06-21		FORM CN	AS-2540-10		4190 (Cont.)
	ed by law (42 USC 1395g; 42 CFR 413.20(b)). Fai e the beginning of the cost reporting period being de	•			FORM APPROVED OMB NO. 0938-0463 Expires: 12/31/2021
FACILITY HEAL	NG FACILITY AND SKILLED NURSING TH CARE COMPLEX COST REPORT AND SETTLEMENT SUMMARY	PROVIDER CCN:		IOD : M	WORKSHEET S PARTS I, II & III
PART I - COST	REPORT STATUS				
Provider	1. [ ] Electronically prepared cost rep	ort Date	:	Time:	
use only	2. [ ] Manually <i>prepared</i> cost report				
	3. [ ] If this is an amended report enter	the number of times the	provider resubmitted this co	ost report.	
	3.01. [ ] No Medicare Utilization. Enter "	" for yes or leave blank	for no.		
Contractor	4. [ ] Cost Report Status	6.	Contractor No.		
use only:	[ 1 ] As Submitted:	7.	[ ] First Cost Report for	this Provider CCN	
	[2] Settled without audit	8.	[ ] Last Cost Report for	this Provider CCN	
[3] Settled with audit		9.	NPR Date:		
	[4] Reopened	10.	If line 4, column 1 is "4":	Enter number of times re	opened
	[5] Amended	11.	Contractor Vendor Code		
	<ol><li>Date Received</li></ol>	12.	Medicare Utilization, En	ter "F" for full. "L" for lov	v. or "N" for no utilization

## PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

## CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

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 R	evenue and Expenses prepared by	Provider Name(s) and Provider CCN(s)} for the cost reporting
period beginning and e	ending and that to the best	of my knowledge and belief, this report and statement are true, correct, complete and
prepared from the books and records of th	e provider in accordance with applicable inst	uctions, except as noted. I further certify that I am familiar with the laws and regulations
regarding the provision of health care serv	rices, and that the services identified in this co	st report were provided in compliance with such laws and regulations.

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

PART III - SETTLEMEN	T SUMMARY					
				TITLE XVIII		
		TITLE V	A	В	TITLE XIX	
		1	2	3		
1 SKILLED NURSIN	IG FACILITY					1
2 NURSING FACILIT	ГҮ					2
3 I C F / IID						3
4 SNF - BASED HH	A					4
5 SNF - BASED RHO	C					5
6 SNF - BASED FQF	IC .					6
7 SNF - BASED CM	HC					7
100 TOTAL						100

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

FORM CMS-2540-10 (06/2021) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4103)

Rev. 10 41-303

4190	(Cont.)		FORM	И CMS-2540-10						06-21
	ED NURSING FACILITY AND SKILLED NURSING			PROVIDEI	R CCN:	PERIOD:		WORKSHEET S-	.2	
	ITY HEALTH CARE COMPLEX					FROM		PART I	_	
	IFICATION DATA					ТО				
				l.						
Skilled	Nursing Facility and Skilled Nursing Facility Complex	Address:								
	Street:		P.O. Box:							1
2	City:		State:	ZIP Code						2
3	County:		CBSA Code:	Urban / Ru	ral:					3
				*					-	
SNF ar	nd SNF - Based Component Identification:		_							
								Payment System		
					Provider	Date		(P, O or N)		
	Component		Compor	ent Name	CCN	Certified	V	XVIII	XIX	
	0			1	2	3	4	5	6	
4	SNF									4
	Nursing Facility									5
	I C F/IID									6
	SNF-Based HHA									7
	SNF-Based RHC									8
	SNF-Based FQHC									9
	SNF-Based CMHC									10
	SNF-Based OLTC									11
	SNF-Based HOSPICE									12
	OTHER (specify)									13
	Cost Reporting Period (mm/dd/yyyy)	From:	To:							14
15	Type of Control (see instructions)									15
Type o	f Freestanding Skilled Nursing Facility				Y / N					
	Is this a distinct part skilled nursing facility that meets the r									16
	Is this a composite distinct part skilled nursing facility that			83.5?						17
18	Are there any costs included in Worksheet A that resulted t	rom transactions with	n related							18

19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)		19.01
Depreci	ation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.		
20	Straight Line		20
21	Declining Balance		21
22	Sum of the Year's Digits		22
	Sum of line 20 through 22		23
	If depreciation is funded, enter the balance as of the end of the period.		24
	Were there any disposal of capital assets during the cost reporting period? (Y/N)		25
	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)		26
	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y?N)		27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)		28

organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.

19 Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.

Miscellaneous Cost Reporting Information

41-304 Rev. 10

If th	s facility is part of a chain organization, enter	the name and address of the home office o	n the lines below.			
	45 Name:			Contractor Name:	Contractor Number:	45
	46 Street:	P.O. Box:				46
	47 City	State	ZIP Code			47

43

44

43 Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?

44 If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.

Rev. 10 41-305

4190 (Cont.)	FORM CMS-2540-10	)		06-21
SKILLED NURSING FACILITY AND SKILLED NURSING	PROVIDER CCN:	PERIOD ·	WORKSHEET S-2	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD : FROM TO		WORKSHEET PART II	S-2		
General Instruction: For all column 1 responses, enter in column 1, "Y For all dates responses, use the format mm/dd/yy							
Completed by All Skilled Nursing Facilities							
				Y/N	Date		
Provider Organization and Operation		0		1	2	Ţ.,	
1 Has the provider changed ownership immediately prior to the buff column 1 is "Y", enter the date of the change in column 2. (s		?				1	
if commit i is 1, enter the date of the change in commit 2. (5)	ee instructions)			1			
			Y/N	Date	V/I		
2 Has the provider terminated participation in the Medicare Progr	am? If column 1 is "V"		1	2	3	2	
enter in column 2 the date of termination and in column 3, "V"							
3 Is the provider involved in business transactions, including man						3	
entities (e.g., chain home offices, drug or medical supply compa		or					
= -							
			Y/N	Туре	Date		
Financial Data and Reports	ts officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)  al Data and Reports  Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N)						
	ed Public Accountant? (Y/N)		1	2	3	4	
Column 2: If yes, enter "A" for Audited, "C" for Compiled, or		сору					
or enter date available in column 3. (see instructions) If no, see  5 Are the cost report total expenses and total revenues different fr						5	
statements? If column 1 is "Y", submit reconciliation.	om mose on the med manetar						
Approved Educational Activities				Y/N	Y/N 2	-	
6 Column 1: Were costs claimed for nursing school? (Y/N)				1	2	6	
Column 2: Is the provider the legal operator of the program? (							
7 Were costs claimed for allied health programs? (Y/N) (see inst. 8 Were approvals and/or renewals obtained during the cost report				1		7 8	
allied health program? (Y/N) (see instructions)	ing period for nursing school and/or					8	
				•			
Bad Debts					Y/N 1	4	
9 Is the provider seeking reimbursement for bad debts? (Y/N) (s	ee instructions)				1	9	
10 If line 9 is "Y", did the provider's bad debt collection policy cha		<ol><li>If "Y", submit copy.</li></ol>				10	
11 If line 9 is "Y", are patient deductibles and/or coinsurance wait	ved? If "Y", see instructions.					11	
Bed Complement							
12 Have total beds available changed from prior cost reporting per	iod? If "Y", see instructions.					12	
		Y/N	Date	Y/N	Date	1	
		Part A	Part A	Part B	Part B		
PS&R Report Data		1	2	3	4		
13 Was the cost report prepared using the PS&R only?  If either col. 1 or 3 is "Y", enter the paid-through date of the PS	&P used					13	
to prepare this cost report in cols. 2 and 4. (see Instructions)	acit useu						
14 Was the cost report prepared using the PS&R for total and the p						14	
for allocation? If either col. 1 or 3 is "Y", enter the paid-througused to prepare this cost report in columns 2 and 4.	h date of the PS&R						
15 If line 13 or 14 is "Y", were adjustments made to PS&R data for	r additional claims that					15	
have been billed but are not included on the PS&R used to file	this cost report?						
If "Y", see instructions.  16 If line 13 or 14 is "Y", were adjustments made to PS&R data for	r corrections of other			_			
PS&R Report information? If yes, see instructions.	i corrections of other					16	
17 If line 13 or 14 is "Y", were adjustments made to PS&R data for	r Other?					17	
Describe the other adjustments:  18 Was the cost report prepared only using the provider's records?	If "V" see instructions			_		18	
To 1 was the cost report prepared only using the provider's records?	11 1 , see instructions.					10	
Cost Report Preparer Contact Information		I m				1	
19 First Name: Last Name: 20 Employer:		Title:				19 20	
20 Employer.						20	

19	First Name:	Last Name:	Title:	19		
20	20 Employer:					
21	Phone Number:	Email Address	:	21		

FORM CMS-2540-10 (06/2021) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4104.1)

41-306 Rev. 10

				(
SKILLED NURSING FACILITY AND	PROVIDER CCN:	PERIOD:	WORKSHEET S-3	
SKILLED NURSING FACILITY HEALTH CARE COMPLEX		FROM	PART I	
STATISTICAL DATA		TO		

