64 Ratio of Medicare Usable Organs to Total Usable					64
Organs (line 63 ÷ line 62)					
65 Medicare Cost/Charges (see instructions)					65
66 Revenue for Organs Sold					66
67 Subtotal (line 65 minus line 66)					67
68 Organs Furnished Part B					68
69 Net Organ Acquisition Cost and Charges (see instructions)					69

## PART IV - 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				73
74	Total (sum of lines 70 thru 73)				74
75	Organs Transplanted				75
76	Organs Sold to Other Hospitals				76
77	Organs Sold to OPOs				77
78	Organs Sold to Transplant Hospitals				78
79	Organs Sold to Military or VA Hospitals				79
80	Organs Sold Outside the U.S.				80
81	Organs Sent Outside the U.S. (no revenue received)				81
82	Organs Used for Research				82
83	Unusable/Discarded Organs				83
84	Total (sum of lines 75 through 83 should equal line 74)				84

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

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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4028.3) Rev. 4

# 4090 (Cont.)

## FORM CMS-2552-10

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS					PERIOD:	WORKSHEET D-5,
					FROM	PART I
					то	
Check applicable box:	[] Hospital Staff	[] Medical Staff				

#### PART I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION

Line	Specialty	Total	Professional	RCE	Physician/ Professional	Unadjusted	5 Percent of Unadjusted	
No.	Description/Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
140.	Description/1 nystelait identifier	Remuneration	Component	Alloulit	Component Hours	KCE Lillin		-
1	2	3	4	5	6	7	8	
1	General Practitioner Family Practice							1
2	Internal Medicine							2
3	Surgery							3
4	Pediatrics							4
5	Obstetrics-Gynecology							5
6	Radiology							6
7	Psychiatry							7
8	Anesthesiology							8
9	Pathology							9
10	All Other							10
11	Total							11

		Cost of Membership	Professional	Cost of Physician	Professional		Adjust Cost of Physician's	
Line	Specialty	& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	
9	10	11	12	13	14	15	16	
1	General Practitioner Family Practice							1
2	Internal Medicine							2
3	Surgery							3
4	Pediatrics							4
5	Obstetrics-Gynecology							5
6	Radiology							6
7	Psychiatry							7
8	Anesthesiology							8
9	Pathology							9
10	All Other							10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)							11

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4029.1) 40-582

Rev. 4

PORTIONMENT OF COST FO	OR THE SERVICES OF TEACHING PHYSICIANS	PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-5, PART II
			то	-
ck	[] Hospital	[] IPF		
licable box:	[] IRF	[] Subprovider (other)		
	ST FOR THE SERVICES OF TEACHING PHYSICIANS			
THE ALLOCHOMMENT OF CO.	TOK THE SERVICES OF TEACHING THIS ICIANS		Medical School	Total
		Hospital Staff	Faculty	$(\operatorname{col} 1 + \operatorname{col} 2)$
		1	2	3
1 Adjusted Cost of Physician	's Direct Medical and Surgical Services			
2 Total Inpatient Days and O	utpatient Visit Days			
3 Average Per Diem (line 1 ÷	line 2)			
HEALTH CARE PROGRA	AM REIMBURSABLE DAYS		•	
4 Title V - Inpatient				
5 Title V - Outpatient			_	
6 Title XVIII - Part A				
7 Title XVIII - Part B				
8 Title XIX - Inpatient 9 Title XIX - Outpatient				
	J			
0 Inpatient and Outpatient Ki 1 Inpatient and Outpatient Li	ž ž			
<ol> <li>Inpatient and Outpatient Li</li> <li>Inpatient and Outpatient He</li> </ol>	-			
3 Inpatient and Outpatient Lu	*			
4 Inpatient and Outpatient Pa	· · ·			
5 Inpatient and Outpatient In	•			
6 Inpatient and Outpatient Isl	*			
7 Other Organ Acquisition	et requisition			
• • • • • • • • • • • • • • • • • • • •				
HEALTH CARE PROGRA	AM REIMBURSABLE COST			
8 Title V - Inpatient (line 3 x	(line 4)			
9 Title V - Outpatient (line 3	x line 5)			
0 Title XVIII - Part A (line 3	,			
Title XVIII - Part B (line 3				
2 Title XIX - Inpatient (line				
23 Title XIX - Outpatient (lin				
	dney Acquisition (line 3 x line 10)			
	ver Acquisition (line 3 x line 11)			
·	eart Acquisition (line 3 x line 12)			
	ng Acquisition (line 3 x line 13)			
	ncreas Acquisition (line 3 x line 14)		+	
· · ·	testine Acquisition (line 3 x line 15)		+	
	et Acquisition (line 3 x line 16)			
31 Inpatient and Outpatient Ot	her Organ Acquisition (line 3 x line 17)			

Add lines 18 and 19, and transfer to Worksheet E-3, Part VII

Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate

Line 21 to Worksheet E, Part B

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate

Sum of lines 24 through 31 to Worksheet D-4, Part III, line 60

Rev. 4

4090 (Cont.)	FORM CMS-2552-10				09-13
CALCULATION OF REIMBURSEMENT	I	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTLEMENT	-		FROM	PART A	
	0	COMPONENT CCN:	то		

Check	[] Hospital	
applicable box:		

## PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG amounts other than outlier payments	
2	Outlier payments for discharges (see instructions)	2
	Outlier reconciliation amount	2.01
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	1 · · ·
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or	5
5	before 12/31/1996 (see instructions)	5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in	6
0	in accordance with 42 CFR 413.79(e)	0
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)	7.01
7.01	If the cost report straddles July 1, 2011 then see instructions.	7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance	8
0	with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register,	Ű
	page 50069, August 1, 2002.	
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA.	8.01
	If the cost report straddles July 1, 2011, see instructions.	
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under	8.02
	section 5506 of ACA. (see instructions)	
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	9
10		10
11		11
12	Current year allowable FTE (see instructions)	12
13		13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	14
15	Sum of lines 12 through 14 divided by 3	15
16	Adjustment for residents in initial years of the program	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)	22
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	<u> </u>
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 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 (see instructions)	27
28	IME Adjustment (see instructions)	28
29	Total IME payment (sum of lines 22 and 28)	29
	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	32
33	Allowable disproportionate share percentage (see instructions)	33
34	Disproportionate share adjustment (see instructions)	34

 $\label{eq:form_cms} Form\ cms\ 2552\ 10\ (09\ 2013)\ (instructions\ for\ this\ worksheet\ are\ published\ in\ cms\ publishe\ in\ cms\ published\$ 

Rev. 4

09-13		FORM CMS-2552-1	0		4090 (Cont.)
CALCULATION OF REIMBUR	SEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT				FROM	PART A (Cont.)
			COMPONENT CCN:	ТО	
Check	[] Hospital				

[] Hospital applicable box:

## PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	Additional payment for high percentage of ESRD beneficiary discharges	
40	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683,	40
	684 and 685 (see instructions)	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)	41
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)	43
44	Ratio of average length of stay to one week (line 43 divided by line 41 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)	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 SCH and MDH only (see instructions)	49
50	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	50
51	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)	51
52	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).	52
53	Nursing and allied health managed care payment	53
54	Special add-on payments for new technologies	54
55	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	55
56	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	56
57	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	57
58	Ancillary service other pass through costs Worksheet D, Part 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 applicable to MS-DRG (see instructions)	68
69	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)	69
70	Other adjustments (specify) (see instructions)	70
70.92	Bundled Model 1 discount amount	70.92
70.93	HVBP payment adjustment (see instructions)	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	70.94
70.95	Recovery of Accelerated depreciation	70.95
70.96	Low volume adjustment for fiscal year (yyyy)	70.96
70.97	Low volume adjustment for fiscal year (yyyy)	70.97
71	Amount due provider (see instructions)	71
71.01	Sequestration adjustment (see instructions)	71.01
72	Interim payments	72
73	Tentative settlement (for contractor use only)	73
74	Balance due provider (Program) line 71 minus <i>lines 71.01, 72 and 73</i>	74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	75

## TO BE COMPLETED BY CONTRACTOR

90 Operating outlier amount from Worksheet E, Part A line 2 (see instructions).					
Capital outlier from Worksheet L, Part I, line 2	9	91			
Operating outlier reconciliation adjustment amount (see instructions)	9	92			
Capital outlier reconciliation adjustment amount (see instructions)	9	93			
The rate used to calculate the Time Value of Money (see instructions)	9	94			
Time Value of Money for operating expenses (see instructions)	9	95			
Time Value of Money for capital related expenses (see instructions)	9	96			
	Capital outlier from Worksheet L, Part I, line 2 Operating outlier reconciliation adjustment amount (see instructions) Capital outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money (see instructions) Time Value of Money for operating expenses (see instructions)	Capital outlier from Worksheet L, Part I, line 2			

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.1) Rev. 4

4090	) (Cont.) FORM CM	S-2552-10			09-13
CALC	ULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
REIM	BURSEMENT SETTLEMENT		FROM	PART B	
		COMPONENT CCN:	то		
Check	applicable box: [] Hospital [] IPF [] IRF [] Subp	provider (Other) [ ] SNF			
	B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions).				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Worksheet D, Part IV, colu	umn 13, line 200			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12	Ancillary service charges				12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	Customary charges				
15	Aggregate amount actually collected from patients liable for payment for se				15
16	Amounts that would have been realized from patients liable for payment for	or services on a charge			16
	basis had such payment been made in accordance with 42 CFR 413.13(e)				
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18	8 exceeds line 11) (see instructions)			19
20	Excess of reasonable cost over customary charges (complete only if line 11				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instruction	s)			21
22	Interns and residents (see instructions)				22
23	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pt	ub. 15-1, §2148)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)			_	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	<u>.</u>			25
26	Deductibles and Coinsurance relating to amount on line 24 (see instruction				26
27	Subtotal [(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of line				27
28	Direct graduate medical education payments (from Worksheet E-4, line 50)	)			28
29	ESRD direct medical education costs (from Worksheet E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIO	NAL SERVICES)			32
33	Composite rate ESRD (from Worksheet I-5, line 11)	JUAL SERVICES			33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				34
	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
30	Subtotal (see instructions)				30
37	MSP-LCC reconciliation amount from PS&R				37
39	Other adjustments (specify) (see instructions)				39
39.99	Recovery of Accelerated depreciation				39.99
40	Subtotal (see instructions)				40
40.01	Suboral (see instructions) Sequestration adjustment (see instructions)				40.01
40.01	Interim payments				40.01
41	Tentative settlement (for contractors use only)				41
43	Balance due provider/program (see instructions)				43
	provides program (see whit menoria)				

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.2) 40-586

Rev. 4

10-12			FORM	FORM CMS-2552-10			4090 (Cont.)	
CALCULATION OF					PROVIDER CCN:	PERIOD:	WORKSHEET E,	
REIMBURSEMENT SE	TTLEMENT					FROM	PART B (Cont.)	
					COMPONENT CCN:	то		
Check applicable box	[] Hospital [	]IPF []	IRF [] Subp	rovider(Other)	[ ] SNF			
PART B - MEDICAL A	AND OTHER HEA	LTH SERVI	CES					
TO BE COMPL	ETED BY CONT	ACTOR						

90	Original outlier amount (see instructions)	90
91	Outlier reconciliation adjustment amount (see instructions)	91
92	The rate used to calculate the Time Value of Money	92
93	Time Value of Money (see instructions)	93
94	Total (sum of lines 91 and 93)	94

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.2) Rev. 3

4090	) (Cont.)			FORM (	CMS-	2552-10				10-12
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			PROVIDER CCN: 	PROVIDER CCN:  COMPONENT CCN:		PERIOD: FROM TO		WORKSHEET E-1, PART I		
Check [] Hospital [] Subprovider (Other)					I		inpatient			
pplica	able	[] IPF	[ ] SNF				Part A		Part B	
ox:		[] IRF	[] Swing-Bed SNF			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description					1	2	3	4	
1	Total interim pa	syments paid to pr	ovider							1
			vidual bills, either submitted or to be su eporting period. If none, write "NONE"							2
	List separately e				.01					3.01
	lump sum adjus	tment amount bas	ed		.02					3.02
	on subsequent re	evision 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)		zero. (1)		.50					3.50
					.51					3.51
				Provider to	.52					3.52
				Program	.53					3.53
					.54					3.54
Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98) .99								3.99		
	-	•	ines 1, 2, and 3.99)							4
	·	st. E or Wkst. E-3	, line							
	and column as a									
		LETED BY CON							-	
		each tentative settl		Program to	.01					5.01
	1 2	esk review. Also s	show	Provider	.02					5.02
	date of each pay				.03					5.03
	If none, write "N	NONE" or enter a	zero. (1)		.50		_	_	_	5.50
				Provider to	.51				_	5.51
				Program	.52		_			5.52
_	· · · ·		minus sum of lines 5.50 -5.98)		.99					5.99
		settlement amoun	it (balance	Program to provider	.01					6.01
		he cost report (1)		Provider to program	.02				_	6.02
		program liability	(see instructions)			a				7
8	Name of Contra	actor				Contractor Number		NPR Date (Month/Day	// Y ear)	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.

09-13		FORM CMS-255	2-10	4090 (Cont.)					
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET E-1, PART II				
Check Applicable box:	[] Hospital	[]CAH							
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAD COST REPORTS									
HEALTH INFORMATION TEC	CHNOLOGY DATA CO	DLLECTION AND CALCULAT	TION						
1 Total hospital discharges as	s defined in ARRA 84102	from Wkst S-3 Part L column 15	line 14		1				

1	Total hospital discharges as defined in ARRA §4102 from wikst S-5, Part I, column 15, nile 14	1
2	Medicare days from Wkst S-3, Part I, column 6, sum of lines 1, 8-12	2
3	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	3
4	Total inpatient days from S-3, Part I, column 8, sum of lines 1, 8-12	4
5	Total hospital charges from Wkst C, Part I, column 8, line 200	5
6	Total hospital charity care charges from Wkst S-10, column 3, line 20	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part 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 PPS & 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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4031.1) Rev. 4

4000	$\alpha$
	I Ont 1
+0200	Cont.)