	Number	Bed		In	patient Days / Vi	sits				Discharges			T
	of	Days	Title	Title	Title			Title	Title	Title			1
Component	Beds	Available	V	XVIII	XIX	Other	Total	V	XVIII	XIX	Other	Total	
	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Facility													
2 Nursing Facility													
3 ICF / IID													
4 Home Health Agency													
5 Other Long Term Care													
6 SNF-Based CMHC													
7 Hospice													
8 Total (sum of lines 1-7)													

		Average Le	ength of Stay				Admissions				Time ivalent	
Component	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
	13	14	15	16	17	18	19	20	21	22	23	1
1 Skilled Nursing Facility												
2 Nursing Facility												
3 ICF / IID												
4 Home Health Agency												
5 Other Long Term Care												
6 SNF-Based CMHC												T

Rev. 7 41-307

SNF V	VAGE INDEX INFORMATION	PROVIDER CCN:		PERIOD:		WORKSHEET S-3		
				FROM		PARTS II & III		
				ТО				
PART	TII - DIRECT SALARIES							
			Reclass.	Adjusted	Paid Hours	Average		
			of Salaries	Salaries	Related	Hourly Wage		
		Amount	from Wkst.	( col. 1 ±	to Salary	( col. 3 ÷		
		Reported	A-6	col. 2)	in col. 3	col. 4)		
		1	2	3	4	5	7	
SALA	RIES							
1	Total salary (see instructions)						1	
2	Physician salaries-Part A						2	
3	Physician salaries-Part B						3	
	Home office personnel						4	
5	Sum of lines 2 through 4						5	
6	Revised wages (line 1 minus line 5)						6	
7	Other Long Term Care						7	
8	Home Health Agency						8	
9	CMHC						9	
10	Hospice						10	
	Other excluded areas						11	
12	Subtotal excluded salary (sum of lines 7 through 11)						12	
	Total adjusted salaries (line 6 minus line 12)						13	
OTHI	ER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt.						14	
15	Contract Labor: Physician services-Part A						15	
16	Home office salaries & wage related costs						16	
WAG	E RELATED COSTS							
17	Wage related costs core (see Pt. IV)						17	
18	Wage related costs other (see Pt. IV)						18	
19	Wage related costs (excluded units)						19	
20	Physicians Part A - WRC						20	
	Physicians Part B - WRC						21	
22	Total adjusted wage related cost (see instructions)						22	

PART III - OVERHEAD COST - DIRECT SALARIES
--

'			Reclass.	Adjusted	Paid Hours	Average	
			of Salaries	Salaries	Related	Hourly Wage	
		Amount	from	( col. 1 ±	to Salary	( col. 3 ÷	
		Reported	Wkst. A-6	col. 2)	in col. 3	col. 4)	
		1	2	3	4	5	Ī
1	Employee Benefits						1
2	Administrative & General						2
3	Plant Operation, Maintenance & Repairs						3
4	Laundry & Linen Service						4
5	Housekeeping						5
6	Dietary						6
7	Nursing Administration						7
8	Central Services and Supply						8
9	Pharmacy						9
10	Medical Records & Medical Records Library						10
11	Social Service						11
12	Nursing and Allied Health Ed. Act.						12
13	Other General Service (specify)						13
14	Total (sum lines 1 through 13)						14