# FORM CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

PROVIDER CCN:	PERIOD:	WORKSHEET E-2
	FROM	
COMPONENT CCN:	то	

Check	[] Title V	[] Swing Bed - SNF	
applicable	[] Title XVIII	[] Swing Bed - NF	
boxes:	[] Title XIX		

boxes		-		
		PART A	PART B	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)			1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V,			3
	columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days			5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)			10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional			11
	services)			
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for			13
	physician professional services)			
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			15
16	Other adjustments (specify) (see instructions)			16
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)			19
19.01	Sequestration adjustment (see instructions)			19.01
20	Interim payments			20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program line 19 minus lines 19.01, 20 and 21			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			23
	section 115.2			

09-13

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4032) 40-590

09-13	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART I
		COMPONENT CCN:	то	
PART I - CALCULATION OF MEDICARE REIMBURS	FMENT SETTI EMENT LINDE	D - TEEDA		

#### PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER - TEFRA

1	Inpatient hospital services (see instructions)	1
2	Organ acquisition	2
3	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	3
4	Subtotal (sum of lines 1 thru 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 Worksheet 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
18	Total amount payable to the provider (see instructions)	18
18.01	Sequestration adjustment (see instructions)	18.01
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program line 18 minus lines 18.01, 19 and 20	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	22

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.1) Rev. 4

4090 (	Cont.)
--------	--------

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: PERIOD: \_\_\_\_\_\_ FROM \_\_\_\_\_ COMPONENT CCN: TO \_\_\_\_\_ WORKSHEET E-3,

PART II

Check	[] Hospital	
applicable	[] Subprovider IPF	
box:		

#### PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1
2	Net IPF PPS Outlier payment	2
3	Net IPF PPS ECT payment	3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)	4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure,	4.01
	that would not be counted without a temporary cap adjustment under $412.424(d)(1)(iii)(F)(1)$ or (2) (see instructions)	
5	New teaching program adjustment (see instructions)	5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period	6
	of a "new teaching program (see isntructions)	
7	Current year unweighted I&R FTE count for residents within the new program growth period	7
	of a "new teaching program (see isntructions)	
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)	8
9	Average daily census (see instructions)	9
10	<i>Teaching</i> 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 instruction)	13
14	Organ acquisition DO NOT USE THIS LINE	14
15	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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	Subtotal (line 18 minus line 19)	20
21	Coinsurance	21
22	Subtotal (line 20 minus line 21)	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23
24	Adjusted reimbursable bad debts (see instructions)	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	25
26	Subtotal (sum of lines 22 and 24)	26
27	Direct graduate medical education payments (from Worksheet E-4, line 49) (For freestanding IPF only)	27
28	Other pass through costs (see instructions)	28
29	Outlier payments reconciliation	29
30	Other adjustments (specify) (see instructions)	30
31	Total amount payable to the provider (see instructions)	31
31.01	Sequestration adjustment (see instructions)	31.01
32	Interim payments	32
33	Tentative settlement (for contractor use only)	33
34	Balance due provider/program line 31 minus lines 31.01, 32 and 33	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	35

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

 $\frac{1}{40-592} FORM \ \text{CMS-2552-10} \ (09-2013) \ (\text{INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.2)}{40-592}$ 

$\Omega \Omega^{-1}$	12
119-	۱ ۱

# FORM CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

4090 (Cont.)

PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
	FROM	PART III
COMPONENT CCN:	то	

## PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	Net Federal PPS payment (see instructions)	
2	Medicare SSI ratio (IRF PPS only) (see instructions)	2
3	Inpatient Rehabilitation LIP payments (see instructions)	3
4	Outlier payments	4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending	5
5	on or prior to November 15, 2004 (see instructions)	5
5.01		5.01
5.01	that would not be counted without a temporary cap adjustment under $\$412.424(d)(1)(iii)(F)(1)$ or (2)	5.01
6	New teaching program adjustment (see instructions)	6
7	Current year unweighted FTE count of I&R <i>excluding</i> FTEs in the <i>new program growth period</i>	7
,	of a "new teaching program (see isntructions)	,
8	Current year unweighted I&R FTE count for residents within the <i>new program growth period</i>	8
0	of a "new teaching program (see isntructions)	0
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	9
10	Average daily census (see instructions)	10
11	<i>Teaching</i> Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	11
12	Teaching Adjustment (line 1 multiplied by line 11).	12
13	Total PPS Payment (sum of lines 1, 3, 4 and 12)	13
14		14
15	Organ acquisition DO NOT USE THIS LINE	15
16	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	16
17	Subtotal (see instructions)	17
18		18
19	Subtotal (line 17 less line 18).	19
20	Deductibles	20
21	Subtotal (line 19 minus line 20)	21
22	Coinsurance	22
23	Subtotal (line 21 minus line 22)	23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	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 Worksheet E-4, line 49) (For free standing IRF only).	28
29	Other pass through costs (see instructions)	29
30	Outlier payments reconciliation	30
31	Other adjustments (specify) (see instructions)	31
32	Total amount payable to the provider (see instructions)	32
32.01	Sequestration adjustment (see instructions)	32.01
33	Interim payments	33
34	Tentative settlement (for contractor use only)	34
35	Balance due provider/program line 32 minus lines 32.01, 33 and 34	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	36

## TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part 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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.3) Rev. 4

1000	(Cont.)
4090	(Cont.)

# FORM CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Check	[] Hospital	
applicable		
box:		

## PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	1
2	Outlier payments	2
3	Total PPS payments (sum of lines 1 and 2)	3
4	Nursing and allied health managed care payments (see instructions)	4
5	Organ acquisition DO NOT USE THIS LINE	5
6	Cost of teaching physicians	6
7	Subtotal (see instructions)	7
8	Primary payer payments	8
9	Subtotal (line 7 less line 8)	9
10	Deductibles	10
11	Subtotal (line 9 minus line 10)	11
12	Coinsurance	12
13	Subtotal (line 11 minus line 12)	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14
15	Adjusted reimbursable bad debts (see instructions)	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	16
17	Subtotal (sum of lines 13 and 15)	17
18	Direct graduate medical education payments (from Worksheet 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
22	Total amount payable to the provider (see instructions)	22
22.01	Sequestration adjustment (see instructions)	22.01
23	Interim payments	23
24	Tentative settlement (for contractor use only)	24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	26

## TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Worksheet E-3, Part IV, line 3 (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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.4) 40-594

# FORM CMS-2552-10

4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT	

 PROVIDER CCN:
 PERIOD:
 WORKSHEET E-3,

 \_\_\_\_\_\_\_
 FROM \_\_\_\_\_\_
 PART V

 COMPONENT CCN:
 TO \_\_\_\_\_\_

## PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	Inpatient services		1
2	Nursing and allied health managed care payment (see instruction)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1 thru 3)		4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (see instructions)		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		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 instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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 line 20)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)		25
26	Adjusted reimbursable bad debts (see instructions)		26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 25 or 26)		28
29	Other adjustments (specify) (see instructions)'		29
30	Subtotal (line 28, plus or minus line 29)		30
30.01	Sequestration adjustment (see instructions)		30.01
31	Interim payments		31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program line 30 minus lines 30.01, 31, and 32		33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		34
		· · · · · · · · · · · · · · · · · · ·	

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.5) Rev. 4

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
		FROM	PART VI
	COMPONENT CCN .:	то	

# PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR 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 6 & 7 plus 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
15	Subtotal (line 12 minus 13 ± lines 14	15
15.01	Sequestration adjustment (see instructions)	15.01
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program line 15 minus 15.01, 16 and 17	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS	19
	Pub. 15-2, section 115.2	

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.6) 40-596

09-13		FORM CMS-2552-10	)		4090 (Cont.)
CALCULATION OF REIMBURS	EMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
				FROM	PART VII
			COMPONENT CCN:	то	
Check	[] Title V	[] Hospital	[] NF	[ ] PPS	
applicable	[] Title XIX	[] Subprovider	[] ICF/MR	[] TEFRA	
boxes:		[ ] SNF		[] Other	

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

		Inpatient	Outpatient	
		Title V or	Title V or	
	COMPUTATION OF NET COST OF COVERED SERVICES	Title XIX	Title XIX	
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	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
11	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
19	Interns and residents (see instructions)			19
20	Cost of teaching physicians (see instructions)			20
21	Cost of covered services (enter the lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	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
28	Customary charges (title V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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				36
37	Other adjustments (specify) (see instructions)			37
38	Subtotal (line $36 \pm line 37$ )			38
39	Direct graduate medical education payments (from Worksheet 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
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			43

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.7) Rev. 4

4090	(Cont.) FORM CMS-255	2-10			09-13
DIREC	T GRADUATE MEDICAL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	<u> </u>
& ESRI	D OUTPATIENT DIRECT MEDICAL		FROM	_	
EDUCA	ATION COSTS		то	_	
Check	[] Title V				
applical	ble [] Title XVIII				
box:	[] Title XIX				
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost	t reporting periods ending on	or before December 31,	1996	1
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (	see instructions)			2
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 CF	R §413.79 (m). (see instruct	ions		3.01
	for cost reporting periods straddling 7/1/2011)				
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic progra	ims due 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 report	ting periods straddling 7/1/20	011)		4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for	or cost reporting periods strad	Idling 7/1/2011)		4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 p	lus lines 4.01 and 4.02 plus a	pplicable subscripts		5
6		current year from your record	ds (see instructions)		6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	<u> </u>
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for	r			8
	the current year				
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 tir	nes			9
	the result of line 5 divided by the amount on line 6				
10	Weighted dental and podiatric resident FTE count for the current year				10
11	Total weighted FTE count				11
12					12
13		instr.)			13
14					14
15					15
16					16
17					17
18					18
19					19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap	slots received under 42 Sec. 4	413.79(c)(4)		20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)	• 、		-	22
23		ions)			23
24					24
25		Inpatient Part A	Managed Care		25
26	COMPUTATION OF PROGRAM PATIENT LOAD	inpatient Part A	managed Care		26
20					26 27
27					27
28					28
30					30
31					31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE -	TITLE XVIII ONLY (NURS	SING SCHOOL AND		
	PARAMEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE -				
32		columns 20 and 23. lines 74	and 94)		32
33					33
34					34
35					35
	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4034) 40-598

10-12	2	FORM CMS-2552-10			4090 (Cont.)
DIREC	T GRADUATE MEDICA	AL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4
& ESRI	D OUTPATIENT DIREC	_ (Cont.)			
EDUCA	ATION COSTS			то	_
Check		[] Title V			
applical	ble	[] Title XVIII			
box:		[] Title XIX			
	APPORTIONMENT OF	F MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost				
37	Reasonable cost (see in	nstructions)			37
38	Organ acquisition costs	(Worksheet D-4, Part III, column 1, line 69)			38
39	Cost of teaching physici	ians (Worksheet D-5, Part II, column 3, line 20)			39
40	Primary payer payments	s (see instructions)			40
41	Total Part A reasonable	e cost (sum of lines 37 through 39 minus line 40)			41
	Part B Reasonable Cost				
42	Reasonable cost (see in	nstructions)			42
43	Primary payer payments	s (see instructions)			43
44	Total Part B reasonable	cost (line 42 minus line 43)			44
45	Total reasonable cost (s	sum of lines 41 and 44)			45
46	Ratio of Part A reasonal	ble cost to total reasonable cost (line $41 \div \text{line } 45$ )			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47	
	ALLOCATION OF ME	DICARE DIRECT GME COSTS BETWEEN PART	A AND PART B		
48	Total program GME pag	yment (line 31)			48
49	Part A Medicare GME	payment (line 46 x 48)(Title XVIII only) (see instru	ctions)		49
50	Part B Medicare GME	payment (line 47 x 48) (title XVIII only) (see instru	ctions)		50

4090 (Cont.)		FORM CMS-2552-10				10-12	
(If you	NCE SHEET 1 are nonproprietary and do not maintain fund-type nting records, complete the General Fund column only)		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET G		
	Assets (Omit cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4		
	CURRENT ASSETS		2	U			
1						1	
2						2	
3						3	
4	Accounts receivable					4	
5						5	
6	Allowances for uncollectible notes and accounts receivable					6	
7	Inventory					7	
8						8	
9	Other current assets					9	
10						10	
11	Total current assets (sum of lines 1-10)					11	
	FIXED ASSETS		•				
12	Land					12	
13	Land improvements					13	
14	Accumulated depreciation					14	
15	Buildings					15	
16	Accumulated depreciation					16	
17	Leasehold improvements					17	
18	Accumulated depreciation					18	
19	Fixed equipment					19	
20	Accumulated depreciation					20	
21	Automobiles and trucks					21	
22	Accumulated depreciation					22	
23	Major movable equipment					23	
24	Accumulated depreciation					24	
25	Minor equipment depreciable					25	
26	Accumulated depreciation					26	
27	HIT designated Assets					27	
28	Accumulated depreciation					28	
29	Minor equipment-nondepreciable					29	
30	Total fixed assets (sum of lines 12-29)					30	
	OTHER ASSETS			1	1	-	
31	Investments				_	31	
32	Deposits on leases					32	
33				-		33	
34	Other assets		_		_	34	
35	Total other assets (sum of lines 31-34)					35	
36	Total assets (sum of lines 11, 30, and 35)					36	

10-12	FORM CMS-2	2552-10		4090 (Cont	t.)
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 of	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)				2	40
41 Deferred income				2	41
42 Accelerated payments				4	42
43 Due to other funds				2	43
44 Other current liabilities				2	44
45 Total current liabilities (sum of				2	45
lines 37 thru 44)					
LONG TERM LIABILITIES 46 Mortgage payable 47 Notes payable					46 47
47 Notes payable 48 Unsecured loans					48
49 Other long term liabilities					48
50 Total long term liabilities (sum of					49 50
lines 46 thru 49)					50
51 Total liabilities (sum of lines 45 and 50)					51
51 Total habilities (sum of lines 45 and 50)					51
CAPITAL ACCOUNTS					
52 General fund balance				4	52
53 Specific purpose fund				4	53
54 Donor created - endowment fund				4	54
balance - restricted					
55 Donor created - endowment fund				4	55
balance - unrestricted					
56 Governing body created - endowment				4	56
fund balance					
57 Plant fund balance - invested in plant				4	57
58 Plant fund balance - reserve for plant					58
improvement, replacement, and expansion					
59 Total fund balances (sum of lines 52 thru 58)				4	59
60 Total liabilities and fund balances (sum of				6	60
lines 51 and 59)					

4090 (Cont.) FORM CMS-2552-10						10-12			
STATEMENT OF CHANGES IN FUND BALANCES				PROVIDER CCN	[:	PERIOD: FROM TO		WORKSHEE	T G-1
	GENER	AL FUND		JRPOSE FUND		MENT FUND	PLANT		
	1	2	3	4	5	6	7	8	_
1 Fund balances at beginning of period									1
2 Net income (loss) (from Worksheet G-3, line 29)									2
3 Total (sum of line 1 and line 2)									3
4 Additions (credit adjustments) (specify)									4
5									5
6		]							6
7									7
8									8
9									9
10 Total additions (sum of lines 4-9)									10
11 Subtotal (line 3 plus line 10)									11
12 Deductions (debit adjustments) (specify)									12
13									13
14									14
15									15
16									16
17									17
18 Total deductions (sum of lines 12-17)									18
19 Fund balance at end of period per balance									19
sheet (line 11 minus line 18)									

10-12	FORM CMS-2552-10		4090 (Cont.)
STATEMENT OF PATIENT REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-2,
AND OPERATING EXPENSES		FROM	PARTS I & II
		ТО	

# PART I - PATIENT REVENUES

	INPATIENT	OUTPATIENT	TOTAL	
REVENUE CENTER	1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 Hospital				1
2 Subprovider IPF				2
3 Subprovider IRF				3
4 Subprovider (Other)				4
5 Swing bed - SNF				5
6 Swing bed - NF				6
7 Skilled nursing facility				7
8 Nursing facility				8
9 Other long term care				9
10 Total general inpatient care services (sum of lines 1-9)				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 17-27) (transfer column 3 to				28
Worksheet G-3, line 1)				

## PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)			29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			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 CMS-2552-10	10-12
STATEMENT OF REVENUES	PROVIDER CCN: PERIOD:	WORKSHEET G-3
AND EXPENSES	FROM	
	ТО	

	Description	 
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1
2	Less contractual allowances and discounts on patients' accounts	2
3	Net patient revenues (line 1 minus line 2)	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	4
5	Net income from service to patients (line 3 minus line 4)	5

#### OTHER INCOME

6	Contributions, donations, bequests, etc	6
7	Income from investments	7
8	Revenues from telephone and other miscellaneous communication services	8
9	Revenue from television and radio service	9
10	Purchase discounts	10
11	Rebates and refunds of expenses	11
12	Parking lot receipts	12
13	Revenue from laundry and linen service	13
14	Revenue from meals sold to employees and guests	14
15	Revenue from rental of living quarters	15
16	Revenue from sale of medical and surgical supplies to other than patients	16
17	Revenue from sale of drugs to other than patients	17
18	Revenue from sale of medical records and abstracts	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)	19
20	Revenue from gifts, flowers, coffee shops, and canteen	20
21	Rental of vending machines	21
22	Rental of hospital space	22
23	Governmental appropriations	23
24	Other (specify)	24
25	Total other income (sum of lines 6-24)	25
26	Total (line 5 plus line 25)	26
27	Other expenses (specify)	27
28	Total other expenses (sum of line 27 and subscripts)	28
29	Net income (or loss) for the period (line 26 minus line 28)	29

10-12 FORM CMS-2552-10										4090 (Cont.)	
ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS						PROVIDER CO	CN:	PERIOD: FROM		WORKSHEET H	
						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 (col. 8 + col. 9)	
	1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS											
1 Capital Related-Bldgs. and Fixtures											1
2 Capital Related-Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General											5
HHA REIMBURSABLE SERVICES											
6 Skilled Nursing Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech Pathology											9
10 Medical Social Services											10
11 Home Health Aide											11
12 Supplies (see instructions)											12
13 Drugs											13
14 DME											14
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											22
23 All Others											23
24 Total (sum of lines 1-23)											24

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

4090 (Cont.)		FO	RM CMS-255	2-10	1	10-12			
COST ALLOCATION - HHA GENERAL SERVICE COST				PROVIDER CCN: _		PERIOD: FROM		WORKSHEET H- PART I	1
	NET EXPENSES CAPITAL FOR COST RELATED COSTS			HHA CCN:		ТО			$\square$
	ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	TOTAL (cols. 4a + 5)	
CENTER AL GERNIGE COOT CENTERS	0	1	2	3	4	4a	5	6	<u> </u>
GENERAL SERVICE COST CENTERS 1 Capital Related-Bldgs. and Fixtures				1					<u> </u>
2 Capital Related-Movable Equipment									2
3 Plant Operation & Maintenance									3
4 Transportation (see instructions)									4
5 Administrative and General									5
HHA REIMBURSABLE SERVICES									
6 Skilled Nursing Care									6
7 Physical Therapy									7
8 Occupational Therapy									8
9 Speech Pathology									9
10 Medical Social Services									10
11 Home Health Aide									11
12 Supplies (see instructions)									12
13 Drugs									13
14 DME									14
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									22
23 All Others									23
24 Totals (sum of lines 1-23)									24

09-1	3	FORM CMS-255	FORM CMS-2552-10								
COST	ALLOCATION - HHA STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM		WORKSHEET H-1 PART II	l,			
			HHA CCN:		ТО						
			PITAL ED COSTS MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANS- PORTATION (MILEAGE)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)				
		1	2	3	4	5a	5				
	GENERAL SERVICE COST CENTERS										
	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										
	Skilled Nursing Care							6			
	Physical Therapy							7			
	Occupational Therapy							8			
	Speech Pathology							9			
	Medical Social Services							10			
_	Home Health Aide							11			
	Supplies (see instructions)							12			
	Drugs							13			
14	DME							14			
	HHA NONREIMBURSABLE SERVICES										
	Home Dialysis Aide Services							15			
	Respiratory Therapy							16			
	Private Duty Nursing							17			
	Clinic							18			
	Health Promotion Activities							19			
	Day Care Program							20			
	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			

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4042) Rev. 4

409	0 (Cont.)			FORM C	CMS-2552-10 (								
	OCATION OF GENERAL SERVICE 'S TO HHA COST CENTERS		PROVIDER CCN:           HHA CCN:					WORKSHEET H-2, PART I					
	HHA COST CENTER	From Wkst, H-1	HHA TRIAL	-	PITAL ED COSTS	EMPLOYEE		TO	MAIN-		LAUNDRY	Τ	
	(omit cents)	Part I, col. 6,	BALANCE (1)	BLDGS. & FIXTURES	-	BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	& LINEN SERVICE		
		line	0	1	2	4	4A	5	6	7	8	+	
	Administrative and General Skilled Nursing Care	5										2	
- 2	Physical Therapy	7										3	
	Occupational Therapy	8										4	
5		9										5	
6		10										6	
7	Home Health Aide	11										7	
8	Supplies	12										8	
9	Drugs	13										9	
10	DME	14			1							10	
11	Home Dialysis Aide Services	15										11	
12	Respiratory Therapy	16										12	
13	Private Duty Nursing	17										13	
14	Clinic	18										14	
15	Health Promotion Activities	19										15	
16	Day Care Program	20										16	
17	Home Delivered Meals Program	21										17	
18		22										18	
_	All Others	23										19	
20	Totals (sum of lines 1-19) (2)											20	
21	Unit Cost Multiplier: column 26, line 1 divided by minus column 26, line 1, rounded to 6 decimal placed		6, line 20									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.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4043.1) 40-608

10-1	2	FORM CM	I CMS-2552-10						4090 (Cont.)				
	ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS					PROVIDER CCN:			PERIOD: FROM TO		WORKSHEET H-2, PART I (CONT.)		
	HHA COST CENTER (omit cents)	HOUSE KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	
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
	DME												10
	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
	All Others												19
	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1 divided by		1 26, line 20										21
	minus column 26, line 1, rounded to 6 decimal place	ces.											

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4043.1) Rev. 3

4090	O (Cont.)		FO	RM CMS-2552-10									
	CATION OF GENERAL SERVICE S TO HHA COST CENTERS	PROVIDER CCN	:		PERIOD: FROM		WORKSHEET H-2, PART I (CONT.)						
		1	HHA CCN:			TO INTERN &		+					
	HHA COST CENTER (omit cents)	NURSING SCHOOL 20	INTERNS & SALARY AND FRINGES 21	RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL (sum of cols. 4a-23) 24	RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	SUBTOTAL (cols. 23 ± 24) 26	ALLOCATED HHA A&G (see Part II) 27	TOTAL HHA COSTS 28			
1	Administrative and General										1		
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		
	Homemaker Service										18		
19	All Others										19		
20	Totals (sum of lines 1-19) (2)										20		
21	<ul> <li>Potas (sum of mes (19)(2)</li> <li>Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.</li> </ul>										21		

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4043.1) 40-610

09-13			FOI	RM CMS-2552-10	И CMS-2552-10					
COSTS	ATION OF GENERAL SERVICE FO HHA COST CENTERS TICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET H-2, PART II		
STATIS	IICAL BASIS	RELATE	ITAL ED COST	EMPLOYEE		ADMINIS-	MAIN-			
	HHA COST CENTER	BLDGS. & FIXTURES (SQUARE FEET) 1	MOVABLE EQUIPMENT (DOLLAR VALUE) 2	BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 4A	TRATIVE & GENERAL (ACCUM. COST) 5	TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7		
1 A	Administrative and General		_				· · · ·		1	
2 S	killed Nursing Care								2	
3 P	Physical Therapy								3	
4 C	Occupational Therapy								4	
5 S	peech Pathology								5	
6 N	Aedical Social Services								6	
7 H	Iome Health Aide								7	
8 S	upplies								8	
9 E	Drugs								9	
10 E	DME								10	
11 H	Iome Dialysis Aide Services								11	
12 R	Respiratory Therapy								12	
13 P	Private Duty Nursing								13	
14 C	Clinic								14	
15 H	Health Promotion Activities								15	
16 E	Day Care Program								16	
17 H	Iome Delivered Meals Program								17	
18 H	Iomemaker Service								18	
19 A	All Others								19	
20 T	Totals (sum of lines 1-19)								20	
21 T	otal cost to be allocated								21	
22 U	Jnit Cost Multiplier								22	

4090 (Cont.) FORM CMS-2552-10											
COST	CATION OF GENERAL SERVICE 'S TO HHA COST CENTERS 'ISTICAL BASIS	1				PROVIDER CCN	·	PERIOD: FROM TO		WORKSHEET H PART II (CONT.	· ·
	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1	Administrative and General	0	,	10		12	15	14	15	10	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				1						7
8	Supplies										8
9	Drugs				1	1					9
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
13	Private Duty Nursing										13
14	Clinic										14
15	Health Promotion Activities										15
16	Day Care Program										16
17	Home Delivered Meals Program										17
18	Homemaker Service										18
	All Others										19
	Totals (sum of lines 1-19)										20
	Total cost to be allocated										21
22	Unit Cost Multiplier										22

10-1	2		FOF	RM CMS-2552-10	4090 (Cont.)				
COST	CATION OF GENERAL SERVICE 'S TO HHA COST CENTERS ISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET H-2, PART II (CONT.)	
	HHA COST CENTER	SOCIAL SERVICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY & FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
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
	Day Care Program								16
17	Home Delivered Meals Program								17
18	Homemaker Service								18
	All Others								19
20	Totals (sum of lines 1-19)								20
	Total cost to be allocated								21
22	Unit Cost Multiplier								22

4090 (Cont.)			FORM	CMS-2552-10					
APPORTIONMENT OF PATIENT	SERVICE COS	TS		PROVIDER CCN:	PERIOD:	WORKSHEET H-3,			
					FROM	Parts I & II			
				HHA CCN:	то				
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX						

### PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

	Limitation Cost Computation			Program Visits		
				Par	rt B	
				Not Subject to	Subject to	
	Patient Services			Deductibles	Deductibles	
		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 8-13)					14

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

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

				Total			
			Cost	HHA Charges	HHA Shared	Transfer to	
		From Wkst. C,	to Charge	(from provider	Ancillary Costs	Part I	
		Part I, col. 9,	Ratio	records)	(col. 1 x col. 2)	as Indicated	
		line	1	2	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

DRAFT	FORM CMS-25	52-10		4090 (Cont.)
CALCULATION OF HHA REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET H-4,
SETTLEMENT		HHA CCN:	FROM TO	Parts I & II
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				3
for services on a charge basis (from your records)				
4 Amount that would have been realized from patients liable				4
for payment for services on a 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				7
cost (complete only if line 6 exceeds line 1)				
8 Excess of reasonable cost over customary charges				8
(complete only if line 1 exceeds line 6)				
9 Primary payer amounts				9

T

# 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	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
31	Subtotal (line 29 plus/minus line 30)			31
31.01	Sequestration adjustment (see instructions)			31.01
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, 32 and 33			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS			35
	Pub. 15-2, section 115.2			

FORM CMS-2552-12 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4045.1 - 4045.2) Rev. 4

4090	O (Cont.)		FC	ORM CMS-2552	2-10			09-13	
BASE	LYSIS OF PAYMENTS TO PROVIDER- D HHAS FOR SERVICES				PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-5		
RENL	DERED TO PROGRAM BENEFICIARIES				HHA CCN:	то			
	Description			F	Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
				1	2	3	4		
1	Total interim payments paid to provider							1	
2	Interim payments payable on individual bills eith							2	
	to be submitted to the intermediary for services r								
	cost reporting period. If none, write "NONE" or	enter a zer	1		_			_	
3			.01		-		_	3.01	
	adjustment amount based on subsequent revision		.02		-		_	3.02	
	of the interim rate for the cost reporting period.	Program	.03					3.03	
	Also show date of each payment. If none, write	to	.04					3.04	
	"NONE" or enter a zero.(1)	Provider	.05					3.05	
			.50					3.50	
		D 1	.51					3.51	
		Provider to	.52 .53		-			3.52 3.53	
		Program	.55		-			3.55	
	Subtotal (sum of lines 3.01-3.49 minus sum	Flogram	.34					3.34	
	of lines 3.50-3.98)		.99					3.99	
4	Total interim payments (sum of lines 1, 2, and 3.	00)	.99					3.99	
-	(transfer to Wkst. H-4, Part II, column as approp		2)					-	
	(umblet to which if i, i at it, column as approp	inate, inte o	_)						
	TO BE COMPLETED BY IN	TERMEDI	ARY						
		n	0.1					5.01	
5	List separately each tentative settlement payment	-	.01					5.01	
	after desk review. Also show date of each	to	.02					5.02	
	payment. If none, write "NONE" or enter	Provider Provider	.03					5.03	
	a zero. (1)	to	.50					5.50 5.51	
		Program	.51					5.51	
	Subtotal (sum of lines 5.01-5.49 minus sum	Flogram	.52					5.52	
	of lines 5.50-5.98)		.99					5.99	
6	Determine net settlement amount (balance due)	Program	.,,,					5.77	
0	based on the cost report (see instructions)	to	.01						
	based on the cost report (see instructions)	Provider	.01					6.01	
		Provider						0.01	
		to	.02						
		Program						6.02	
7	TOTAL MEDICARE PROGRAM LIABILITY							7	
	(see instructions)		1						
8	Name of Contractor	Contrac	ctor N	umber	NPR Date: Month, Da	NPR Date: Month, Day, Year			