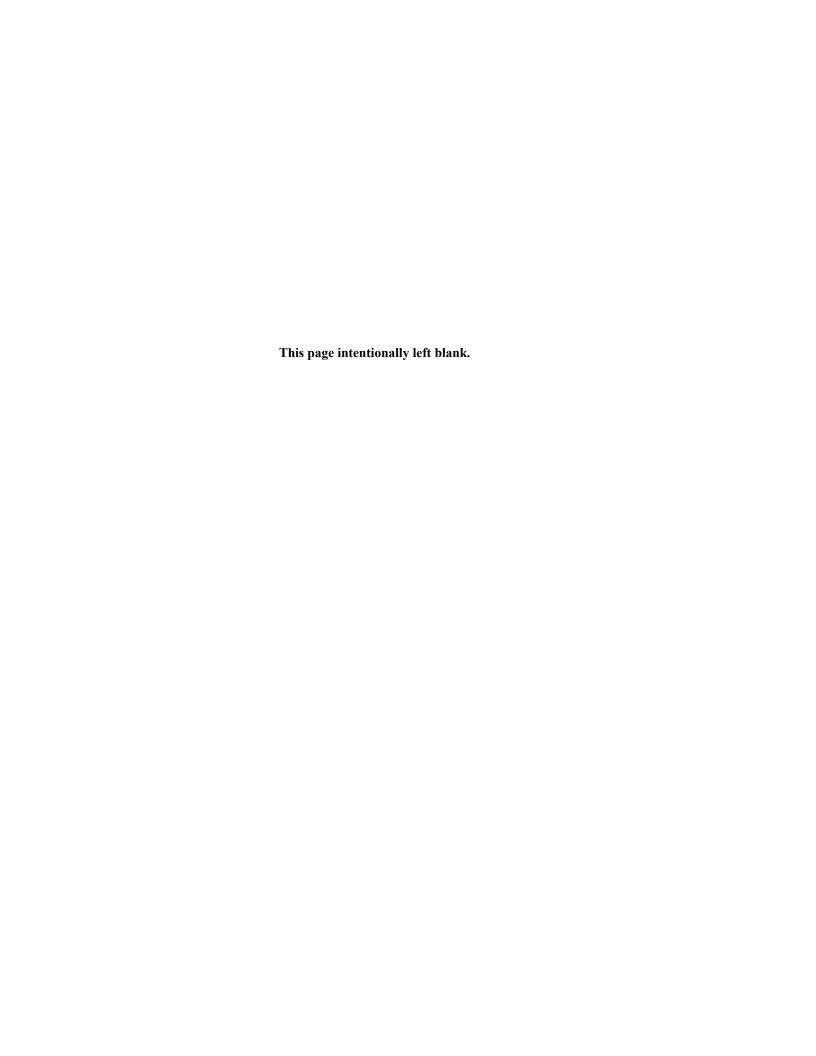
41-308 Rev. 7

PART IV	08-16	FORM CMS-2540-10		4190	(Cont.)
RETIREMENT COST    401k Employer Contributions   1   2 Tax Sheltered Annuity (TSA) Employer Contribution   2   2 Tax Sheltered Annuity (TSA) Employer Contribution   3   3 Qualified and Non-Qualified Pension Plan Cost   4   4 Prior Year Pension Service Cost   4   5 ADMINISTRATIVE COSTS (Paid to External Organizations)   5   5 (Legal/Accounting/Management Pees-Pension Plan   6   6 Legal/Accounting/Management Pees-Pension Plan   6   7 Employee Managed Care Program Administration Fees   7   7 Employee Managed Care Program Administration Fees   7   8 Health Insurance (Purchased or Self Funded)   7   8 Health Insurance (Purchased or Self Funded)   8   9 Prescription Drug Plan   9   10 Dental, Hearing and Vision Plan   10   11 Life Insurance (If employee is owner or beneficiary)   11   12 Accidental Insurance (If employee is owner or beneficiary)   12   13 Disability Insurance (If employee is owner or beneficiary)   12   14 Long-Term Care Insurance (If employee is owner or beneficiary)   13   14 Long-Term Care Insurance (If employee is owner or beneficiary)   13   15 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)   17   17 FICA - Employers Portion Only   17   18 Medicare Taxes - Employers Portion Only   18   19 Unemployment Insurance   19   20 State or Federal Unemployment Taxes   20   20 THER   2   21 Executive Deferred Compensation   2   22 Day Care Cost and Allowances   22   23 Tution Reimbursement   23   24 Total Wage Related cost (sum of lines 1-23)   24   27 Total Wage Related cost (sum of lines 1-23)   24   28 Part B Other than Core Related Cost   30   3 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   4 Part B Other than Core Related Cost   30   5 Part B Other than Core Related Cost   30   5 Part B Other than Core Relate	SNF WAGE RELATED COSTS	PROVIDER CCN:	FROM		
RETIREMENT COST	Part A - Core List				
2   Tax Sheltered Annuity (TSA) Employer Contribution   2   3   3   3   4   7   7   7   7   7   7   7   7   7	RETIREMENT COST				
3   Qualified and Non-Qualified Pension Plan Cost   4   Prior Year Pension Service Cost   4   Prior Year Pension Service Cost   4   Prior Year Pension Service Cost   5   4   Prior Year Pension Plan   5   5   5   4   Prior Year Pension Plan   6   7   Prior Year Pension Plan   6   7   Prior Year Pension Plan   8   Prescription Drug Plan   9   9   Prescription Drug Plan   9   9   9   Prescription Drug Plan   9   9   9   9   9   9   9   9   9	1 401k Employer Contributions				1
4   Prior Year Pension Service Cost   4	2 Tax Sheltered Annuity (TSA) Employer Contribution	1			2
PLAN   ADMINISTRATIVE COSTS (Paid to External Organizations)	3 Qualified and Non-Qualified Pension Plan Cost				3
5   40   K/TSA Plan Administration Fees   5					4
6   Legal/Accounting/Management Fees-Pension Plan   6   6   7   Employee Managed Care Program Administration Fees   7   7   Employee Managed Care Program Administration Fees   7   7   EMAILTH AND INSURANCE COST		Organizations)			
7   Employee Managed Care Program Administration Fees   7	5 401K/TSA Plan Administration fees				5
HEALTH AND INSURANCE COST   Health Insurance (Purchased or Self Funded)   8   8   9   Prescription Drug Plan   9   10   11   Life Insurance (If employee is owner or beneficiary)   11   Life Insurance (If employee is owner or beneficiary)   12   Accidental Insurance (If employee is owner or beneficiary)   13   Disability Insurance (If employee is owner or beneficiary)   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   Long-Term Care Insurance (If employee is owner or beneficiary)   15   Workers' Compensation Insurance   15   Workers' Compensation Insurance   15   Retirement Health Care Cost (Only current year, not the extraordinary a carual required by FASB 106 Non cumulative portion)   17   18   Medicare Taxes - Employers Portion Only   17   18   Medicare Taxes - Employers Portion Only   18   Medicare Taxes - Employers Portion Only   19   Unemployment Insurance   19   20   State or Federal Unemployment Taxes   20   OTHER   21   Executive Deferred Compensation   22   Day Care Cost and Allowances   22   23   Tuition Reimbursement   23   24   Total Wage Related Cost (sum of lines 1-23)   Amount Reported   24   Reported   25   Reported   26   Reported   27   27   28   Reported   28   Reported   29   Rep					6
Realth Insurance (Purchased or Self Funded)   8   9   Prescription Drug Plan   9   9   9   9   9   9   9   9   9		ees			7
Prescription Drug Plan					
10   Dental, Hearing and Vision Plan					8
11   Life Insurance (If employee is owner or beneficiary)   11   12   Accidental Insurance (If employee is owner or beneficiary)   12   13   Disability Insurance (If employee is owner or beneficiary)   13   13   13   13   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   15   Workers' Compensation Insurance   15   16   Retirement Health Care Cost (Only current year, not the extraordinary acrual required by FASB 106 Non cumulative portion)   16   16   17   18   Medicare Taxes - Employers Portion Only   18   18   19   Unemployment Insurance   19   19   Unemployment Insurance   19   19   19   19   19   19   19   1					9
12 Accidental Insurance (If employee is owner or beneficiary)       12         13 Disability Insurance (If employee is owner or beneficiary)       13         14 Long-Term Care Insurance (If employee is owner or beneficiary)       14         15 Workers' Compensation Insurance       15         16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)       16         TAXES         17 FICA - Employers Portion Only       17         18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER       20         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       23         24 Total Wage Related cost (sum of lines 1 -23)       Amount Reported					10
13   Disability Insurance (If employee is owner or beneficiary)   13   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   15   Workers' Compensation Insurance   15   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106   Non cumulative portion)   16   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106   Non cumulative portion)   16   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106   Non cumulative portion)   16   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106   Non cumulative portion)   17   RAXES   17   FICA - Employers Portion Only   18   Medicare Taxes - Employers Portion Only   18   Punemployment Insurance   19   Punemployment Insurance   19   Punemployment Insurance   19   Punemployment Taxes   19   Pu					11
14 Long-Term Care Insurance (If employee is owner or beneficiary)       14         15 Workers' Compensation Insurance       15         16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)       16         TAXES         17 FICA - Employers Portion Only       17         18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER       20         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       23         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported	( 1 )	37			12
15   Workers' Compensation Insurance   15					13
16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)       16         TAXES         17 FICA - Employers Portion Only       17         18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER       21         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       23         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported		beneficiary)			
accrual required by FASB 106 Non cumulative portion)					
TAXES         17 FICA - Employers Portion Only       17         18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER       21         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       23         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported					16
17 FICA - Employers Portion Only       17         18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       22         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported	1 /	ion)			
18 Medicare Taxes - Employers Portion Only       18         19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       22         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported					
19 Unemployment Insurance       19         20 State or Federal Unemployment Taxes       20         OTHER         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       22         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported					17
20 State or Federal Unemployment Taxes       20         OTHER       21         21 Executive Deferred Compensation       21         22 Day Care Cost and Allowances       22         23 Tuition Reimbursement       23         24 Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported					
OTHER         21           21         Executive Deferred Compensation         21           22         Day Care Cost and Allowances         22           23         Tuition Reimbursement         23           24         Total Wage Related cost (sum of lines 1 -23)         24           Part B Other than Core Related Cost         Amount Reported					
21       Executive Deferred Compensation       21         22       Day Care Cost and Allowances       22         23       Tuition Reimbursement       23         24       Total Wage Related cost (sum of lines 1 -23)       24         Part B Other than Core Related Cost       Amount Reported					20
22         Day Care Cost and Allowances         22           23         Tuition Reimbursement         23           24         Total Wage Related cost (sum of lines 1 -23)         24           Part B Other than Core Related Cost         Amount Reported					
23 Tuition Reimbursement 23 24 Total Wage Related cost (sum of lines 1 -23) 24 Part B Other than Core Related Cost Amount Reported					
24 Total Wage Related cost (sum of lines 1 -23)  Part B Other than Core Related Cost  Amount Reported					
Part B Other than Core Related Cost  Amount Reported					
Reported	ž (				24
	Part B Other than Core Related Cost				
23   Other wage Related Costs (specify)	25 Other Wese Poleted Costs (smarify)			Reported	25
	25 Other Wage Related Costs (specify)				

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	J (Cont.)	FORM	CMS-2540-10	)			08-16
SNF REPORTING OF DIRECT CARE EXPENDITURES		PROVIDER CCN:		PERIOD : FROM TO		WORKSHEET S-3 PART V	
				Adjusted Salaries	Paid Hours Related	Average Hourly Wage	T
		Amount	Fringe	( col. 1 +	to Salary	( col. 3 ÷	
		Reported	Benefits	col. 2)	in col. 3	col. 4)	
	OCCUPATIONAL CATEGORY	1	2	3	4	5	
Direct	t Salaries						
	Nursing Occupations						
1	Registered Nurses (RNs)						1
2	Licensed Practical Nurses (LPNs)						2
3	Certified Nursing Assistants/Nursing Assistants/Aides						3
4	Total Nursing (sum of lines 1 through 3)						4
5	Physical Therapists						5
6	Physical Therapy Assistants						6
7	Physical Therapy Aides						7
8	Occupational Therapists						8
9	Occupational Therapy Assistants						9
	Occupational Therapy Aides						10
	Speech Therapists						11
	Respiratory Therapists						12
13	Other Medical Staff						13
Contra	act Labor						
	Nursing Occupations						
14	Registered Nurses (RNs)						14
15	Licensed Practical Nurses (LPNs)						15
16	Certified Nursing Assistants/Nursing Assistants/Aides						16
17	Total Nursing (sum of lines 14 through 16)						17
18	Physical Therapists						18
19	Physical Therapy Assistants						19
20	Physical Therapy Aides						20
21	Occupational Therapists						21
22	Occupational Therapy Assistants						22
23	Occupational Therapy Aides						23
24	Speech Therapists						24
25	Respiratory Therapists						25
26	Other Medical Staff						26

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4190 (Cont.)	FORM CM	S-2540-10				1	11-12
SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CO	CN:	PERIOD : FROM TO	WORKSHEET S-4		S-4	
HOME HEALTH ACENCY CTATICTICAL DATA							
HOME HEALTH AGENCY STATISTICAL DATA  1 County					1		1
1 County							
		Title V	Title XVIII	Title XIX	Other	Total	Т
DESCRIPTION		1	2	3	4	5	1
2 Home Health Aide Hours		-			· ·		2
3 Unduplicated Census Count (see instructions)							3
				Staff	Contract	Total	
HOME HEALTH AGENCY - NUMBER OF EMPLO		T)		1	2	3	
4 Enter the number of hours in your normal work wee	ek						4
5 Administrator and Assistant Administrator(s)							5
6 Directors and Assistant Director(s)							6 7
7 Other Administrative Personnel							
8 Direct Nursing Service 9 Nursing Supervisor							8
10 Physical Therapy Service 11 Physical Therapy Supervisor							10
11 Physical Therapy Supervisor 12 Occupational Therapy Service							11 12
13 Occupational Therapy Supervisor							13
14 Speech Pathology Service							13
15 Speech Pathology Supervisor					-		15
16 Medical Social Service							16
17 Medical Social Service Supervisor							17
18 Home Health Aide							18
19 Home Health Aide Supervisor							19
20 Other (specify)							20
(-F/)							
HOME HEALTH AGENCY CBSA CODES							
21 Enter in column 1 the number of CBSAs where you	provided services during the cost rep	orting period.					21
22 List those CBSA code(s) in column 1 serviced duri			code).				22
			•				-
		Full 1	Episodes			Total	1
		Without	With	LUPA	PEP only	( cols. 1	
		Outliers	Outliers	Episodes	Episodes	through 4)	J
PPS ACTIVITY DATA		1	2	3	4	5	<u> </u>
23 Skilled Nursing Visits							23
24 Skilled Nursing Visit Charges							24
25 Disseit The Wisite							25

		run Ep	risoucs			1 Otal	
		Without	With	LUPA	PEP only	( cols. 1	
		Outliers	Outliers	Episodes	Episodes	through 4)	
PPS A	ACTIVITY DATA	1	2	3	4	5	
23	Skilled Nursing Visits						23
	Skilled Nursing Visit Charges						24
25	Physical Therapy Visits						25
26	Physical Therapy Visit Charges						26
27	Occupational Therapy Visits						27
28	Occupational Therapy Visit Charges						28
	Speech Pathology Visits						29
	Speech Pathology Visit Charges						30
	Medical Social Service Visits						31
32	Medical Social Service Visit Charges						32
33	Home Health Aide Visits						33
34	Home Health Aide Visit Charges						34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)						35
36	Other Charges						36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)						37
38	Total Number of Episodes (standard/non outlier)						38
39	Total Number of Outlier Episodes						39
40	Total Non-Routine Medical Supply Charges						40
	_	•	•	•	•	•	