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4046) 40-616

2       Licensed Practical Nurses       Hours of Service       2         3       Nurses Aides       Hours of Service       2         4       Technicians       Hours of Service       2         5       Social Workers       Hours of Service       2         6       Dieticians       Hours of Service       2         7       Physicians       Accumulated Cost       2         8       Non-patient Care Salary       Accumulated Cost       2         9       Subtotal (sum of lines 1-8)       2       2         10       Employce Benefits       Salary       10         11       Capital Related Costs-Mov. Equip.       Percentage of Time       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       11         13       Machine Costs & Repairs       Percentage of Time       12         14       Supplies       Requisitions       14         15       Drugs       Requisitions       14         16       Other       Accumulated Cost       16         17       Subtotal (sum of lines 9-16)*       Accumulated Cost       16         18       Capital Related Costs-Mov. Equip.       Percentage of Time       17 <t< th=""><th>09-1</th><th>3</th><th>FO</th><th>RM CMS-255</th><th>52-10</th><th></th><th colspan="3">4090 (Cont.)</th></t<>	09-1	3	FO	RM CMS-255	52-10		4090 (Cont.)		
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$	ANAL	YSIS OF RENAL DIALYSIS I.	DEPARTMENT COSTS		PROVIDER CCN:	FROM	WORKSHEET I-1		
$\begin{tabular}{ c c c c c } \hline COSTS & BASIS & STATISTICS & 2080 Hours \\ \hline 1 & 2 & 3 & 4 \\ \hline 1 & 2 & 2 & 3 & 4 \\ \hline 1 & 2 & 2$	Check	applicable box:	[] Renal Dialysis Department		n Dialysis				
I         2         3         4           1         Registered Nurses         Hours of Service         1           2         Licensed Practical Nurses         Hours of Service         1           3         Nurses Aides         Hours of Service         2           4         Technicians         Hours of Service         2           5         Social Workers         Hours of Service         2           6         Dieticians         Hours of Service         2           7         Physicians         Accumulated Cost         2           8         Nor-patient Care Selary         Accumulated Cost         2           9         Subtotal (sum of lines 1-8)         Salary         1         1           10         Employce Benefits         Salary         1         1           11         Capital Related Costs-Mox. Equip.         Percentage of Time         11           12         Capital Related Costs-Mox. Equip.         Percentage of Time         11           13         Machine Costs & Repairs         Percentage of Time         11           14         Supplies         Requisitions         14           15         Drugs         Requisitions         15 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>							-		
1       Registered Nurses       Hours of Service       1         2       Licensed Practical Nurses       Hours of Service       2         3       Nurses Aides       Hours of Service       2         4       Technicians       Hours of Service       2         5       Social Workers       Hours of Service       2         6       Dieticians       Hours of Service       2         7       Physicians       Accumulated Cost       2         8       Non-patient Care Salary       Accumulated Cost       2         9       Subtotal (sum of lines 1-8)       2       2         10       Employee Benefits       Salary       10         11       Capital Related Costs-Bidgs, & Fixtures       Square Feet       11         12       Capital Related Cost-Supp.       Percentage of Time       12         13       Machine Costs & Repairs       Percentage of Time       13         14       Supplies       Requisitions       14         15       Drugs       Requisitions       14         16       Other       Accumulated Cost       16         17       Salatotal (sum of lines 9-16)*       Salary       20         18       Capita				COSTS	BASIS				
2       Licensed Practical Nurses       Hours of Service       2         3       Nurses Aides       Hours of Service       2         4       Technicians       Hours of Service       2         6       Dieticians       Hours of Service       2         7       Physicians       Hours of Service       2         8       Non-patient Care Salary       Accumulated Cost       2         9       Subtotal (sum of lines 1-8)       Salary       2         10       Employce Benefits       Salary       10         11       Capital Related Costs-Holgs, & Fixtures       Square Feet       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       12         13       Machine Costs & Repairs       Percentage of Time       12         14       Supplies       Requisitions       14         15       Drug S       Requisitions       15         16       Other       Accumulated Cost       22         17       Subtotal (sum of lines 9-16)*       Accumulated Cost       16         18       Capital Related Costs-Mov. Equip.       Percentage of Time       17         18       Capital Related Costs-Mov. Equip.       Percentage of Time				1	2	3	4		
3       Nurses Aides       Hours of Service       2         4       Technicians       Hours of Service       2         5       Social Workers       Hours of Service       2         6       Dieticians       Hours of Service       2         7       Physicians       Accumulated Cost       7         8       Non-patient Care Salary       Accumulated Cost       7         9       Subtotal (sum of lines 1-8)       2       2         10       Employce Benefits       Salary       10         11       Capital Related Costs-Mov. Equip.       Percentage of Time       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       11         13       Machine Costs & Repairs       Percentage of Time       11         14       Supplies       Requisitions       14         15       Drugs       Requisitions       14         16       Other       Accumulated Cost       17         18       Capital Related Costs-Mov. Equip.       Percentage of Time       18         14       Supplies       Requisitions       14       16         15       Drugs       Requisitions       14         16 <t< td=""><td>1</td><td>Registered Nurses</td><td></td><td></td><td>Hours of Service</td><td></td><td></td><td>1</td></t<>	1	Registered Nurses			Hours of Service			1	
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       7         9       Subtotal (sum of lines 1-8)       5       6         10       Employee Benefits       Salary       10         11       Capital Related Costs-Mov. Equip.       Percentage of Time       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       11         13       Machine Costs & Repairs       Percentage of Time       11         14       Supplies       Requisitions       11         15       Drugs       Requisitions       11         16       Other       Accumulated Cost       10         17       Subtotal (sum of lines 9-16)*       11       11         18       Capital Related Costs-Mov. Equip.       Percentage of Time       11         19       Capital Related Costs-Mov. Equip.       Percentage of Time       11         19       Capital Related Costs-Mov. Equip.       Percentage of Time       1	2	Licensed Practical Nurses			Hours of Service			2	
5       Social Workers       Hours of Service       9         6       Dieticians       Hours of Service       0         7       Physicians       Accumulated Cost       0         8       Non-patient Care Salary       Accumulated Cost       0         9       Subtotal (sum of lines 1-8)       0       0         10       Employee Benefits       Salary       0       0         11       Capital Related Costs-Mov. Equip.       Percentage of Time       0       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       0       12         13       Machine Costs & Repairs       Percentage of Time       0       13         14       Supplies       Requisitions       0       14         15       Drugs       Requisitions       0       15         16       Other       Accumulated Cost       0       17         18       Capital Related Costs-Mov. Equip.       Percentage of Time       16       17         18       Capital Related Costs-Mov. Equip.       Percentage of Time       17       18         19       Capital Related Costs-Mov. Equip.       Percentage of Time       16       17         19       Capi	3	Nurses Aides			Hours of Service			3	
6       Dieticians       Hours of Service       0         7       Physicians       Accumulated Cost       77         8       Non-patient Care Salary       Accumulated Cost       77         9       Subtotal (sum of lines 1-8)       2       2         10       Employee Benefits       Salary       10         11       Capital Related Costs-Mov. Equip.       Square Feet       111         12       Capital Related Costs-Mov. Equip.       Percentage of Time       112         13       Machine Costs & Repairs       Percentage of Time       112         14       Supplies       Requisitions       114         15       Drugs       Requisitions       116         16       Other       Accumulated Cost       116         17       Subtotal (sum of lines 9-16)*       117       117         18       Capital Related Costs-Mov. Equip.       Percentage of Time       117         19       Capital Related Costs-Mov. Equip.       Percentage of Time       117         10       Employee Benefits Department       Salary       120         20       Employee Benefits Department       Salary       21       21         21       Administrative and General       Acc	4	Technicians			Hours of Service			4	
7PhysiciansAccumulated Cost78Non-patient Care SalaryAccumulated Cost89Subtotal (sun of lines 1-8)9910Employee BenefitsSalary1011Capital Related Costs-Bidgs. & FixturesSquare Feet1112Capital Related Costs-Bidgs. & FixturesSquare Feet1113Machine Costs & RepairsPercentage of Time1214SuppliesRequisitions1415DrugsRequisitions1616OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*201718Capital Related Costs-Mov. Equip.Percentage of Time1719Capital Related Costs-Mov. Equip.Percentage of Time1716OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*201718Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits <i>Department</i> Salary2021Administrative and GeneralAccumulated Cost2123Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2227Subtotal (sun of lines 17-26)*Accumulated Cost2228Laboratory (see instructions)Charges2229Respiratory Therapy	5	Social Workers			Hours of Service			5	
8Non-patient Care SalaryAccumulated Cost89Subtotal (sum of lines 1-8)610Employee BenefitsSalary1011Capital Related Costs-Bldgs. & FixturesSquare Feet1112Capital Related Costs-Mov. Equip.Percentage of Time1113Machine Costs & RepairsPercentage of Time1114SuppliesRequisitions1115DrugsRequisitions1116OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*111618Capital Related Costs-Bldgs. & FixturesSquare Feet1119Capital Related Costs-Bldgs. & FixturesSquare Feet1120Employee Benefits <i>Department</i> Salary2221Administrative and GeneralAccumulated Cost2122Maint-Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs222324Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2227Subtotal (sum of lines 17-26)*2228Laboratory (see instructions)Charges2229Respiratory Therapy (see instructions)Charges22	6	Dieticians			Hours of Service			6	
9       Subtotal (sum of lines 1-8)       9       9         10       Employee Benefits       Salary       10         11       Capital Related Costs-Bldgs. & Fixtures       Square Feet       11         12       Capital Related Costs-Mov. Equip.       Percentage of Time       11         13       Machine Costs & Repairs       Percentage of Time       11         14       Supplies       Requisitions       11         15       Drugs       Requisitions       11         16       Other       Accumulated Cost       16         17       Subtotal (sum of lines 9-16)*       17       17         18       Capital Related Costs-Bldgs. & Fixtures       Square Feet       18         19       Capital Related Costs-Mov. Equip.       Percentage of Time       17         20       Employee Benefits <i>Department</i> Salary       22         21       Administrative and General       Accumulated Cost       21         22       Maint./Repairs-Operation-Housekeeping       Square Feet       22         23       Medical Education Program Costs       22       22       23         24       Central Services & Supplies       Requisitions       22         25       Pharmacy	7	Physicians			Accumulated Cost			7	
10Employee BenefitsSalary1011Capital Related Costs-Bldgs. & FixturesSquare Feet1112Capital Related Costs-Mov. Equip.Percentage of Time1213Machine Costs & RepairsPercentage of Time1314SuppliesRequisitions1415DrugsRequisitions1616OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*91718Capital Related Costs-Bldgs. & FixturesSquare Feet1719Capital Related Costs-Bldgs. & FixturesSquare Feet1610Chrinistrative and GeneralAccumulated Cost2220Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint./Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated Costs2227Subtotal (sum of lines 17-26)*2228Laboratory (see instructions)Charges2229Respiratory Therapy (see instructions)Charges22	8	Non-patient Care Salary			Accumulated Cost			8	
11Capital Related Costs-Bldgs. & FixturesSquare Feet1112Capital Related Costs-Mov. Equip.Percentage of Time1213Machine Costs & RepairsPercentage of Time1214SuppliesRequisitions1415DrugsRequisitions1416OtherAccumulated Cost1617Subtoal (sum of lines 9-16)*Accumulated Cost1718Capital Related Costs-Bldgs. & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits <i>Department</i> Salary2021Administrative and GeneralAccumulated Cost2123Medical Education Program Costs22Requisitions2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2227Subtotal (sum of lines 17-26)*Accumulated Cost2228Laboratory (see instructions)Charges22	9	Subtotal (sum of lines 1-8)						9	
12Capital Related Costs-Mov. Equip.Percentage of Time1113Machine Costs & RepairsPercentage of Time1314SuppliesRequisitions1415DrugsRequisitions1416OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*161718Capital Related Costs-Bldgs. & FixturesSquare Feet1619Capital Related Costs-Mov. Equip.Percentage of Time1620Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint./Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2425ParmacyRequisitions2426Other Allocated CostsAccumulated Cost2228Laboratory (see instructions)Charges2429Respiratory Therapy (see instructions)Charges24	10	Employee Benefits			Salary			10	
13Machine Costs & RepairsPercentage of Time1314SuppliesRequisitions1415DrugsRequisitions1416OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*171818Capital Related Costs-Bldgs. & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2123Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2227Subtotal (sum of lines 17-26)*Charges2229Respiratory Therapy (see instructions)Charges23	11	Capital Related Costs-Bldgs. &	z Fixtures		Square Feet			11	
14SuppliesRequisitions1415DrugsRequisitions1516OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*Accumulated Cost1718Capital Related Costs-Bldgs. & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1620Employee Benefits <i>Department</i> Salary2021Administrative and GeneralAccumulated Cost2122Maint./Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2027Subtotal (sum of lines 17-26)*Charges2229Respiratory Therapy (see instructions)Charges23	12	Capital Related Costs-Mov. Ec	uip.		Percentage of Time			12	
15DrugsRequisitions1516OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*1718Capital Related Costs-Bldgs. & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint./Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*Charges2229Respiratory Therapy (see instructions)Charges23	13	Machine Costs & Repairs			Percentage of Time			13	
16OtherAccumulated Cost1617Subtotal (sum of lines 9-16)*1718Capital Related Costs-Bldgs, & FixturesSquare Feet1819Capital Related Costs-Mov, Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint, Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2426Other Allocated CostsAccumulated Cost2227Subtotal (sum of lines 17-26)*24Charges2529Respiratory Therapy (see instructions)Charges252429Respiratory Therapy (see instructions)Charges25	14	Supplies			Requisitions			14	
17Subtotal (sum of lines 9-16)*1718Capital Related Costs-Bldgs. & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint/Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2225PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2227Subtotal (sum of lines 17-26)*242428Laboratory (see instructions)Charges2429Respiratory Therapy (see instructions)Charges24	15	Drugs			Requisitions			15	
18Capital Related Costs-Bldgs, & FixturesSquare Feet1819Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint./Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2425PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2027Subtotal (sum of lines 17-26)*Accumulated Cost2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	16	Other			Accumulated Cost			16	
19Capital Related Costs-Mov. Equip.Percentage of Time1920Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint/Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2224Central Services & SuppliesRequisitions2425PharmacyRequisitions2226Other Allocated CostsAccumulated Cost2027Subtotal (sum of lines 17-26)*Accumulated Cost2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	17	Subtotal (sum of lines 9-16)*						17	
20Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint/Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2324Central Services & SuppliesRequisitions2425PharmacyRequisitions2526Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	18	Capital Related Costs-Bldgs. &	z Fixtures		Square Feet			18	
20Employee Benefits DepartmentSalary2021Administrative and GeneralAccumulated Cost2122Maint/Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2324Central Services & SuppliesRequisitions2425PharmacyRequisitions2426Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*242728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	19	Capital Related Costs-Mov. Ec	Juip.		Percentage of Time			19	
22Maint/Repairs-Operation-HousekeepingSquare Feet2223Medical Education Program Costs2324Central Services & SuppliesRequisitions2425PharmacyRequisitions2426Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*2628Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	20	Employee Benefits Departmen	t					20	
23Medical Education Program Costs2324Central Services & SuppliesRequisitions2425PharmacyRequisitions2526Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*262728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	21	Administrative and General			Accumulated Cost			21	
24Central Services & SuppliesRequisitions2425PharmacyRequisitions2526Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*02728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	22	Maint./Repairs-Operation-Hou	sekeeping		Square Feet			22	
25PharmacyRequisitions2526Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*272828Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	23	Medical Education Program Co	osts					23	
26Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	24	Central Services & Supplies			Requisitions			24	
26Other Allocated CostsAccumulated Cost2627Subtotal (sum of lines 17-26)*2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	25	Pharmacy			Requisitions			25	
27Subtotal (sum of lines 17-26)*2728Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29	26	Other Allocated Costs						26	
28Laboratory (see instructions)Charges2829Respiratory Therapy (see instructions)Charges29								27	
29 Respiratory Therapy (see instructions)   Charges   29		· · · · · /			Charges			28	
	29		uctions)		ě			29	
	30				ě.			30	
31 Total costs (sum of lines 27-30) 31			)					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 26 for line 74 or line 94 as appropriate.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4048) Rev. 4

# 4090 (Cont.)

## FORM CMS-2552-10

ALLOCATION OF RENAL DEPARTMENT COST	S TO TREATMEN	NT MODALITIES	5			PROVIDER C	CCN:	PERIOD: FROM TO		WORKSHEET	I-2	
Check applicable box:	[] Renal Dial	ysis Department	[] Home I	Program Dialysi	s							
OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPITA RELATE BUILDING	AL AND D COSTS EQUIPMENT	CARE S RNs	PATIENT GALARY OTHER	EMPLOYEE BENEFITS DEPARTMENT	DRUGS	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
	1	2	3	4	5	6	7	8	9	10	11	+
1 Total Renal Department Costs												<u> </u>
MAINTENANCE												<u> </u>
2 Hemodialysis												2
3 Intermittent Peritoneal												3
TRAINING												<del></del>
4 Hemodialysis 5 Intermittent Peritoneal												4
												5
6 CAPD 7 CCDP												6
HOME												
8 Hemodialysis												8
9 Intermittent Peritoneal												9
10 CAPD												10
11 CCDP												11
OTHER BILLABLE SERVICES												- 11
12 Inpatient Dialysis												12
13 Method II Home Patient					1		1	1				13
14 EPO (included in Renal Department)												14
15 ARENESP (included in Renal Department)												15
16 Other												16
17 Total (sum of lines 2-16)												17
18 Medical Educational Program Costs												18
19 Total Renal Costs (line 17 + line 18)												19

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4049) 40-618

09-13 DIRECT AND INDIRECT RENAL DIALYSIS CO STATISTICAL BASIS	OST ALLOCATION	ION - Dialysis Department [] Home Program Dialysis				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET I-3		ont.
Check applicable box:	[] Renal Dia	lysis Department	[] Home I	Program Dialysis	s							
COMPOSITE PAYMENT SERVICES		CAPITA RELATE	AL AND	DIRECT	PATIENT SALARY OTHERS (HOURS) 4	EMPLOYEE BENEFITS DEPARTMENT (SALARY) 5	DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUB- TOTAL 9	OVERHEAD (ACCUM. COST) 10	
1 Total Renal Department Costs		1	2	5		5	0	,	0	,	10	1
MAINTENANCE												⊢÷
2 Hemodialysis												2
3 Intermittent Peritoneal												3
TRAINING												
4 Hemodialysis												4
5 Intermittent Peritoneal												5
6 CAPD												e
7 CCDP												7
HOME												
8 Hemodialysis												8
9 Intermittent Peritoneal												9
10 CAPD												10
11 CCDP												11
OTHER BILLABLE SERVICES												
12 Inpatient Dialysis Treatments												12
13 Method II Home Patient												13
14 EPO												14
15 ARENESP												15
16 Other												16
17 Total Statistical Basis												17
18 Unit Cost Multiplier (line 1 ÷ line 17)												18