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08-1	5				FC	ORM CMS	S-2540-1	0							4190	(Cont.)
SNF-E	ASED RHC/FQHC STATISTICAL DATA							PROVIDER	R CCN:		PERIOD:			WORKSHI	EET S-5	
								DIICEOUG	CON		FROM		_			
								RHC/FQHC	CCN:		10		-			
								1						ı		
C	heck applicable box: [ ] RHC		[ ] FQHC													
Clinic	Address and Identification:															
	Street:											County:				1
	City:							State:				Zip Code:				2
3	Designation (for FQHC's only) - "U" for urban of	or "R" for rural														3
	CF 1 1 C 1												. 1			
	of Federal funds: Community Health Center (Section 330(d), PHS	7 A at)										Grant	Award	L	ate	4
	Migrant Health Center (Section 329(d), PHS Ac															5
	Health Services for the Homeless (Section 340(															6
	Appalachian Regional Commission	a), 1115 / 10t)														7
	Look - Alikes															8
	Other (specify)															9
•												•				•
												1			2	
	Does this facility operate as other than an RHC		for yes or "	N" for no in o	column 1.											10
	If yes, indicate the number of other operations in	n column 2.														
Facilit	y hours of operations (1)															
1 acmit	y nours or operations (1)	Sun	dav	Mo	nday	Tues	sdav	Wedn	nesday	Thur	sdav	Fri	day	Sati	urday	1
	Type of Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
	Clinic											1				- 11

	1	2	
12 Have you received an approval for an exception to the productivity standard?			12
13 Is this a consolidated cost report in accordance with CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1.			13
If yes, enter in column 2 the number of RHC/FQHC's included in this report. List the names of all RHC/FQHC's and numbers below.			
14 RHC/FQHC Name: CCN Number:			14

4190 (Colit.)		LOKIM CIMP	5-2340-10	06-1			
MEN	BASED COMMUNITY TAL HEALTH CENTER AND OTHER OUTPATIENT ABILITATION FACILITIES STATISTICAL DATA		PROVIDER CCN:  COMPONENT CCN:	PERIOD : FROM TO	WORKSHEET S-6		
	Check applicable box: [] CMHC [] CORF	[] OPT	[] OOT	[] OSP			
	Enter the number of hours in your normal workweek						
NUMI	BER OF EMPLOYEES (FULL TIME EQUIVALENT)						
					Total		
			Staff	Contract	( col. 1 + col. 2 )		
			1	2	3		
1	Administrator and Assistant Administrator(s)					1	
2	= = = = = = = = = = = = = = = = = = = =					2	
3						3	
4	8					4	
	Nursing Supervisor					5	
6						6	
7	Physical Therapy Supervisor					7	
	Occupational Therapy Service					8	
	Occupational Therapy Supervisor					9	
	Speech Pathology Service					10	
11	Speech Pathology Supervisor					11	
	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	
10	Other (enecify)					10	

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11-19 4190 (Cont.)

			. /
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	
		TO	i

	то		
	RUG GROUPS (Through September 30, 2019)	Days	
	1	2	—
1	RUX		1
2	RUL		1 2 3 4 5 6 7
3	RVX RVL		3
4	RVL RHX		4
5	RHL		6
7	RMX		7
- 8	RML		8
9	RLX		9
10	RUC		10
11	RUB		11
12	RUA		12
13	RVC		13
14	RVB		14
15	RVA		15
16	RHC		16
17	RHB		17
18	RHA		18
19	RMC		19
20	RMB		20
21	RMA		21
22	RLB		22
23	RLA		22 23 24
24	ES3		24
25	ES2		25
26	ES1		26 27
27	HE2		27
28	HE1		28 29
29	HD2		29
30	HDI		30
31	HC2		32
32	HC1 HB2		33
34	HB1		34
35	LE2		35
36	LE1		36
37	LD2		37
38	LDI		38
39	LC2		39
40	LC1		40
41	LB2		41
42	LB1		42
43	CE2		43
44	CE1		43
45	CD2		45
46	CDI		46
47	CC2		47
48	CC1		48
49	CB2		49
50	CB1		50
51	CA2		51
52	CA1		52
53	SE3		53
54	SE2		54
55	SE1		55 56
56	SSC		56
57	SSB SSA		58
58 59	IB2		59
60	IB1		60
61	IA2		61
62	IA2 IA1		62
63	BB2		63
64	BB1		64
65	BA2		65
66	BA1		66

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4190 (Cont.) 11-19

` '			
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	
		TO	i

	RUG GROUPs (Through September 30, 2019)	Days	T
	1	2	
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PAI		76
99	AAA		99
100	Total (Sum of column 2, lines 1 through 99)		100

A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I line 1 column3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated

with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (see instructions)

	Expenses	Percentage	Y/N	
	1	2	3	
101 Staffing				101
102 Recruitment				102
103 Retention of employees				103
104 Training				104
105 Other (Specify)				105
106 Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)				106

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4109 - 4109.1)

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SNF-BASED HOSPICE IDENTIFICATION DATA	10	PROVIDER CCN:		PERIOD:		WORKSHEET S - 8	, on . ,
		HOSPICE CCN:		FROM TO		PARTS I, II, III & IV	
		nosi ież ce					
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNII	NG BEFORE OCTOBE	R 1, 2015					
				Unduplicate	d Days		
			Title XVIII	Title XIX		Total	
			Skilled Nursing	Nursing	All	( sum of	
	Title XVIII	Title XIX	Facility	Facility	Other	col. 1, 2 & 5)	_
1 Hospice Continuous Home Care	I	2	3	4	5	6	1
1 Hospice Continuous Home Care 2 Hospice Routine Home Care						_	1 2
3 Hospice Routine Tonie Care 3 Hospice Inpatient Respite Care							3
4 Hospice General Inpatient Care						_	4
5 Total Hospice Days						<del></del>	5
5 Total Hospice Buys		<u>.</u>	<u> </u>	L			
PART II - CENSUS DATA FOR COST REPORTING PERIODSENDING BEGIN	NING BEFORE OCTO	BER 1, 2015					
			Title XVIII	Title XIX		Total	
			Skilled	Nursing	All	( sum of	
	Title XVIII	Title XIX	Nursing facility	Facility	Other	col. 1, 2 & 5)	
	1	2	3	4	5	6	
6 Number of patients receiving hospice care							6
7 Total number of unduplicated Continuous Care hours billable to Medicare							7
8 Average length of stay (line 5 / line 6)							8
9 Unduplicated census count							9
DARTH TWO IN THE DAME DAME DAME OF CASE OF COMPANY	ODEDIO DEDIODO DE	CONDIDIC ON OR AFT	ED OCTODED 1 2015				
PART III - ENROLLMENT DAYS BASED ON LEVEL OF CARE FOR COST REF	ORTING PERIODS BE	GINNING ON OR AFT	ER OCTOBER 1, 2015	TT. d U.	-4- 1 D		
				Unduplic	ated Days	Total	т —
						(sum of	
			Title XVIII	Title XIX	Other	cols. 1 through 3)	
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2	3	4	4
10 Hospice Continuous Home Care			1	2	3		10
11 Hospice Routine Home Care						<del></del>	11
12 Hospice Inpatient Respite Care						_	12
13 Hospice General Inpatient Care						_	13
14 Total Hospice Days						_	14
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERI	ODS BEGINNING ON	OR AFTER OCTOBER	1, 2015				
			ĺ			Total	
						(sum of	
			Title XVIII	Title XIX	Other	cols. 1 through 3)	
			1 1	2	3	4	4
15 Hospice Inpatient Respite Care			1		3	+ +	15
16 Hospice General Inpatient Care			+			+	16
10 Hospice General impatient Care			1	1	l .		10