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4050) Rev. 4

409	) (Cont.)	FORM	A CMS-25	552-10										0	9-13
	PUTATION OF AVERAGE COST PER TREATMENT DUTPATIENT RENAL DIALYSIS					PROVIDER CO	CN:			PERIOD: FROM TO				WORKSHEET	[-4
Check	applicable box: [] Renal Dialysis Depart	ment []Ho	ome Program I	Dialysis		-	-	-			-		-	-	
		Number of Total Treatments		Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments	Number of Program Treatments	Total Program Expenses ( <i>see instructions</i> )	Total Program Payment	Total Program Payment		Average Payment Rate (col. 6 ÷ col. 4)	· · · · · ·	Average Payment Rate (col. 6.02 ÷ col. 4.02)	
		1	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	<u> </u>
- 1	Maintenance - Hemodialysis Maintenance - Peritoneal Dialysis														2
3	Training - Hemodialysis														3
4	Training - Peritoneal Dialysis														4
5	Training - Continuous Ambulatory Peritoneal Dialysis														5
6	Training - Continuous Cycling Peritoneal Dialysis														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis														8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
10	Home Program - Continuous Cycling Peritoneal Dialysis														10
11	Totals (sum of lines 1 through 8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and $6$ )														11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))														12

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4051) 40-620

09-13	FORM CMS-255	52-10		4090 (Cont.)
CALCULATION OF REIMBURSABLE		PROVIDER CCN:	PERIOD:	WORKSHEET I-5
BAD DEBTS - TITLE XVIII - PART B			FROM	
			то	

## Description

1	Total expenses related to care of program beneficiaries (see instructions)			1
		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	Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments			2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)			3
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)			3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)			4
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)			4.03
5	Bad debts for deductibles and coinsurance, net of bad debt recoveries			5
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.01
	services rendered on or after 1/1/2011 but before 1/1/2012			
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.02
	services rendered on or after 1/1/2012 but before 1/1/2013			
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.03
	services rendered on or after 1/1/2013 but before 1/1/2014			
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for			5.04
	services rendered on or after 1/1/2014			
5.05	Total bad debts (sum of line 5 through line 5.04)			5.05
6	Allowable bad debts (see instructions)			6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			7
8	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)			8
9	Program payment (see instructions)			9
10	Unrecovered from Medicare (Part B) patients (see instructions)			10
11	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)			11

PAR	T II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE	
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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4052) Rev. 4

4090	) (Cont.)	FOR	M CMS-2	552-10						0	9-13
	CATION OF GENERAL SERVICE COSTS TO MUNITY MENTAL HEALTH CENTERS			PROVID	ER CCN:		PERIOD: FROM		WORKSHEET PART I	ſJ-1,	
				COMPO	NENT CCN:		TO				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY	MENTAL HEALTH CE	NTER COST	CENTER	s				•		
		NET									
		EXPENSES	CAPI	TAL							l
	COMPONENT COST CENTER	FOR COST	RELATED	COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	l
	(omit cents)	ALLOCATION	BLDGS. &	MOVABL	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE	OPERATION	& LINEN	l
		(see instru.)	FIXTURES	QUIPMEN	DEPARTMENT	(cols. 0-4)	GENERAL	& REPAIRS	OF PLANT	SERVICE	l
		0	1	2	4	4A	5	6	7	8	I
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
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
10	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)(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.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4053.1) 40-622

10-1	2			FOF	RM CMS-25	552-10						4090 (C	ont.)
ALLC	CATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEE	Г J-1,	
COM	MUNITY MENTAL HEALTH CENTERS								FROM		PART I (CON	T.)	
						COMPONEN	Г CCN:		ТО				
PART	<b>TI - ALLOCATION OF GENERAL SERVICE</b>	COSTS TO CO	MMUNITY M	ENTAL HEAI	TH CENTER	COST CENTE	RS						
													i i
					MAIN-		CENTRAL		MEDICAL			NON-	
	COMPONENT COST CENTER				TENANCE	NURSING	SERVICES		RECORDS		OTHER	PHYSICIAN	
	(omit cents)	HOUSE-			OF	ADMINIS-	&		&	SOCIAL	GENERAL	ANES-	l l
		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
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
17	Medical Supplies												17
18	Medical Appliances												18
19	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others												21
22	Totals (sum of lines 1-21)(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.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4053.1) Rev. 3

4090	(Cont.)	FOI	RM CMS-25	52-10						1	0-12
	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS			PROVIDER CO	'N:		PERIOD: FROM		WORKSHEET . PART I (CONT	,	
				COMPONENT	CCN:		то				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUN	ITY MENTAL	HEALTH CEN	FER COST CEN	TERS						
							INTERN &				
					PARA-		RESIDENT		ALLOCATED		
	COMPONENT COST CENTER			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.	
		SCHOOL	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	
		20	21	22	23	24	25	26	27	28	
	Administrative and General										1
	Skilled Nursing Care										2
	Physical Therapy										3
	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
7	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
17	Medical Supplies										17
18	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4053.1) 40-624

09-13		FORM CM	<b>4</b> S-2552-10						4090 (C	ont.)
ALLOCATION OF GENERAL SERVICE COSTS TO			PROVIDER C	CN:		PERIOD:		WORKSHEET	J-1,	
COMMUNITY MENTAL HEALTH CENTERS						FROM		PART II		
			COMPONENT	Г ССN:		ТО				
PART II - ALLOCATION OF GENERAL SERVICE COSTS TO CO	OMMUNITY MENTAL HEAD	LTH CENTER	COST CENTE	RS - STATIST	ICAL BASIS					
		CAF	ITAL							1
		RELAT	ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	ł
		BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN	ł
CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	SERVICE	l
(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	l
		FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	i i
	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
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

4090	) (Cont.)				FORM CM	IS-2552-10						0	9-13
ALLC	CATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEET	Г Ј-1,	
COM	MUNITY MENTAL HEALTH CENTERS								FROM		PART II (CON	JT.)	
						COMPONENT	Г ССN:		то				
PART	II - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY N	IENTAL HEAI	LTH CENTER	COST CENTE	RS - STATIST	ICAL BASIS					
					MAIN-							NON-	
					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
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	5												16
17	Medical Supplies												17
18	Medical Appliances												18
19	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others												21
22	Totals (sum of lines 1-21)												22
23	Total Cost to be Allocated												23
24	Unit Cost Multiplier (see instructions)												24

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4053.2) 40-626

10-12				FORM CMS	-2552-10					4090 (0	Cont.)
	N OF GENERAL SERVICE COSTS TO Y MENTAL HEALTH CENTERS			PROVIDER CC		_	PERIOD: FROM TO		WORKSHEET J PART II (CONT.	,	
PART IL AL	LOCATION OF GENERAL SERVICE COSTS T		MENTAL HEA								
TAKI II-AL	LIOCATION OF GENERAL SERVICE COSTS I		I WIENTAL HEA		PARA-	STATISTICAL	DASIS	1	1		<b>—</b>
	CORF COST CENTER (omit cents)	NURSING SCHOOL (ASSIGNED	INTERNS & SALARY & FRINGES (ASSIGNED	RESIDENTS PROGRAM COSTS (ASSIGNED	MEDICAL EDUCATION (SPECIFY) (ASSIGNED						
	(onit conts)	TIME)	TIME)	TIME)	TIME)						
		20	21	22	23	24	25	26	27	28	-
1 Adminis	strative and General										1
2 Skilled l	Nursing Care										2
3 Physical	l Therapy										3
4 Occupat	tional Therapy										4
5 Speech	Pathology										5
6 Medical	l Social Services										6
7 Respirat	tory Therapy										7
8 Psychiat	tric/Psychological Services										8
9 Individu	ual Therapy										9
10 Group T	Therapy										10
11 Individu	ualized Activity Therapies										11
12 Family	Counseling										12
13 Diagnos	stic Services										13
14 Approve	ed Patient Training & Education										14
15 Prosthet	tic and Orthotic Devices										15
16 Drugs a	and Biologicals										16
17 Medical	l Supplies										17
18 Medical	1 Appliances										18
19 Durable	e Medical Equipment-Rented										19
20 Durable	e Medical Equipment-Sold										20
21 All Othe	ers										21
22 Totals (s	(sum of lines 1-21)										22
23 Total Co	ost to be Allocated										23
24 Unit Co	ost Multiplier (see instructions)										24

409	0 (Cont.)		FOF	RM CMS-255	2-10					1	0-12
COM	PUTATION OF COMMUNITY MENTAL HEALTH CENTE		PROVIDER CCM	N:	_	PERIOD: FROM TO		WORKSHEET J PART I	-2,		
PART	I - APPORTIONMENT OF CMHC COST CENTERS										
		(From		Ratio of		Title V		Title XVIII		Title XIX	
		Wkst. J-1, Part I, col. 28)	Total Component Charges	Costs to Charges (col. 1 ÷ col. 2)	Title V Component Charges	Component Costs (col. 3 x col. 4)	Title XVIII Component Charges	Component Costs (col. 3 x col. 6)	Title XIX Component Charges	Component Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	1
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
	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 1-19)										20

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

09-13	FORM CMS-2552-10	.10				
COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS		PERIOD: FROM	WORKSHEET J-2, PART II			
	COMPONENT CCN:	ТО				

#### PART II - APPORTIONMENT OF COST OF CMHC PROVIDER SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		(From				Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Ratio of	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Part 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 Part I, line 20										29
	and the amounts from line 28, columns 5, 7, and 9. (3)										

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

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

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

4090 (Cont.)	FORM CM	<b>I</b> S-2552-10			09-13
CALCULATION OF REIMBURSEMENT SET	TLEMENT COMMUNITY	PROVIDER CCN:	PERIOD:	WORKSHEET J-3	
MENTAL HEALTH CENTER PROVIDER SE	RVICES		FROM		
		COMPONENT CCN:	то		
Check			-		

applicable	[] Title V	[] Title XVIII	[] Title XIX
boxes:			

		PROGRAM	
		COST	
1	Cost of component services (from Worksheet J-2, Part II, line 29)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
6	Total charges for program services		6
	CUSTOMARY CHARGES		
7	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge		8
	basis had such payment been made in accordance with 42 CFR 413.13(e)		8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
10	Total customary charges (see instructions)		10
11	Excess of customary charges over reasonable cost (see instructions)		11
12	Excess of reasonable cost over customary charges (see instructions)		12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
13	Total reasonable cost (from line 5)		13
14	Part B deductible billed to program patients		14
15	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Allowable bad debts (from provider records) (see instructions)		21
22	Adjusted reimbursable bad debts (see instructions)		22
23	Allowable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
26	Total cost (line 24 plus or minus line 25)		26
26.01	Sequestration adjustment (see instructions)		26.01
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program line 26 minus lines 26.01, 27 and 28		29
30	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)		30

10-1	12	FORM CMS-25	52-10		4090 (Cont.)		
		IOSPITAL-BASED COMMUNITY MENTAL HEALTH ERED TO PROGRAM BENEFICIARIES	PROVIDER		PERIOD: FROM	WORKSHEET J-4	
			COMPONE	NT CCN:	то		
Check					•		
applic		[] Title XVIII					
boxes	:					Part B	
	DESCRIPTION				1	2	
	DESCRIPTION				mm/dd/yyyy	Amount	_
1	Total interim payments paid	to providers			nin/dd/yyyy	Tinount	1
2	Interim payments payable on						2
	submitted or to be submitted						
	services rendered in the cost	reporting periods. If					
	none, write "NONE", or ente	er zero.					
3	List separately each retroacti	ve		.01			3.01
	lump sum adjustment amoun	ıt	Program	.02			3.02
	based on subsequent revision	n of	to	.03			3.03
	the interim rate for the		Provider	.04			3.04
	cost reporting period. Also sl	how		.05			3.05
	date of each payment.			.50			3.50
	If none, write "NONE",		Provider	.51			3.51
	or enter zero (1).		to	.52			3.52
			Program	.53			3.53
				.54		_	3.54
	Subtotal (sum of lines 3.01-3						
4	minus sum of lines 3.50-3.98	·		.99			3.99
4	Total interim payments (sum						4
	(transfer to Worksheet J-3, li	me 27)					
	COMPLETED BY INTERM		-			-	
5	List separately each tentative		Program	.01			5.01
	settlement payment after des		to	.02			5.02
	Also show date of each payn	nent.	Provider	.03	-		5.03
	If none, write "NONE,"		Provider	.50			5.50
	or enter zero (1).		to	.51			5.51
		5.40	Program	.52		_	5.52
	Subtotal (sum of lines 5.01-5	5.49 minus		.99			5.00
6	sum of lines 5.50-5.98) Determine net settlement am		Program	.99			5.99
0	(balance due) based on the co		to				
	report (see instructions). (1)		Provider	.01			6.01
	report (see instructions). (1)		to	.01			0.01
			Program	.02			6.02
	1		1 10 grann	.02			0.02
7	Total Medicare liability (see	instructions)					7
8	Name of Contractor	Contractor Number		NPR	Date (Month, Day, Ye	ear)	8

(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.

HOSPICE CC GENE 1 Capita 2 Capita 3 Plant ( 4 Transy 5 Volun 6 Admin INPA' 7 Inpatia 8 Inpatia VISIT 9 Physic 10 Nursin 11 Nursin 12 Physic 13 Occup 14 Speec 15 Medic 16 Spiritu	OF PROVIDER-BASED COSTS COST CENTER DESCRIPTIONS RERAL SERVICE COST CENTERS	SALARIES (from	EMPLOYEE			PROVIDER CCI HOSPICE CCN:			PERIOD: FROM		WORKSHEET	ΓK
GENH 1 Capita 2 Capita 3 Plant ( 4 Transy 5 Volun 6 Admin INPA' 7 Inpatio 8 Inpatio VISIT 9 Physic 10 Nursin 11 Nursin 11 Nursin 12 Physic 13 Occup 14 Speec 15 Medic 16 Spiritu	COST CENTER DESCRIPTIONS					HOSPICE CON-						
GENE GENE GENE GENE GENE GENE GENE GENE				r		HOSPICE CCN-						
GENE GENE GENE GENE GENE GENE GENE GENE						HOSTICE CCN.			ТО			
GENE GENE GENE GENE GENE GENE GENE GENE			DENICETTO		CONTRACTED					I		
GENE GENE GENE GENE GENE GENE GENE GENE		(from	BENEFITS	TRANSPOR-	SERVICES				SUBTOTAL	I	TOTAL	
1       Capitz         2       Capitz         3       Plant (         4       Transg         5       Volun         6       Admin         1       NPA'         7       Inpatit         8       Inpatit         9       Physic         10       Nursir         11       Nursir         12       Physic         13       Occurg         14       Speeci         15       Medic         16       Spiritu         17       Dietar	JERAL SERVICE COST CENTERS	(	(from	TATION	(from		TOTAL	RECLASSI-	(col. 6	ADJUST-	(col. 8	
1       Capitz         2       Capitz         3       Plant (         4       Transg         5       Volun         6       Admin         10       Nursin         11       Nursin         12       Physic         10       Nursin         11       Nursin         12       Physic         13       Occurg         14       Speeci         15       Medic         16       Spiritu         17       Dietar	JERAL SERVICE COST CENTERS	Wkst. K-1)	Wkst. K-2)	(see inst.)	Wkst. K-3)	OTHER	(cols. 1-5)	FICATION	± col. 7)	MENTS	± col. 9)	
1       Capitz         2       Capitz         3       Plant (         4       Transg         5       Volun         6       Admin         10       Nursin         11       Nursin         12       Physic         10       Nursin         11       Nursin         12       Physic         13       Occurg         14       Speeci         15       Medic         16       Spiritu         17       Dietar	JERAL SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	10	_
2 Capita 3 Plant ( 4 Transj 5 Volun 6 Admin INPA' 7 Inpatia 8 Inpatia 9 Physic 10 Nursin 11 Nursin 11 Nursin 12 Physic 13 Occup 14 Speecc 15 Medic 16 Spiritu 17 Dietar												<u> </u>
3 Plant ( 4 Transg 5 Volun 6 Admin INPA' 7 Inpatia 8 Inpatia 9 Physic 10 Nursin 11 Nursin 11 Nursin 12 Physic 13 Occup 14 Speecc 15 Medic 16 Spiritu 17 Dietar	tal Related Costs-Bldg and Fixt.							<b></b>			<b></b>	1
4         Transg           5         Volun           6         Admin           INPA'         T           7         Inpati           8         Inpati           9         Physic           10         Nursin           11         Nursin           12         Physic           13         Occup           14         Speecc           15         Medic           16         Spiritu           17         Dietar	tal Related Costs-Movable Equip.							<b> </b>			───	2
5 Volun 6 Admin INPA' 7 Inpatie 8 Inpatie 9 Physic 10 Nursin 11 Nursin 12 Physic 13 Occup 14 Speec 15 Medic 16 Spiritu	t Operation and Maintenance							<b> </b>			───	3
6         Admin           INPA'         7           7         Inpatio           8         Inpatio           VISIT         9           9         Physic           10         Nursin           11         Nursin           12         Physic           13         Occup           14         Speecl           15         Medic           16         Spiritu           17         Dietar	sportation - Staff							<b></b>			<b></b>	4
INPA' 7 Inpatie 8 Inpatie VISIT 9 Physie 10 Nursir 11 Nursir 12 Physie 13 Occup 14 Speec 15 Medic 16 Spiritu 17 Dietar	Inteer Service Coordination							<b> </b>			<u> </u>	5
7 Inpatie 8 Inpatie VISIT 9 Physie 10 Nursin 11 Nursin 12 Physie 13 Occup 13 Occup 14 Speec 15 Medic 16 Spiritu	ninistrative and General										<u> </u>	6
8 Inpatie VISIT 9 Physic 10 Nursii 11 Nursii 12 Physic 13 Occup 13 Occup 14 Speec 15 Medic 16 Spiritu 17 Dietar	ATIENT CARE SERVICE											<u> </u>
VISTT 9 Physic 10 Nursin 11 Nursin 12 Physic 13 Occup 14 Speec 15 Medic 16 Spiritu 17 Dietar	tient - General Care							┣────			+	7
9Physic10Nursir11Nursir12Physic13Occup14Speeci15Medic16Spiritu17Dietar	tient - Respite Care										<u> </u>	8
10Nursin11Nursin12Physicu13Occup14Speeci15Medici16Spiritu17Dietarr	TING SERVICES											<u> </u>
11Nursin12Physical13Occup14Speech15Medic16Spiritu17Dietarr	sician Services							<b> </b>			───	9
12Physic13Occup14Speech15Medic16Spiritu17Dietar								<b> </b>			───	10
13Occup14Speech15Medic16Spiritu17Dietar	sing Care-Continuous Home Care							<b> </b>			───	11
14Speech15Medic16Spiritu17Dietar	sical Therapy							<b> </b>			<u> </u>	12
15Medic16Spiritu17Dietar	upational Therapy							<b></b>			<b></b>	13
16 Spiritu 17 Dietar	cch/ Language Pathology							<b> </b>			<u> </u>	14
17 Dietar	ical Social Services							<b></b>			<b></b>	15
	itual Counseling							<b></b>			<b></b>	16
18 Couns	ary Counseling							<b> </b>			───	17
10 17	nseling - Other							<b> </b>			───	18
	he Health Aide and Homemaker							<b> </b>			<u> </u>	19
	Aide & Homemaker - Cont. Home Care							<b> </b>				20
21 Other								L			<u> </u>	21
	IER HOSPICE SERVICE COSTS											
	gs, Biological and Infusion Therapy							<b> </b>				22
	gesics							<b> </b>				23
	tives / Hypnotics							<b> </b>			╉─────	25
	er - Specify				<u> </u>			<b> </b>			+	25 26
	able Medical Equipment/Oxygen							<b> </b>			╉─────	26
	ent Transportation			1	ł			l	┨───┤		+	27
	ging Services and Diagnostics			1	ł			l	┨───┤		+	28
	ical Supplies			1	ł			l	┨───┤		+	30
	patient Services (including E/R Dept.)				ł				<u>├</u>		+	30
	ation Therapy				ł				<u>├</u>		+	31
	motherapy										+	33
34 Other					<u> </u>						+	34
	er SPICE NONREIMBURSABLE SERVICE											34
	avement Program Costs									1	1	35
	inteer Program Costs							<b></b>			+	36
	-										+	37
-	traising							l			+	38
39 Total	Iraising er Program Costs		1									- X X

10-12 FC				8-2552-10	4090 (Cont.)					
HOSICE COMPENSATION ANALYSIS				PROVIDER CC	N:		PERIOD:		WORKSHEET	K-1
SALARIES AND WAGES				HOSPICE CCN:			FROM TO			
COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Bldg and Fixt.										1
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								1		14
15 Medical Social Services										15
16 Spiritual Counseling								1		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								1	1	28
29 Labs and Diagnostics				1						29
30 Medical Supplies								1	1	30
31 Outpatient Services (including E/R Dept.)				1				1		31
32 Radiation Therapy								1		32
33 Chemotherapy								1		33
34 Other								1		34
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										35
36 Volunteer Program Costs				1				1		36
37 Fundraising		1	1	1	1			1	1	37
38 Other Program Costs		1	1	1	1			1	1	38
39 Total (sum of lines 1 thru 38)								1		39

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

4090 (Cont.) HOSPICE COMPENSATION ANALYSIS EMPLOYEE								10-12					
			PROVIDER CCN	N:		PERIOD: FROM		WORKSHEET K-2					
			HOSPICE CCN:			то							
ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)					
1	2	3	4	5	6	7	8	9	┿──				
							-		<u> </u>				
									$\frac{1}{2}$				
									2				
									3				
									4				
							-		5				
_									6				
									<u> </u>				
									7				
									8				
									<u> </u>				
									9				
									10				
									11				
									12				
									13				
									14				
									15				
									16				
									17				
									18				
									19				
									20				
									21				
									22				
									23				
									24				
									25				
								1	26				
									27				
									28				
				İ			1		29				
				İ			1		30				
			1						31				
				İ			1		32				
			1						33				
				t			1		34				
									<u> </u>				
						1		1	35				
							1	1	36				
							1	1	37				
			1				+		38				
			1	<del> </del>			+		39				
		ADMINIS- TRATOR DIRECTOR	ADMINIS- TRATOR DIRECTOR WORKERS	HOSPICE CCN: ADMINIS- TRATOR DIRECTOR WORKERS VISORS	PROVIDER CCN:       HOSPICE CCN:       ADMINIS-       TRATOR       DIRECTOR       WORKERS       VISORS       NURSES	PROVIDER CCN:	ADMINIS- TRATOR     MEDICAL SOCIAL     NURSES     TOTAL TOTAL       MEDICAL SOCIAL     SUPER- VISORS     TOTAL	PROVIDER CCN:     PERIOD:       HOSPICE CCN:     TO       HOSPICE CCN:     TO       TO     TO       ADMINIS-     SOCIAL       TRATOR     DIRECTOR       WORKERS     VISORS       NURSES     THERAPISTS       AIDES     ALL OTHER	PROVIDER CCN:     PERIOD:     WORKSHEET I       HOSPICE CCN:     TO     TO       ADMINIS-     MEDICAL     SOCIAL     SUPER-       TRATOR     DIRECTOR     WORKERS     VISORS     NURSES       THERAPISTS     AIDES     ALL OTHER     TOTAL (1)				

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

HOSPICE COMPENSATION ANALYSIS			FORM CM	PROVIDER CCI	N.		PERIOD:	4090 (Cont.) WORKSHEET K-3		
CONTRACTED SERVICES/PURCHASED SERVICES				TROTIDERCE			FROM			
				HOSPICE CCN:			то			
			MEDICAL							Τ
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	
GENERAL SERVICE COST CENTERS										_
1 Capital Related Costs-Bldg and Fixt.										_
2 Capital Related Costs-Movable Equip.										
3 Plant Operation and Maintenance										
4 Transportation - Staff										
5 Volunteer Service Coordination										
6 Administrative and General										(
INPATIENT CARE SERVICE										4
7 Inpatient - General Care										
8 Inpatient - Respite Care										
VISITING SERVICES										
9 Physician Services										
10 Nursing Care										1
11 Nursing Care-Continuous Home Care										1
12 Physical Therapy										1
13 Occupational Therapy										1
14 Speech/ Language Pathology										1
15 Medical Social Services										1
16 Spiritual Counseling										1
17 Dietary Counseling										1
18 Counseling - Other										1
19 Home Health Aide and Homemaker										1
20 HH Aide & Homemaker - Cont. Home Care										2
21 Other										2
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy										2
23 Analgesics										2
24 Sedatives / Hypnotics										2
25 Other - Specify										2
26 Durable Medical Equipment/Oxygen										2
27 Patient Transportation										2
28 Imaging Services										2
29 Labs and Diagnostics										2
30 Medical Supplies										3
31 Outpatient Services (including E/R Dept.)										3
32 Radiation Therapy										3
33 Chemotherapy										3
34 Other										3
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										3
36 Volunteer Program Costs										3
37 Fundraising										3
38 Other Program Costs										3
39 Total (sum of lines 1 thru 38)										3

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

4090	O (Cont.)	FORM CMS	CMS-2552-10						09-13			
COST	ALLOCATION - HOSPICE GENERAL SERVICE COST				PROVIDER CCI	N:		PERIOD: FROM		WORKSHEET K-4, PART I		
					HOSPICE CCN:			то		TARTI		
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	LATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICES COORDI- NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL (col. 5 $\pm$ col. 6) 7		
	GENERAL SERVICE COST CENTERS	0	1	2	3	4	5	5A	6	7	<u> </u>	
1	Capital Related Costs-Bldg and Fixt.										1	
2	Capital Related Costs-Didg and Fixt.										2	
3	Plant Operation and Maintenance										3	
	Transportation - Staff										4	
	Volunteer Service Coordination										5	
											6	
0	INPATIENT CARE SERVICE											
7	Inpatient - General Care				1					1	7	
8	Inpatient - Respite Care	1						1			8	
	VISITING SERVICES										Ť	
9	Physician Services										9	
	Nursing Care										10	
	Nursing Care-Continuous Home Care										11	
	ě – – – – – – – – – – – – – – – – – – –										12	
	Occupational Therapy										13	
	Speech/Language Pathology										14	
-	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							1			21	
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy										22	
23	Analgesics										23	
24	Sedatives / Hypnotics										24	
25	Other - Specify										25	
	Durable Medical Equipment/Oxygen										26	
	Patient Transportation										27	
	Imaging Services										28	
	Labs and Diagnostics										29	
											30	
	Outpatient Services (including E/R Dept.)										31	
32	Radiation Therapy	ļ						ļ			32	
	Chemotherapy	<b> </b>									33	
34	Other	L									34	
	HOSPICE NONREIMBURSABLE SERVICE										<b>-</b>	
-	Bereavement Program Costs	ł			ł			<b> </b>			35	
	•	ł			ł			<b> </b>			36	
	Fundraising	<del> </del>									37	
38	Other Program Costs	<b> </b>						<b> </b>			38	
39	Total (sum of lines 1 thru 38)										39	

09-13	FORM CMS-	-2552-10		4090 (Cont.)				
COST ALLOCATION - HOSPICE STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET K- PART II	4,
			HOSPICE CCN:		то			
	CAPITAL RE	LATED COST	PLANT		VOLUNTEER		ADMINIS-	
	BUILDINGS	MOVABLE	OPERATION	TRANS-	SERVICES		TRATIVE &	
COST CENTER DESCRIPTIONS	& FIXTURES	EQUIPMENT	& MAINT.	PORTATION	COORDINATOR	RECONCIL-	GENERAL	
	(SQ. FT.)	(\$ VALUE)	(SQ. FT.)	(MILEAGE)	(HOURS)	IATION	(ACC. COST)	
	1	2	3	4	5	6A	6	-
GENERAL SERVICE COST CENTERS			-					1
1 Capital Related Costs-Bldg and Fixt.								1
2 Capital Related Costs-Movable Equip.								2
3 Plant Operation and Maintenance								3
4 Transportation - Staff								5
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			1				<b> </b>	28
29 Labs and Diagnostics								29
30 Medical Supplies								30
31 Outpatient Services (including E/R Dept.)								31
32 Radiation Therapy								32
33 Chemotherapy								33
34 Other								34
HOSPICE NONREIMBURSABLE SERVICE								
35 Bereavement Program Costs			1	ļ				35
36 Volunteer Program Costs								36
37 Fundraising			1	ļ				37
38 Other Program Costs			1	ļ				38
39 Cost To be Allocated (per Wkst. K-4, Part I)								39
40 Unit Cost Multiplier								40

4090	) (Cont.)		FC	ORM CMS-2	2552-10					0	9-13
	CATION OF GENERAL SERVICE				PROVIDER CO	CN:		PERIOD:		WORKSHEET K-5,	
COST	S TO HOSPICE COST CENTERS					_		FROM		PART I	
					HOSPICE CCN	l:		ТО			
PAR	1 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSP	ICE COST CENT	TERS	r		r		r	r	1	
		From	HOSPICE	CAL	PITAL						
	HOSPICE COST CENTER	Wkst. K-4	TRIAL	RELATI	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
2	Inpatient - General Care	7									2
3	Inpatient - Respite Care	8									3
4	Physician Services	9									4
5	Nursing Care	10									5
6	Nursing Care-Continuous Home Care	11									6
7	Physical Therapy	12									7
8	Occupational Therapy	13									8
9	Speech/ Language Pathology	14									9
10	Medical Social Services	15									10
11	Spiritual Counseling	16									11
12	Dietary Counseling	17									12
13	Counseling - Other	18									13
14	Home Health Aide and Homemaker	19									14
15	HH Aide & Homemaker - Cont. Home Care	20									15
16	Other	21									16
17	Drugs, Biological and Infusion Therapy	22									17
18	Analgesics	23									18
19	Sedatives / Hypnotics	24									19
20	Other - Specify	25									20
21	Durable Medical Equipment/Oxygen	26									21
22	Patient Transportation	27									22
23	Imaging Services	28									23
24	Labs and Diagnostics	29									24
25	Medical Supplies	30									25
26	Outpatient Services (including E/R Dept.)	31									26
27	Radiation Therapy	32									27
28	Chemotherapy	33									28
29	Other	34									29
30	Bereavement Program Costs	35									30
31	Volunteer Program Costs	36									31
32	Fundraising	37									32
33	Other Program Costs	38									33
34	Totals (sum of lines 1-33) (2)										34
35	Unit Cost Multiplier (see instructions)										35

(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.