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

	ICATION AND ADJUSTMENT BALANCE OF EXPENSES			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET A	
	Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease ( from Wkst. A-6 )	RECLASSIFIED TRIAL BALANCE ( col. 3 +/- col. 4 )	ADJUSTMENTS TO EXPENSES Increase/Decrease ( from Wkst. A-8 )	NET EXPENSES FOR COST ALLOCATION ( col. 5 +/- col. 6 )	
A B	С	1	2	3	4	5	6	7	Α
	SERVICE COST CENTERS								
1 0100	Capital-Related Costs - Buildings & Fixtures								1
2 0200	Capital-Related Costs - Movable Equipment								2
	Employee Benefits								3
4 0400	Administrative and General								4
5 0500	Plant Operation, Maintenance and Repairs								4
6 0600	Laundry and Linen Service								(
7 0700	) Housekeeping								
8 0800	) Dietary								
9 0900	Nursing Administration								9
10 1000	Central Services and Supply								10
11 1100									11
12 1200	Medical Records and Library								13
	Social Service								13
14 1400	Nursing and Allied Health Education								14
15	Other General Service Cost								1:
	ROUTINE SERVICE COST CENTERS								
	Skilled Nursing Facility								30
	Nursing Facility								3
	ICF/IID								32
	Other Long Term Care								33
	Y SERVICE COST CENTERS								
	) Radiology								40
41 4100									4
42 4200									42
43 4300									43
	Physical Therapy								4
	Occupational Therapy								45
	Speech Pathology								4
47 4700	) Electrocardiology	1		1					4

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		ATION AND ADJUSTMENT ALANCE OF EXPENSES			PROVIDER CCN:		PERIOD : FROM TO _		WORKSHEET A (Co	
		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease ( from Wkst. A-6 )	RECLASSIFIED TRIAL BALANCE ( col. 3 +/- col. 4 )	ADJUSTMENTS TO EXPENSES Increase /Decrease ( from Wkst. A-8 )	NET EXPENSES FOR COST ALLOCATION ( col. 5 +/- col. 6 )	
A	В	С	1	2	3	4	5	6	7	1
48	4800	Medical Supplies Charged to Patients								48
49	4900	Drugs Charged to Patients								49
50	5000	Dental Care - Title XIX only								50
51	5100	Support Surfaces								51
52		Other Ancillary Service Cost								52
OUTPA	ATIENT	SERVICE COST CENTERS								
60	6000	Clinic								60
61	6100	Rural Health Clinic (RHC)								61
62		FQHC								62
63		Other Outpatient Service Cost								63
OTHE	R REIM	BURSABLE COST CENTERS								
70	7000	Home Health Agency Cost								70
71	7100	Ambulance								71
72		Outpatient Rehabilitation (specify)								72
73	7300	CMHC								73
74		Other Reimbursable Cost								74
SPECIA	AL PUR	RPOSE COST CENTERS								
80	8000	Malpractice Premiums & Paid Losses							-0-	80
		Interest Expense							- 0 -	81
82		Utilization Review							- 0 -	82
83	8300	Hospice								83
84		Other Special Purpose Cost								84
89		SUBTOTALS (sum of lines 1 through 84)								89
NON R	EIMBU	TRSABLE COST CENTERS								
90		Gift, Flower, Coffee Shops and Canteen								90
		Barber and Beauty Shop								91
92		Physicians' Private Offices								92
		Nonpaid Workers								93
94	9400	Patients' Laundry								94
95		Other Nonreimbursable Cost								95
100		TOTAL								100

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD :	WORKSHEET A-6
		FROM	ĺ
		TO	1

		CODE	CODE INCREASE				DECREASE				
		(1)	COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	1
	EXPLANATION OF RECLASSIFICATION(S)	1	2	3	4	5	6	7	8	9	
1											
2											2
3											
4											4
5											
6											•
7											,
8											-
9											9
10											10
11											1
12											12
13											13
14											14
15											1:
16											10
17											1'
18											18
19											19
20								1 1			20
21											2
22								1 1			23
23 24								1 1			2.
24								1 1			2.
25											2:
26 27											20
27											2'
28				ļ				++			23
29 30 31											29
30				ļ				++			30
31								+			3
32 33								1			32
33								+			33
34								+			34
35	FOTAL PROPERCY ACCURACY (C	لببل						$\bot$			35
	FOTAL RECLASSIFICATIONS (Sum of columns 4 and sum of columns 8 and 9 (2)	5 must equal									100

<sup>(1)</sup> A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

<sup>(2)</sup> Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

ANALYSIS OF CHANGES IN	PROVIDER CCN:	PERIOD:	WORKSHEET A-7
CAPITAL ASSET BALANCES		FROM	
		то	

				Acquisitions				Fully	
		Beginning				and	Ending	Depreciated	1
		Balances	Purchases	Donation	Total	Retirements	Balance	Assets	1
	Description	1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 7 minus line 8)								9

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4115)

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	JSTMENTS TO EXPENSES		PROVIDER CCN:	PERIOD : FROM	WORKSHEET A-8	03 11
		Basis for		to/from which the a	fication on Wkst. A amount is to be adjusted	
	Description (1)	Adjustment (2)	Amount	Cost Center		
1	0 Investment income on restricted funds	1	2	3	4	1
1	Investment income on restricted funds (Chapter 2)					1
2	Trade, quantity and time discounts			+	+	2
2	on purchases (Chapter 8)					2
3	Refunds and rebates of expenses			+	+	3
3	Chapter 8)					3
4	Rental of provider space by suppliers					4
7	Chapter 8)					1
5	Telephone services (pay stations					5
,	excluded) (Chapter 21)					
6	Television and radio service					6
	(Chapter 21)					
7	Parking lot (Chapter 21)					7
8	Remuneration applicable to provider-	Worksheet				8
	based physician adjustment	A-8-2				
9	Home office costs (Chapter 21)					9
10	Sale of scrap, waste, etc.					10
	(Chapter23)					
11	Nonallowable costs related to certain					11
	Capital expenditures (Chapter 24)					
12	Adjustment resulting from transactions	Worksheet				12
	with related organizations (Chapter 10)	A-8-1				
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
1.5						1.5
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients			+	+	16
10	Sale of friedreaf supplies to other than patients					10
17	Sale of drugs to other than patients					17
1,	Sale of drugs to other than patients					1 ,
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest,					20
	finance or penalty charges (Chapter 21)					
21	Interest expense on Medicare overpayments					21
	and borrowings to repay Medicare overpayments					
22	Utilization reviewphysicians'			Utilization Review- SNF	82	22
	compensation (Chapter 21)					
23	Depreciationbuildings and fixtures			Capital Related Cost- Build	ing 1	23
				0.101.00		
24	Depreciationmovable equipment			Capital Related Cost-Mova	ble 2	24
25	Other Adirectors					- 25
25	Other Adjustment					25
100	TOTAL (sum of lines 1 through 99)					100
100						100
	(transfer to Wkst. A, col. 6, line 100)					

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1(2) Basis for adjustment (see instructions)

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

STATEMENT OF COSTS OF SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-1
FROM RELATED ORGANIZATIONS AND		FROM	
HOME OFFICE COSTS		TO	
HOME OFFICE COSTS		10	

## PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

				Amount	Amount	Adjustments	
				Allowable	Included in	( col. 4 minus	
	Line No.	Cost Center	Expense Items	In Cost	Wkst. A., col. 5	col. 5)	
	1	2	3	4	5	6	<u> </u>
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10		(sum of lines 1-9)					10
	(Transfer	column 6, line 10 to Wkst. A-8, col. 3, line 12)					

## PART II - INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE

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

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

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

- $(1) \ \ Use the followings symbols to indicate interrelationship to related organizations:$ 
  - A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  - B. Corporation, partnership or other organization has financial interest in provider.
  - C. Provider has financial interest in corporation, partnership, or other organization.
  - D. Director, officer, administrator or key person of provider or organization.

- E. Individual is director, officer, administrator or key person of provider and related organization.
- F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.

<ul> <li>G. Other (financial or non-financial) specify</li> </ul>	7

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( )			
PROVIDER - BASED PHYSICIAN ADJUSTMENTS	PROVIDER CCN:	PERIOD :	WORKSHEET A-8-2
		FROM	
		TO	

	Wkst. A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1		3	4	3	0	/	0	9	<del> </del>
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

			Cost of	Provider	Physician	Provider				
		Cost Center /	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line No.	Identifier	Education	Col. 12	Insurance	Col. 14	R C E Limit	Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	1
1										1
2										2
3										3
4										4
5										5
6										6
7										7
- 8										8
9										9
10										10
11										11
100		TOTAL								100

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COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD : FROM TO		WORKSHEET B PART I	
	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS- TRATIVE & GENERAL	
Cost Center Description	0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							
2 Capital-Related Costs - Movable Equipment							1
3 Employee Benefits							
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							
6 Laundry and Linen Service							(
7 Housekeeping							
8 Dietary							
9 Nursing Administration							Ç
10 Central Services and Supply							10
11 Pharmacy							1
12 Medical Records and Library							1.
13 Social Service							1.
14 Nursing and Allied Health Education							14
15 Other General Service Cost							1:
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							3
32 ICF/IID							32
33 Other Long Term Care							3:
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							4
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							4.
44 Physical Therapy							4
45 Occupational Therapy							4:
46 Speech Pathology							40
47 Electrocardiology							4
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							4
50 Dental Care - Title XIX only							50
51 Support Surfaces							5
52 Other Ancillary Service Cost							5:

COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN:	PERIOD:		WORKSHEET B	
			WORKSHEET B	
	FROM		PART I	
	ТО			
NET EXPENSES				T
FOR COST CAP, REL CAP, REL		SUBTOTAL	ADMINIS-	
ALLOCATION BUILDINGS MOVABLE	EMPLOYEE	( sum of	TRATIVE	
(from Wkst. A, col. 7) & FIXTURES EQUIPMENT	BENEFITS	cols. 0 - 3)	& GENERAL	
Cost Center Description 0 1 2	3	3 A	4	1
OUTPATIENT SERVICE COST CENTERS				
60 Clinic				60
61 Rural Health Clinic (RHC)				61
62 FQHC				62
63 Other Outpatient Service Cost				63
OTHER REIMBURSABLE COST CENTERS				
70 Home Health Agency Cost				70
71 Ambulance				71
72 Outpatient Rehabilitation (specify)				72
73 CMHC				73
74 Other Reimbursable Cost				74
SPECIAL PURPOSE COST CENTERS				
83 Hospice				83
84 Other Special Purpose Cost				84
89 Subtotals				89
NON REIMBURSABLE COST CENTERS				
90 Gift, Flower, Coffee Shops and Canteen				90
91 Barber and Beauty Shop				91
92 Physicians' Private Offices				92
93 Nonpaid Workers				93
94 Patients' Laundry				94
95 Other Nonreimbursable Cost				95
98 Cross Foot Adjustments				98
99 Negative Cost Center				99
100 Total				100

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COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		
	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
Cost Center Description	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								1
2 Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

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4190 (Cont.)	(Cont.)				WI3-2340-10						
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:	PROVIDER CCN:		PERIOD: FROM TO					
Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS 5	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9	CENTRAL SERVICES & SUPPLY	PHARMACY 11	-			
OUTPATIENT SERVICE COST CENTERS											
60 Clinic								60			
61 Rural Health Clinic (RHC)								61			
62 FQHC								62			
63 Other Outpatient Service Cost								63			
OTHER REIMBURSABLE COST CENTERS											
70 Home Health Agency Cost								70			
71 Ambulance								71			
72 Outpatient Rehabilitation (specify)								72			
73 CMHC								73			
74 Other Reimbursable Cost								74			
SPECIAL PURPOSE COST CENTERS											
83 Hospice								83			
84 Other Special Purpose Cost								84			
89 Subtotals								89			
NON REIMBURSABLE COST CENTERS											
90 Gift, Flower, Coffee Shops and Canteen								90			
91 Barber and Beauty Shop								91			
92 Physicians' Private Offices								92			
93 Nonpaid Workers								93			
94 Patients' Laundry								94			
95 Other Nonreimbursable Cost								95			
98 Cross Foot Adjustments								98			
99 Negative Cost Center								99			
100 Total								100			

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COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		
	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								1
2 Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

4190 (Cont.)	FORM CMS							
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART I	
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL 18	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry			-					94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

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COS	T ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD : FROM		WORKSHEET B - 1	
	Cost Center Description		CAP. REL. BUILDINGS & FIXTURES ( Square Feet )	CAP. REL. MOVABLE EQUIPMENT ( Dollar Value or Square Feet )	EMPLOYEE BENEFITS ( Gross Salaries )	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL ( Accumulated Cost )	
		0	1	2	3	4 A	4	
GEN	ERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Buildings & Fixtures							1
	Capital-Related Costs - Movable Equipment							2
	Employee Benefits							3
	Administrative and General							4
	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
	Housekeeping							7
8	Dietary							8
	Nursing Administration							9
10	Central Services and Supply							10
	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education							14
15	Other General Service Cost							15
INP/	ATIENT ROUTINE SERVICE COST CENTERS							
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF/IID							32
	Other Long Term Care							33
ANC	TILLARY SERVICE COST CENTERS							
40	Radiology							40
41	Laboratory							41
42	Intravenous Therapy							42
	Oxygen (Inhalation) Therapy							43
44	Physical Therapy							44
45	Occupational Therapy							45
	Speech Pathology							46
47	Electrocardiology							47
	Medical Supplies Charged to Patients							48
	Drugs Charged to Patients							49
	Dental Care - Title XIX only							5(
	Support Surfaces							51
	Other Ancillary Service Cost							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B - 1	
Cost Center Description		CAP. REL. BUILDINGS & FIXTURES ( Square Feet )	CAP. REL. MOVABLE EQUIPMENT ( Dollar Value or Square Feet )	EMPLOYEE BENEFITS ( Gross Salaries )	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL ( Accumulated Cost )	
	0	1	2	3	4 A	4	1
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							- 02
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals NON REIMBURSABLE COST CENTERS							89
							- 00
90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop							90
91 Baroer and Beauty Snop 92 Physicians' Private Offices							91 92
93 Nonpaid Workers							93
94 Patients' Laundry							93
95 Other Nonreimbursable Cost					+	+	95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
102 Cost to be allocated (Per Wkst. B, Pt I.)							102
102 Cost to be anocated (Fet Wast, B, Ft I.)  103 Unit Cost Multiplier (Wkst, B, Pt I.)							102
103 Cont Cost Multiplier (Wkst. B, Pt. I)  104 Cost to be allocated (Per Wkst. B, Pt. II)							103
105 Unit Cost Multiplier (Wkst B, Pt. II)							104

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03-10			TORWI CIVIS					4190 (Col			
COST A	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B - 1			
						FROM					
						TO					
		PLANT OPER.	LAUNDRY			NURSING	CENTRAL				
		MAINTENANCE	& LINEN	HOUSE		ADMINIS-	SERVICES				
		& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY			
		( Square	( Pounds of	( Hours of	( Meals	( Direct	( Costed	( Costed			
	Cost Center Description	Feet )	Laundry )	Service)	Served)	Nursing Hrs.)	Requisitions )	Requisitions )			
		5	6	7	8	9	10	11			
	AL SERVICE COST CENTERS										
	Capital-Related Costs - Buildings & Fixtures								1		
2 C	Capital-Related Costs - Movable Equipment								2		
	Imployee Benefits								3		
4 A	Administrative and General								4		
5 P	lant Operation, Maintenance and Repairs								5		
6 L	aundry and Linen Service								6		
7 H	Iousekeeping								7		
8 D	Dietary								8		
9 N	Jursing Administration								9		
	Central Services and Supply								10		
	harmacy								11		
12 M	Medical Records and Library								12		
	ocial Service								13		
14 N	Jursing and Allied Health Education								14		
	Other General Service Cost								15		
INPATIE	ENT ROUTINE SERVICE COST CENTERS										
	killed Nursing Facility								30		
	Jursing Facility								31		
32 IC									32		
	Other Long Term Care								33		
	ARY SERVICE COST CENTERS										
	Ladiology								40		
	aboratory								41		
	ntravenous Therapy								42		
	Oxygen (Inhalation) Therapy							1	43		
44 Pi	hysical Therapy								44		
	Occupational Therapy								45		
	peech Pathology							1	46		
	Electrocardiology							1	47		
	Medical Supplies Charged to Patients							1	48		
	Orugs Charged to Patients							1	49		
	Dental Care - Title XIX only								50		
	upport Surfaces								51		
	Other Ancillary Service Cost								52		
22 0	The I memory Service Cost			1					32		

COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B - 1	
					FROM			
					TO			
	PLANT OPER.	LAUNDRY			NURSING	CENTRAL		
	MAINTENANCE	& LINEN	HOUSE		ADMINIS-	SERVICES		
	& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY	
	( Square	( Pounds of	( Hours of	( Meals	( Direct	( Costed	( Costed	
Cost Center Description	Feet )	Laundry )	Service )	Served)	Nursing Hrs.)	Requisitions )	Requisitions )	
	5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
102 Cost to be allocated (Per Wkst. B, Pt I.)								102
103 Unit Cost Multiplier (Wkst. B, Pt I.)								103
104 Cost to be allocated (Per Wkst. B, Pt. II)								104
105 Unit Cost Multiplier (Wkst B, Pt. II)								105