10-1	2			FC	ORM CMS-2	552-10			4090 (Con			
	CATION OF GENERAL SERVICE 'S TO HOSPICE COST CENTERS					PROVIDER CC	CN:		PERIOD: FROM TO		WORKSHEET PART I (Cont.)	,
PART	<b>FI - ALLOCATION OF GENERAL SERVICE C</b>	COSTS TO HOSPIC	CE COST CENT	ERS		HODI ICE CEI	•		10			
	HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
1	Administrative and General	0	,	10		12	15	14	15	10	17	1
2	Inpatient - General Care											2
3	Inpatient - Respite Care											3
4	Physician Services											4
5	Nursing Care											5
6	Nursing Care-Continuous Home Care					<u> </u>		<u> </u>	<u> </u>	<u> </u>		6
7	Physical Therapy											7
												_
	Occupational Therapy											8
9	Speech/ Language Pathology											9
10	Medical Social Services											10
11	Spiritual Counseling											11
12	Dietary Counseling											12
	Counseling - Other											13
	Home Health Aide and Homemaker											14
15	HH Aide & Homemaker - Cont. Home Care											15
16	Other											16
17	6, 6 17											17
18	Analgesics											18
19	Sedatives / Hypnotics											19
20	Other - Specify											20
21	Durable Medical Equipment/Oxygen											21
22	Patient Transportation				ļ					ļ		22
23	Imaging Services									ļ		23
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (including E/R Dept.)											26
27	Radiation Therapy											27
28	Chemotherapy											28
29	Other											29
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
32	Fundraising											32
33	Other Program Costs											33
34												34
35	Unit Cost Multiplier (see instructions)											35

(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.

4090							MS-2552-10						10-12	
ALLC	CATION OF GENERAL SERVICE						PROVIDER C	CN:		PERIOD:		WORKSHEET	Г К-5,	
COST	S TO HOSPICE COST CENTERS									FROM		PART I (Cont.	.)	
							HOSPICE CC	N:		то				
PART	I - ALLOCATION OF GENERAL SERVICE	COSTS TO HO	SPICE COST	CENTERS										
									INTERN &					
			NON-				PARA-		RESIDENT		ALLOCATED	TOTAL		
	HOSPICE COST CENTER	OTHER	PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL		COST & POST	ſ	HOSPICE	HOSPICE		
	(omit cents)	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	SUBTOTAL	STEPDOWN	SUBTOTAL	A&G (see	COSTS		
		SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)	ADJUST.	$(cols. 24 \pm 25)$	Part II)	$(cols. \frac{26 \pm 27}{20})$	1	
		`8	19	20	21	22	23	24	25	26	27	28		
1	Administrative and General												1	
2	Inpatient - General Care												2	
3	Inpatient - Respite Care												3	
4	Physician Services												4	
5	Nursing Care												5	
6	Nursing Care-Continuous Home Care												6	
7	Physical Therapy												7	
8	Occupational Therapy												8	
9	Speech/ Language Pathology		1		1								9	
10	Medical Social Services												10	
11	Spiritual Counseling												11	
12	Dietary Counseling		1		1								12	
13	Counseling - Other												13	
14	Home Health Aide and Homemaker		1		1								14	
15	HH Aide & Homemaker - Cont. Home Care		1		1								15	
16													16	
17	Drugs, Biological and Infusion Therapy		1		1								17	
18	Analgesics		1		1								18	
19	Sedatives / Hypnotics												19	
20	Other - Specify												20	
21	Durable Medical Equipment/Oxygen												21	
	Patient Transportation												22	
23	Imaging Services												23	
24	Labs and Diagnostics												24	
25	Medical Supplies												25	
26	Outpatient Services (including E/R Dept.)												26	
27	Radiation Therapy												27	
28	Chemotherapy												28	
29	Other												29	
30	Bereavement Program Costs												30	
31	Volunteer Program Costs												31	
32	Fundraising												32	
33	Other Program Costs												33	
34	Totals (sum of lines 1-33) (2)												34	
35	Unit Cost Multiplier (see instructions)												35	

(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.

09-1	3	RM CMS-255	2-10		4090 (Cont.)				
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CCN		PERIOD:		WORKSHEET K	-5,
HOSP	ICE COST CENTERS STATISTICAL BASIS					FROM		PART II	
				HOSPICE CCN:		то			
PART	II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE	E COST CENTERS - STATISTI	ICAL BASIS						
		CAF	PITAL						
		RELAT	ED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
	HOSPICE 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	<u>5</u> A	5	6	7	
1									1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
	Nursing Care-Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
9									9
	Medical Social Services								10
11	1 0								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care								15
16									16
	Drugs, Biological and Infusion Therapy								17
18									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
28	Chemotherapy								28
29									29
30	Bereavement Program Costs								30
31									31
32	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)								36

4090 (Cont.)			FO	RM CMS-255	52-10				0	)9-13
ALLOCATION OF GENERAL SERVICE COST HOSPICE COST CENTERS STATISTICAL BAS					PROVIDER CCN HOSPICE CCN:	:	PERIOD: FROM TO			-5,
PART II - ALLOCATION OF GENERAL SEI	DVICE COSTS TO HOS	DICE COST CEN	TEDS STATIST	ICAL DASIS	HOSPICE CCN:		10			
FART II - ALLOCATION OF GENERAL SEE	WICE COSTS TO HOS	FICE COST CEN	1EK5 - 51A1151	ICAL BASIS						1
HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1 Administrative and General	0	<i></i>	10		12	10		10	10	1
2 Inpatient - General Care										2
3 Inpatient - Respite Care										3
4 Physician Services										4
5 Nursing Care								1		5
6 Nursing Care-Continuous Home Care										6
7 Physical Therapy										7
8 Occupational Therapy										8
9 Speech/ Language Pathology										9
10 Medical Social Services										10
11 Spiritual Counseling										11
12 Dietary Counseling										12
13 Counseling - Other										13
14 Home Health Aide and Homemaker										14
15 HH Aide & Homemaker - Cont. Home Car	re									15
16 Other										16
17 Drugs, Biological and Infusion Therapy										17
18 Analgesics								1		18
19 Sedatives / Hypnotics								1		19
20 Other - Specify								1		20
21 Durable Medical Equipment/Oxygen										21
22 Patient Transportation										22
23 Imaging Services										23
24 Labs and Diagnostics										24
25 Medical Supplies										25
26 Outpatient Services (including E/R Dept.)										26
27 Radiation Therapy										27
28 Chemotherapy										28
29 Other										29
30 Bereavement Program Costs										30
31 Volunteer Program Costs										31
32 Fundraising										32
33 Other Program Costs										33
34 Totals (sum of lines 1-33) (2)										34
35 Total cost to be allocated										35
36 Unit Cost Multiplier (see instructions)										36

10-1	2	CMS-2552-10	)		4090 (Cont.)				
	CATION OF GENERAL SERVICE COSTS TO ICE COST CENTERS STATISTICAL BASIS			PROVIDER CCN	:	PERIOD: FROM		WORKSHEET K PART II (Cont.)	-5,
				HOSPICE CCN:		ТО			
PART	<b>FII - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST</b>	CENTERS STATIST	ICAL BASIS						
				NON- PHYSICIAN		INTERNS &	RESIDENTS	PARA- MEDICAL	
	HOSPICE COST CENTER	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	ANES- THETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	SALARY & FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)	EDUCATION (SPECIFY) (ASSIGNED TIME)	
- 1		17	18	19	20	21	22	23	
	Administrative and General								1
_	Inpatient - General Care								2
	Inpatient - Respite Care		<del> </del>			1	<del> </del>		3
	Physician Services								4
_	Nursing Care		<b> </b>				l		5
	Nursing Care-Continuous Home Care								6
7	- 1								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemaker								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biological and Infusion Therapy								17
18	Analgesics								18
19	Sedatives / Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26			1				1		26
27			1				1	1	27
28	Chemotherapy								28
29									29
	Bereavement Program Costs		İ				İ		30
	Volunteer Program Costs		1			1			31
	Fundraising		İ				İ		32
	Other Program Costs		1			1	1		33
34	ž – – – – – – – – – – – – – – – – – – –		1			1			34
35			1	1	1	1	1	1	35
	Unit Cost Multiplier (see instructions)		1				1		36
50	ent cost multiplier (see instructions)			1	1	1	I	1	50

4090 (Cont.)	FORM CMS-2	552-10			10-12		
APPORTIONMENT OF HOSPICE SHARED SERVIC			PERIOD: FROM		WORKSHEET K-5 PART III	,	
	HOSPICE CCN:		ТО				
PART III - COMPUTATION OF TOTAL HOSPICE SI	HARED COSTS	-		1			
COST CENTER		Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)		
		0	1	2	3	<u> </u>	
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	

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

4090 (Cont.)			FORM C	CMS-2552-10				10-12
CALC	ULATION OF CAPITAL PA	AYMENT	PROVIDER CCN:		PERIOD:		WORKSHEET L	
					FROM			
			COMPONENT CCM	N:	то			
Check		[] Title V		[] Hospital		[] PPS		
applical	ble	[] Title XVIII, Pa	art A	[] Subprovider (or	ther)	[] Cost Method		
boxes:		[] Title XIX			,			
PART	I - FULLY PROSPECTIV	VE METHOD		-				
	CAPITAL FEDERAL AMO	DUNT						
1	Capital DRG other than out	tlier						1
2	Capital DRG outlier payme	ents						2
3	Total inpatient days divided	d by number of days i	in the cost reporting peri	iod (see instructions)				3
4	Number of interns & reside	ents (see instructions)						4
5	Indirect medical education	percentage (see instr	uctions)					5
6	Indirect medical education	adjustment (line 1 tin	nes line 5)					6
7	Percentage of SSI recipient	patient days to Medi	care Part A patient days	(Worksheet E, Part A	line 30) (see instru	actions)		7
8	Percentage of Medicaid pat	tient days to total day	s (see instructions)					8
9	Sum of lines 7 and 8							9
10	Allowable disproportionate	share percentage (se	e instructions)					10
11	Disproportionate share adju							11
12								12
PART	II - PAYMENT UNDER I							
1	Program inpatient routine c	1						1
2	Program inpatient ancillary	1					_	2
3	Total inpatient program cap	-	line 2)					3
4	Capital cost payment factor						_	4
	Total inpatient program cap							5
-	III - COMPUTATION O						-	
1	Program inpatient capital co						_	1
2	Program inpatient capital co			tructions)			_	2
3	Net program inpatient capit						_	3
4	Applicable exception perce						_	4
5	Capital cost for comparison							5
6	Percentage adjustment for e	,		,				6
7	Adjustment to capital minir			stances (line 2 x line 6)				7
8	Capital minimum payment						-	8
-	Current year capital paymen		**		- 0)		-	
10	Current year comparison of Carryover of accumulated of				e 9)		+	10
11			inent ievei ovei capitai p	bayment				11
12	(from prior year Worksheet Net comparison of capital r		vel to canital navmente (	(line 10 plus line 11)				12
12	Current year exception pays						+	12
13	Carryover of accumulated of						+	13
14	for the following period (if							14
15	Current year allowable ope	ě.					1	15
16		<u> </u>		,				15
17	Current year operating and Current year exception offs	· · ·					1	10
	,, j enception ons	(see instit	,					

09-1	3		FORM CMS	8-2552-10					4090 (C	ont.)
ALLO	CATION OF ALLOWABLE COSTS FOR				PROVIDER CC	N:	PERIOD:		WORKSHEET I	1,
EXTR	AORDINARY CIRCUMSTANCES						FROM		PART I	
							то			
		EXTRA-		PITAL						
		ORDINARY	RELATE	ED COSTS						
		CAPITAL	DI D.C.C.	MOULDE	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-	ODED ATION	
	Cost Center Descriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION	
		COSTS 0	FIXTURES 1	EQUIPMENT 2	cols. 0-2) 2A	DEPARTMENT 4	GENERAL 5	REPAIRS 6	OF PLANT 7	1
	GENERAL SERVICE COST CENTERS	0	1	2	ZA	4	3	0	/	<u> </u>
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			1	1	İ			1	6
7	Operation of Plant					1				7
8	Laundry and Linen Service			İ	1	İ			1	8
9	Housekeeping									9
10	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
16	Medical Records & Medical Records Library									16
17	Social Service					1				17
18	Other General Service (specify)					1				18
19	Nonphysician Anesthetists					1				19
20	Nursing School									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									0
30										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
40	Subprovider IPF				ļ	ļ			ļ	40
41	Subprovider IRF									41
42	Subprovider									42
43	Nursery									43
										44
45	Nursing Facility									45
46	Other Long Term Care									46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 4

4690	0 (Cont.)		FORM CMS	8-2552-10					0	9-13
	OCATION OF ALLOWABLE COSTS FOR RAORDINARY CIRCUMSTANCES				PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET I PART I (Cont.)	1,
		EXTRA- ORDINARY		PITAL ED 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 6	OPERATION OF PLANT 7	-
	ANCILLARY SERVICE COST CENTERS	0	1	2	ZA	4	5	0	/	
50	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic			1	1	1	1	1	1	54
	Radiology-Therapeutic					1		1		55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59										59
60	Laboratory									60
	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.					1		1		63
64	Intravenous Therapy					1		1		64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients			ļ						73
	Renal Dialysis			ļ						74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									0
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
90										90
91										91
92										92
93	Other Outpatient (specify)									93

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) 40-648

09-1	13	FORM CMS	8-2552-10		4090 (C	Cont.)				
	CATION OF ALLOWABLE COSTS FOR RAORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET I PART I (Cont.)	L-1,
		EXTRA- ORDINARY		PITAL ED COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	2A	4	5	6	7	
	OTHER REIMBURSABLE COST CENTERS									<u> </u>
	Home Program Dialysis									94
95										95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold					ļ		ļ		97
98										98
99										99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
	SPECIAL PURPOSE COST CENTERS									0
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 1-117)									118
	NONREIMBURSABLE COST CENTERS									0
	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
	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 of line 118 and lines190-201)									202
203	Total Statistical Basis									203
204	Unit Cost Multiplier									204

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 4

4090 (Cont.)			FORM CM	AS-2552-10						(	09-13
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES						PROVIDER	CCN:	PERIOD: FROM TO		WORKSHEE PART I (Con	
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	8	9	10	11	12	15	14	15	10	17	
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment											2
4 Employee Benefits <i>Department</i>											4
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping			1								9
10 Dietary											10
11 Cafeteria											11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply								1			14
15 Pharmacy											15
16 Medical Records & Medical Records Library										1	16
17 Social Service								1			17
18 Other General Service (specify)								1			18
19 Nonphysician Anesthetists								1			19
20 Nursing School											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Ed. Program (specify)											23
0 INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) 40-650

LLOCATION OF ALLOWABLE COSTS FOR (TRAORDINARY CIRCUMSTANCES						PROVIDER C	CCN:	PERIOD: FROM TO		4090 (C WORKSHEE PART I (Cont	ET L-1
Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	8	9	10	11	12	13	14	15	16	17	1
ANCILLARY SERVICE COST CENTERS											_
50 Operating Room											
51 Recovery Room											:
52 Labor Room and Delivery Room											1
53 Anesthesiology							L				
54 Radiology-Diagnostic											
55 Radiology-Therapeutic											
56 Radioisotope											
57 Computed Tomography (CT) Scan											
58 Magnetic Resonance Imaging (MRI)											
59 Cardiac Catherization											
60 Laboratory											
61 PBP Clinical Laboratory Service-Program Only											
62 Whole Blood & Packed Red Blood Cells											
63 Blood Storing, Processing, & Trans.											
64 Intravenous Therapy											
65 Respiratory Therapy											
66 Physical Therapy											
67 Occupational Therapy						1					
68 Speech Pathology											
69 Electrocardiology											
70 Electroencephalography											
71 Medical Supplies Charged to Patients											
72 Implantable Devices Charged to Patients			l					1			
73 Drugs Charged to Patients			1					1			
74 Renal Dialysis			1					1			
75 ASC (Non-Distinct Part)			1					1			
76 Other Ancillary (specify)			İ	İ		1	1	İ		İ	
0 OUTPATIENT SERVICE COST CENTERS											t-
88 Rural Health Clinic (RHC)											
89 Federally Qualified Health Center (FQHC)			1					1			
90 Clinic			1			1	1	1			
91 Emergency			<u> </u>			1	1	<u> </u>			-
92 Observation Beds											
93 Other Outpatient (specify)											