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03-10			TORNI CIVIS-			-			(Cont.)
COST ALLOCATION - STATISTICAL BASIS				PROVIDER CCN:		PERIOD:		WORKSHEET B - 1	
						FROM			
						TO			
		MEDICAL		NURSING &					
		RECORDS	SOCIAL	ALLIED	OTHER				
		& LIBRARY	SERVICE	HEALTH	GENERAL		POST		
		( Time	( Time	EDUCATION	SERVICE		STEP-DOWN		
Cost Center De	escription	Spent )	Spent )	( Assigned Time )	COST	SUBTOTAL	ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS									
1 Capital-Related Costs - Buildings & Fix	tures								1
2 Capital-Related Costs - Movable Equips	ment								2
3 Employee Benefits									3
4 Administrative and General									4
5 Plant Operation, Maintenance and Repa	nirs								5
6 Laundry and Linen Service									6
7 Housekeeping									7
8 Dietary									8
9 Nursing Administration									9
10 Central Services and Supply									10
11 Pharmacy									11
12 Medical Records and Library									12
13 Social Service									13
14 Nursing and Allied Health Education									14
15 Other General Service Cost									15
INPATIENT ROUTINE SERVICE COST C	ENTERS								- 13
30 Skilled Nursing Facility	ZI. TERO								30
31 Nursing Facility									31
32 ICF/IID									32
33 Other Long Term Care									33
ANCILLARY SERVICE COST CENTERS									33
40 Radiology									40
41 Laboratory									41
42 Intravenous Therapy									42
43 Oxygen (Inhalation) Therapy									43
44 Physical Therapy		1							43
45 Occupational Therapy									44
46 Speech Pathology									46
46 Speech Pathology 47 Electrocardiology									40
48 Medical Supplies Charged to Patients									48
48 Medical Supplies Charged to Patients 49 Drugs Charged to Patients									48
50 Dental Care - Title XIX only									50
51 Support Surfaces 52 Other Ancillary Service Cost									51
32 Other Anciliary Service Cost									52

4190 (Colli.)		FORM CMS	TOKW CW3-2340-10						
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B - 1		
					FROM				
					TO				
	MEDICAL		NURSING &						
	RECORDS	SOCIAL	ALLIED	GENERAL					
	& LIBRARY	SERVICE	HEALTH EDU	SERVICE		POST			
	( Time	( Time	EDUCATION	COST		STEP-DOWN			
Cost Center Description	Spent )	Spent)	( Assigned Time )	COST	SUBTOTAL	ADJUSTMENTS	TOTAL		
Cost Contact Description	12	13	14	15	16	17	18	-	
OUTPATIENT SERVICE COST CENTERS									
60 Clinic								60	
61 Rural Health Clinic (RHC)								61	
62 FQHC								62	
63 Other Outpatient Service Cost								63	
OTHER REIMBURSABLE COST CENTERS									
70 Home Health Agency Cost								70	
71 Ambulance								71	
72 Outpatient Rehabilitation (specify)								72	
73 CMHC								73	
74 Other Reimbursable Cost								74	
SPECIAL PURPOSE COST CENTERS									
83 Hospice								83	
84 Other Special Purpose Cost								84	
89 Subtotals								89	
NON REIMBURSABLE COST CENTERS									
90 Gift, Flower, Coffee Shops and Canteen								90	
91 Barber and Beauty Shop								91	
92 Physicians' Private Offices								92	
93 Nonpaid Workers								93	
94 Patients' Laundry								94	
95 Other Nonreimbursable Cost								95	
98 Cross Foot Adjustments								98	
99 Negative Cost Center								99	
102 Cost to be allocated (Per Wkst. B, Pt I.)								102	
103 Unit Cost Multiplier (Wkst. B, Pt I.)								103	
104 Cost to be allocated (Per Wkst. B, Pt. II)								104	
105 Unit Cost Multiplier (Wkst B, Pt. II)	1							105	

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ALLOCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD : FROMTO		WORKSHEET B PART II	
	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
Cost Center Description	0	1	2	2 A	3	4	5	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								1
2 Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

4190 (Colit.)	FORM CMS-								
ALLOCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD: FROMTO		WORKSHEET B PART II		
Cost Center Description	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL 2 A	EMPLOYEE BENEFITS 3	ADMINIS- TRATIVE & GENERAL 4	PLANT OPER. MAINTENANCE & REPAIRS		
OUTPATIENT SERVICE COST CENTERS									
60 Clinic								60	
61 Rural Health Clinic (RHC)								61	
62 FQHC								62	
63 Other Outpatient Service Cost								63	
OTHER REIMBURSABLE COST CENTERS									
70 Home Health Agency Cost								70	
71 Ambulance								71	
72 Outpatient Rehabilitation (specify)								72	
73 CMHC								73	
74 Other Reimbursable Cost								74	
SPECIAL PURPOSE COST CENTERS									
83 Hospice								83	
84 Other Special Purpose Cost								84	
89 Subtotals								89	
NON REIMBURSABLE COST CENTERS									
90 Gift, Flower, Coffee Shops and Canteen								90	
91 Barber and Beauty Shop								91	
92 Physicians' Private Offices								92	
93 Nonpaid Workers								93	
94 Patients' Laundry		•						94	
95 Other Nonreimbursable Cost								95	
98 Cross Foot Adjustments								98	
99 Negative Cost Center								99	
100 Total								100	

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ALLOCATION OF CAPITAL - RELATED COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART II	
		& I	INDRY LINEN RVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	Cost Center Description		6	7	8	9	10	11	
GENERAL SERVICE CO									
	sts - Buildings & Fixtures								1
	sts - Movable Equipment								2
3 Employee Benefits									3
4 Administrative and									4
5 Plant Operation, M									5
6 Laundry and Linen	Service								6
7 Housekeeping									7
8 Dietary									8
9 Nursing Administra									9
10 Central Services an	d Supply								10
11 Pharmacy									11
12 Medical Records ar	nd Library								12
13 Social Service									13
14 Nursing and Allied									14
15 Other General Serv									15
	SERVICE COST CENTERS								
30 Skilled Nursing Fac	cility								30
31 Nursing Facility									31
32 ICF/IID									32
33 Other Long Term C	Care								33
ANCILLARY SERVICE	COST CENTERS								
40 Radiology									40
41 Laboratory									41
42 Intravenous Therap									42
43 Oxygen (Inhalation	) Therapy								43
44 Physical Therapy									44
45 Occupational Thera	ру								45
46 Speech Pathology									46
47 Electrocardiology									47
48 Medical Supplies C									48
49 Drugs Charged to I	Patients								49
50 Dental Care - Title	XIX only								50
51 Support Surfaces									51
52 Other Ancillary Ser	vice Cost								52

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ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART II		
Cost Center Description	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9	CENTRAL SERVICES & SUPPLY	PHARMACY 11		
OUTPATIENT SERVICE COST CENTERS								
60 Clinic							60	
61 Rural Health Clinic (RHC)							61	
62 FQHC							62	
63 Other Outpatient Service Cost							63	
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost							70	
71 Ambulance							71	
72 Outpatient Rehabilitation (specify)							72	
73 CMHC							73	
74 Other Reimbursable Cost							74	
SPECIAL PURPOSE COST CENTERS								
83 Hospice							83	
84 Other Special Purpose Cost							84	
89 Subtotals							89	
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen							90	
91 Barber and Beauty Shop							91	
92 Physicians' Private Offices							92	
93 Nonpaid Workers							93	
94 Patients' Laundry							94	
95 Other Nonreimbursable Cost							95	
98 Cross Foot Adjustments							98	
99 Negative Cost Center							99	
100 Total							100	

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ALLO	OCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART II	
		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
	Cost Center Description	12	13	14	15	16	17	18	
	ERAL SERVICE COST CENTERS								
	Capital-Related Costs - Buildings & Fixtures								1
	Capital-Related Costs - Movable Equipment								2
	Employee Benefits								3
	Administrative and General								4
	Plant Operation, Maintenance and Repairs								5
	Laundry and Linen Service								6
	Housekeeping								7
	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
	Nursing and Allied Health Education								14
	Other General Service Cost								15
INPA	TIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
	ICF/IID								32
33	Other Long Term Care								33
	ILLARY SERVICE COST CENTERS								
	Radiology								40
	Laboratory								41
	Intravenous Therapy								42
	Oxygen (Inhalation) Therapy								43
	Physical Therapy								44
	Occupational Therapy								45
	Speech Pathology								46
	Electrocardiology								47
	Medical Supplies Charged to Patients								48
	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
	Support Surfaces								51
52	Other Ancillary Service Cost								52

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ALLOCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART II	
	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								83
83 Hospice 84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								0.9
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

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			(
POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD :	WORKSHEET B-2
		FROM	
		TO	