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 3

4090 (Cont.)				10-12							
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES						PROVIDER O	CCN:	PERIOD: FROM TO		WORKSHEE PART I (Cont	
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
OTHER REIMBURSABLE COST CENTERS	8	2	10	- 11	12	15	14	15	10	17	
94 Home Program Dialysis											94
95 Ambulance Services		-									95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold			1			1	1	1		1	97
98 Other Reimbursable (specify)							1	1		1	98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)							1	1		1	100
101 Home Health Agency								1		1	101
0 SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition						1					106
107 Liver Acquisition						1					107
108 Lung Acquisition											108
109 Pancreas Acquisition						1					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 1-117)											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 of line 118 and lines190-201)							L				202
203 Total Statistical Basis										ļ	203
204 Unit Cost Multiplier											204

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) 40-652

4090 (Cont.)			FORM CM	S-2552-10						09-13
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	,
Cost Center Descriptions	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL 26	
GENERAL SERVICE COST CENTERS	18	19	20	21	22	23	24	25	20	+
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits <i>Department</i>										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										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										0
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit							L	ļ	ļ	31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)									ļ	35
40 Subprovider IPF									ļ	40
41 Subprovider IRF							ļ		ļ	41
42 Subprovider										42
43 Nursery							ļ		ļ	43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 4

4690	0 (Cont.)			FORM CM	IS-2552-10						09-13
	CATION OF ALLOWABLE COSTS FOR RAORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	'
	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	20	
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology									1	53
	Radiology-Diagnostic				1				1	1	54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catherization										59
-	Laboratory										60
	PBP Clinical Laboratory Service-Program Only				1		1				61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76											76
	OUTPATIENT SERVICE COST CENTERS										0
88	Rural Health Clinic (RHC)									ļ	88
89										ļ	89
90										ļ	90
	Emergency									L	91
92	Observation Beds										92
93	Other Outpatient (specify)										93

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) 40-654

10-12		IS-2552-10			4090 (Cont.)						
	ALLOWABLE COSTS FOR Y CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	
	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
OTHER REI	MBURSABLE COST CENTERS	18	19	20	21	22	23	24	25	20	
94 Home Progra											94
95 Ambulance S											95
	lical Equipment-Rented										96
	lical Equipment-Sold								1	1	97
	pursable (specify)									1	98
	ehabilitation Provider (specify)										99
	ent Service (not appvd. tchng. prgm.)										100
101 Home Health										1	101
	JRPOSE COST CENTERS										0
105 Kidney Acqu											105
106 Heart Acquis											106
107 Liver Acquisi											107
108 Lung Acquisi	tion										108
109 Pancreas Acq					1		1				109
110 Intestinal Acc					1		1				110
111 Islet Acquisit											111
112 Other Organ	Acquisition (specify)										112
115 Ambulatory S	Surgical Center (Distinct Part)										115
116 Hospice	•							1			116
117 Other Special	Purpose (specify)										117
118 SUBTOTAL	S (sum of lines 1-117)							1			118
NONREIMB	URSABLE COST CENTERS										0
	Coffee Shop, & Canteen										190
191 Research											191
192 Physicians' Pr											192
193 Nonpaid Wor											193
	mbursable (specify)										194
200 Cross Foot A	0					ļ					200
201 Negative Cos						<u> </u>					201
	f line 118 and lines190-201)					ļ					202
203 Total Statistic						ļ					203
204 Unit Cost Mu	ıltiplier										204

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 3

4090	) (Cont.)		FORM CMS-25						
	PUTATION OF PROGRAM INPATIE FAL COSTS FOR EXTRAORDINAR			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET L-1, PART II	
Check applica box:	ble [] T	`itle V `itle XVIII, Part A `itle XIX		•		·		•	
	Cost Center Description	Capital Cost for Extraordinar Circumstances (from Wkst. L- Part I, col. 26)	I, Swing Bed Adjustment	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	4	5	6	7	
30	Adults & Pediatrics (General Routine	e Care)							30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
200	Total (sum of lines 30-199)								200

(A) Worksheet A line numbers

10-12

## FORM CMS-2552-10

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN:	PERIOD:	WORKSHEET L-1,
	FROM	PART III
COMPONENT CCN:	то	

Check		[] Hospital	[] Title V						
applica	ble	[] Subprovider	[] Title XVIII, Part A						
boxes:			[] Title XIX						
				Capital Cost for					
				Extraordinary				Program	
				Circumstances	Total Charges	Ratio of Cost		Extraordinary	
	Cost Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)				1	2	3	4	5	
	ANCILLARY SERVICE CO	OST CENTERS							
50	Operating Room								50
51	Recovery Room								51
	Labor Room and Delivery R	loom							52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT	") Scan							57
58	Magnetic Resonance Imagin	g (MRI)							58
59	Cardiac Catherization								59
	Laboratory								60
61	PBP Clinical Laboratory Ser	vice-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
70	Electroencephalography								70
71	Medical Supplies Charged to	o Patients							71
	Implantable Devices Charge	d to Patients							72
	Drugs Charged to Patients								73
74	Renal Dialysis								74
	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76

(A) Worksheet A line numbers

## 4090 (Cont.)

## FORM CMS-2552-10

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN:	PERIOD:	WORKSHEET L-1,
	FROM	PART III (CONT.)
COMPONENT CCN:	то	

		I	I						
Check		[] Hospital	[] Title V						
applical	ble	[] Subprovider	[] Title XVIII, Part A						
boxes:			[] Title XIX						
				Capital Cost for					
				Extraordinary				Program	
				Circumstances	Total Charges	Ratio of Cost		Extraordinary	
	Cost Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
	-			Part I, col. 26)	Part I, col. 6)	$(col. 1 \div col. 2)$	Program Charges	(col. 3 x col. 4)	
(A)				1	2	3	4	5	-
	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 (specify)								93
	OTHER REIMBURSABLE	E COST CENTERS							
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment	nt-Rented							96
97	Durable Medical Equipment	nt-Sold							97
98	Other Reimbursable (speci	fy)							98
200	Total (sum of lines 50 through	ugh 199)							200

(A) Worksheet A line numbers

10-12

Check applicable box:

FORM CMS-2552-10

4090 (Cont.)

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

[] RHC

[]FOHC

PROVIDER CCN:	PERIOD:	WORKSHEET M-1
	FROM	
COMPONENT CCN:	то	

RECLASSIFIED NET EXPENSES TRIAL FOR COMPEN-TOTAL RECLASS-BALANCE ALLOCATION SATION OTHER COSTS (col. 1 + col. 2)IFICATIONS (col. 3 + col. 4)ADJUSTMENTS (col. 5 + col. 6)3 4 6 1 2 5 7 FACILITY HEALTH CARE STAFF COSTS Physician 1 Physician Assistant 2 2 Nurse Practitioner 3 3 Visiting Nurse 4 5 Other Nurse Clinical Psychologist 6 6 Clinical Social Worker 7 7 8 Laboratory Technician 8 Other Facility Health Care Staff Costs 9 9 10 Subtotal (sum of lines 1-9) 10 COSTS UNDER AGREEMENT 11 Physician Services Under Agreement 11 12 12 Physician Supervision Under Agreement 13 Other Costs Under Agreement 13 14 Subtotal (sum of lines 11-13) 14 OTHER HEALTH CARE COSTS 15 Medical Supplies 15 16 Transportation (Health Care Staff) 16 17 17 Depreciation-Medical Equipment 18 Professional Liability Insurance 18 19 Other Health Care Costs 19 20 Allowable GME Costs 20 21 Subtotal (sum of lines 15-20) 21 22 Total Cost of Health Care Services 22 (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 23 Pharmacy 23 24 24 Dental 25 25 Optometry 26 All other nonreimbursable costs 26 27 Nonallowable GME costs 27 28 Total Nonreimbursable Costs (sum of lines 23-27) 28 FACILITY OVERHEAD 29 Facility Costs 29 30 Administrative Costs 30 31 Total Facility Overhead (sum of lines 29 and 30) 31 32 Total facility costs (sum of lines 22, 28 and 31) 32

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4066)

409	0 (Cont.)	FOR	M CMS-2	552-10			10-12
	OCATION OF OVERHEAD HC/FQHC SERVICES			PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-2	
	-			COMPONENT CCN:	то		
Check	applicable box:	[] RHC	[] FQHC				
VISI	IS AND PRODUCTIVITY						
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	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 4-7)						8
9	Physician Services Under Agreements						9
DETI	ERMINATION OF ALLOWABLE COST APPLICA	ABLE TO RHC/I	FQHC SERVI	CES			
10	Total costs of health care services (from Worksheet M	-1, column 7, line	22)				10
11	Total nonreimbursable costs (from Worksheet M-1, co	olumn 7, line 28)					11
12	Cost of all services (excluding overhead) (sum of line	s 10 and 11)					12
13	Ratio of RHC/FQHC services (line 10 divided by line	12)					13
14	Total facility overhead (from Worksheet M-1, column	7, line 31)					14
15	Parent provider overhead allocated to facility (see ins	tructions)					15
16	Total overhead (sum of lines 14 and 15)						16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtract line 17 from line 16						18
19	Overhead applicable to RHC/FQHC services (line 13	x line 18)					19
20	Total allowable cost of RHC/FOHC services (sum of	lines 10 and 19)					20

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

09-13			FORM CMS-255	52-10		4090(	Cont.)
CALCULATION OF REIMBURSEMENT				PROVIDER CCN:	PERIOD:	WORKSHEET M-3	
	T FOR RHC/FQHC SE				FROM		
				COMPONENT CCN:			
Check			[] Title V	[] Title XIX			
		[] RHC					
applicable box		[] FQHC	[] Title XVIII				
		R RHC/FQHC SERVI				1	1
		QHC services (from W					1
		inistration (from Works					2
	8	vaccine (line 1 minus li	ne 2)				3
	isits (from Worksheet N		• • • • • • •				4
	ě.	ent (from Worksheet M	-2, column 5, line 9)				5
	djusted visits (line 4 plu						6
7 Adjuste	ed cost per visit (line 3 o	divided by line 6)					7
							-
						ion of Limit (1)	_
					Prior to	On or after	
					January 1	January 1	_
					1	2	_
			ter 9, §20.6 or your contracted	or)			8
	r Program covered visit						9
	ON OF SETTLEME				1		
×		ě.	es (from contractor records)				10
	8	for mental health service					11
12 Program	n covered visits for me	ntal health services (fror	n contractor records)				12
U		ental health services (line					13
14 Limit a	djustment for mental he	ealth services (see instru	ctions)				14
		ass-through cost (see in					15
	rogram cost (sum of lin	es 11, 14, and 15, colum	nns 1, 2 and 3)				16
16.01 Total p	rogram charges (see in:	structions)(from contrac	tor's records)				16.01
16.02 Total p	rogram preventive char	ges (see instructions)(fr	om provider's records)				16.02
16.03 Total p	rogram preventive costs	s (see instructions)					16.03
16.04 Total p	rogram non-preventive	costs (see instructions)					16.04
16.05 Total p	rogram cost (see instru	ctions)					16.05
17 Primary	y payer amounts						17
18 Less: H	Beneficiary deductible f	for RHC only (see instru	ctions) (from contractor reco	rds)			18
19 Less: H	Beneficiary coinsurance	for RHC/FQHC service	es (see instructions) (from co	ntractor records)			19
20 Net Me	dicare cost excluding v	accines (see instructions	)				20
	n cost of vaccines and t	heir administration (from	n Worksheet M-4, line 16)				21
22 Total re	eimbursable Program co	ost (line 20 plus line 21)					22
	ble bad debts (see instr	,					23
23.01 Adjuste	ed reimbursable bad de	bts (see instructions)					23.01
	ble bad debts for dual e	eligible beneficiaries (see	e instructions)				24
25 Other a	djustments (specify) (s	ee instructions)					25
26 Net rein	mbursable amount (see	instructions)					26
26.01 Seques	tration adjustment (see	instructions)					26.01
27 Interim	payments						27
28 Tentati	ve settlement (for contra	actor use only)					28
29 Balance	e due component/progra	am line 26 minus lines 2	6.01, 27 and 28				29
30 Proteste	ed amounts (nonallowal	ble cost report items) in	accordance with CMS				30
Pub. 15	5-2, chapter 1, section 1	15.2					

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

FORM CMS-2552-10 (099-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4068) Rev. 4

4090	D(Cont.)		FORM CMS-2552-10				
	PUTATION OF PNEUMOCO CINE COST	CCAL AND INFLUENZA	Α	PROVIDER CCN:		WORKSHEET M-4	
				COMPONENT CCN:	то		
Check		[] RHC	[] Title V	[] Title XIX			
applic	able boxes:	[] FQHC	[] Title XVIII			-	
					PNEUMOCOCCAL	INFLUENZA	
					1	2	_
1	Health care staff cost (from V		,				1
2		nfluenza vaccine staff time	to total				2
	health care staff time						_
3	Pneumococcal and influenza		· · · · · ·				3
4	Medical supplies cost - pneur	nococcal and influenza va	ccine				4
	(from your records)						
5	· · · · · · · · · · · · · · · · · · ·						5
6			olumn 7, line 22)				6
7	Total overhead (from Worksh	, ,					7
8	Ratio of pneumococcal and in		st to total direct				8
	cost (line 5 divided by line 6)						_
9	Svemeda esse pheamsesee	1	,				9
10	1		eir				10
	administration costs (sum of	,					
11	Total number of pneumococc	cal and influenza vaccine in	njections				11
	(from your records)						
12		6					12
13	· · · · · · · · · · · · · · · · · · ·	d influenza vaccine injecti	ons administered				13
	to Program beneficiaries						
14			and their				14
	administration costs (line 12	,					
15	1			m of columns			15
	1 and 2, line 10) (transfer thi						+
16	Total Program cost of pneum			costs (sum			16
	of columns 1 and 2, line 14)	(transfer this amount to W	orksheet M-3, line 21)			1	1

FORM CMS 2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4069) 40-662

09-1	3 FORM CMS-2	552-10	4090 (Co			
ANAI	LYSIS OF PAYMENTS TO HOSPITAL-BASED	PROVIDER (	CCN:	PERIOD:	WORKSHEET M-5	
RHC/	FQHC PROVIDER FOR SERVICES RENDERED			FROM	• 	
	ROGRAM BENEFICIARIES	COMPONEN	T CCN:	то		
					1	
Check	applicable box: [] RHC [] FQHC			<u>.</u>		
					Part B	
	DESCRIPTION			1	2	
				mm/dd/yyyy	Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either					2
	submitted or to be submitted to the intermediary, for					
	services rendered in the cost reporting periods. If					
	none, write "NONE", or enter zero.					
3	List separately each retroactive		.01			3.01
	lump sum adjustment amount	Program	.02			3.02
	based on subsequent revision of	to	.03			3.03
	the interim rate for the	Provider	.04			3.04
	cost reporting period. Also show		.05			3.05
	date of each payment.		.50			3.50
	If none, write "NONE",	Provider	.51			3.51
	or enter zero (1).	to	.52			3.52
		Program	.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)					4
	(transfer to Worksheet M-3, line 27)					
					-	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative	Program	.01			5.01
	settlement payment after desk review.	to	.02			5.02
	Also show date of each payment.	Provider	.03			5.03
	If none, write "NONE,"	Provider	.50			5.50
	or enter zero (1).	to	.51			5.51
		Program	.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount	Program				
	(balance due) based on the cost	to				
	report (see instructions). (1)	Provider	.01			6.01
		Provider				
		to				
		Program	.02			6.02
7	Total Medicare liability (see instructions)	0				7
8	Name of Contractor		Con	tractor Number	NPR Date (Month/Day/Ye	

(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. FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4070) Rev. 4