Description			Worksheet B			$\overline{}$
1		Description Par	rt No	Line No	Amount	
1						-
111       112         13       13         144       144         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       26         26       25         26       26         27       27         28       28         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       33         38       39         40       40         41       41         42       42	1	•				+
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       37         38       39         40       40         41       41         42       42						2
111       112         13       13         144       144         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       26         26       25         26       26         27       27         28       28         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       33         38       39         40       40         41       41         42       42						3
111       112         13       13         144       144         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       26         26       25         26       26         27       27         28       28         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       33         38       39         40       40         41       41         42       42						4
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       37         38       39         40       40         41       41         42       42						5
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       37         38       39         40       40         41       41         42       42						6
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       37         38       39         40       40         41       41         42       42						7
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         36       36         37       37         38       39         40       40         41       41         42       42						8
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         37       33         38       33         39       39         40       44         41       44         42						9
11       12         13       13         14       14         15       15         16       16         17       17         18       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       30         31       31         32       33         33       33         34       34         35       35         37       33         38       33         39       39         40       44         41       44         42						10
12	11					11
16       16         17       17         18       18         19       20         21       22         22       23         24       23         25       25         26       25         27       26         27       27         28       29         30       29         30       33         31       31         32       33         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42	12					12
16       16         17       17         18       18         19       20         21       22         22       23         24       23         25       25         26       25         27       26         27       27         28       29         30       29         30       33         31       31         32       33         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42						13
16       16         17       17         18       18         19       20         21       22         22       23         24       23         25       25         26       25         27       26         27       27         28       29         30       29         30       33         31       31         32       33         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42	14					14
16       16         17       17         18       18         19       20         21       22         22       23         24       23         25       25         26       25         27       26         27       27         28       29         30       29         30       33         31       31         32       33         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42	15					15
17       18         19       18         20       22         21       21         22       23         23       23         24       24         25       26         26       26         27       28         29       29         30       30         31       33         32       33         33       33         34       33         35       33         36       33         37       36         38       38         39       39         40       40         41       41         42       42	16					16
18       19         20       20         21       21         22       22         23       22         24       24         25       25         26       25         27       27         28       28         29       30         30       31         31       31         32       32         33       33         34       33         35       33         36       33         37       37         38       38         39       38         40       40         41       41         42       42	17					17
21       21         22       22         23       23         24       24         25       25         26       26         27       26         28       28         29       30         30       30         31       30         31       31         32       32         33       33         34       33         35       33         36       33         37       37         38       39         40       40         41       41         42       42	1 /					1 9
21       21         22       22         23       23         24       24         25       25         26       26         27       26         28       28         29       30         30       30         31       30         31       31         32       32         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42	10					10
21       21         22       22         23       23         24       24         25       25         26       26         27       26         28       28         29       30         30       30         31       30         31       31         32       32         33       33         34       33         35       33         36       33         37       37         38       38         39       39         40       40         41       41         42       42	20					20
25       26         27       26         28       27         29       29         30       30         31       31         32       31         33       32         33       33         34       34         35       35         36       35         37       36         38       37         38       39         40       40         41       41         42       42	20					20
25       26         27       26         28       27         29       29         30       30         31       31         32       31         33       32         33       33         34       34         35       35         36       35         37       36         38       37         38       39         40       40         41       41         42       42	21					21
25       26         27       26         28       27         29       29         30       30         31       31         32       31         33       32         33       33         34       34         35       35         36       35         37       36         38       37         38       39         40       40         41       41         42       42	22					22
25       26         27       26         28       27         29       29         30       30         31       31         32       31         33       32         33       33         34       34         35       35         36       35         37       36         38       37         38       39         40       40         41       41         42       42	23					23
28       29       30       31       32       33       34       35       36       37       38       39       40       41       42	24					24
28       29       30       31       32       33       34       35       36       37       38       39       40       41       42	25					25
28       29       30       31       32       33       34       35       36       37       38       39       40       41       42	26					26
30     30       31     31       32     32       33     33       34     33       35     35       36     36       37     37       38     39       40     40       41     40       42     41	27					27
30     30       31     31       32     32       33     33       34     33       35     34       36     36       37     37       38     38       39     39       40     40       41     40       42     41	28					28
31     31       32     32       33     33       34     34       35     36       37     36       37     38       39     38       40     40       41     41       42     42	29					29
36     36       37     37       38     38       39     40       41     40       42     41	30					30
36     36       37     37       38     38       39     40       41     40       42     41	31					31
36     36       37     37       38     38       39     40       41     40       42     41	32					32
36     36       37     37       38     38       39     40       41     40       42     41	33					33
36     36       37     37       38     38       39     40       41     40       42     41	34					34
39       40       41       42	35					35
39 39 40 40 41 41 41 42	36					36
39 39 40 40 41 41 41 42	37					37
41 41 41	38					38
41 41 41	39					39
41 41 42 42 43 43	40					40
42 43 43 43 43 43 43 43 43 43 43 43 43 43	41					41
43	42					42
	43					43 44 45 46
44	44					44
45 45	45					45
46 46	46				·	46
47   47   47	47					47
48 48	48					48
49 49	49					48 49 50
50 50	50					50

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. ,			
RATIO OF COST TO CHARGES	PROVIDER CCN:	PERIOD:	WORKSHEET C
FOR ANCILLARY AND OUTPATIENT		FROM	
COST CENTERS		TO	

	Cost Center Description	Total ( from Wkst. B, Pt. I, col. 18)	Total Charges 2	Ratio ( col. 1 divided by col. 2 )	
ANICI	LLARY SERVICE COST CENTERS	1		3	
_					40
	Radiology				
41	Laboratory				41
42	Intravenous Therapy				42
43	Oxygen (Inhalation) Therapy				43
44	Physical Therapy				44
45	Occupational Therapy				45
46	Speech Pathology				46
47	Electrocardiology				47
48	Medical Supplies Charged to Patients				48
49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost				52
OUTP	ATIENT SERVICE COST CENTERS				
60	Clinic				60
61	Rural Health Clinic (RHC)				61
62	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

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APPORTIONMENT OF ANCILLARY AND	)			PROVIDER CCN:	PERIOD:	WORKSHEET D
OUTPATIENT COST					FROM	PART I
					ТО	
Check applicable box:	[ ] Title V (1)	[ ] Title XVIII	[ ] Title XIX (1)			
Check applicable box:	[ ] SNF	[ ] NF	[ ] ICF / IID	[ ] Other	[ ] PPS - Must also complete Part II	

## PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

	Ratio of Cost to Charges	Health Care Program Charges			Healthcare Program Cost	
	( from Wkst. C,	Don't A	Don't D	Part A	Part B	
Cost Center Description	col. 3)	Part A	Part B	( col. 1 x col. 2 )	( col. 1 x col. 3 )	-
ANCILLARY SERVICE COST CENTERS	1	2	3	4	3	_
40 Radiology						40
41 Laboratory						41
42 Intravenous Therapy						42
43 Oxygen (Inhalation) Therapy						43
44 Physical Therapy						44
45 Occupational Therapy						45
46 Speech Pathology						46
47 Electrocardiology						47
48 Medical Supplies Charged to Patients						48
49 Drugs Charged to Patients						49
50 Dental Care - Title XIX only						50
51 Support Surfaces						51
52 Other Ancillary Service Cost						52
OUTPATIENT COST CENTERS						
60 Clinic						60
61 Rural Health Clinic (RHC)						61
62 FQHC						62
63 Other Outpatient Service Cost						63
71 Ambulance (2)						71
100 Total (sum of lines 40 - 71)						100

<sup>(1)</sup> For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND	PROVIDER CCN:	PERIOD:	WORKSHEET D
OUTPATIENT COST		FROM	PARTS II & III
		то	
TITLE XVIII ONLY			
PART II - APPORTIONMENT OF VACCINE COST			
1 Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)			1
2 Program vaccine charges (From your records or the PS&R report)			2
3 Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E, Pt. I, line 18)			3

## PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

		Total Cost ( from Wkst. B, Pt. I, col. 18 )	Nursing & Allied Health ( from Wkst. B, Pt. I, col. 14 )	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (col. 2 / col. 1)	Program Part A Cost ( from Wkst. D., Pt. I, col. 4 )	Part A Nursing & Allied Health Costs for Pass Through ( col. 3 x col. 4 )	
	Cost Center Description	I	2	3	4	5	_
	LLARY SERVICE COST CENTERS						
	Radiology						40
	Laboratory						41
42	Intravenous Therapy						42
43	Oxygen (Inhalation) Therapy						43
44	Physical Therapy						44
45	Occupational Therapy						45
46	Speech Pathology						46
47	Electrocardiology						47
48	Medical Supplies Charged to Patients						48
49	Drugs Charged to Patients						49
50	Dental Care - Title XIX only						50
51	Support Surfaces						51
52	Other Ancillary Service Cost						52
100	Total (sum of lines 40 - 52)						100

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COMPUTAT	TION OF INPATIENT	PROVIDER CCN:	PERIOD:	WORKSHEET D-1
ROUTINE C	COSTS		FROM	PARTS I & II
			TO	
Ch1	oplicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX			
Спеск ар	pplicable box: [ ] SNF [ ] NF [ ] ICF/IID			
PART I - C	ALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT				
1 Inpat	ient days including private room days			1
	te room days			2
3 Inpat	ient days including private room days applicable to the Program			3
4 Medi	cally necessary private room days applicable to the Program			4
5 Total	general inpatient routine service cost			5
PRIVATE R	OOM DIFFERENTIAL ADJUSTMENT			
6 Gene	eral inpatient routine service charges			6
7 Gene	eral inpatient routine service cost/charge ratio (line 5 divided by line 6)			7
	private room charges from your records			8
9 Aver	age private room per diem charge (private room charges on line 8 divided by pr	rivate room days on line 2)		9
	semi-private room charges from your records			10
	age semi-private room per diem charge (semi-private room charges on line 10 c	livided by semi-private room	days)	11
	age per diem private room charge differential (line 9 minus line 11)			12
	age per diem private room cost differential (line 7 times line 12)			13
	te room cost differential adjustment (line 2 times line 13)			14
	eral inpatient routine service cost net of private room cost differential (line 5 min	nus line 14)		15
	INPATIENT ROUTINE SERVICE COSTS			
	sted general inpatient service cost per diem (line 15 divided by line 11)			16
	ram routine service cost (line 3 times line 16)			17
	ically necessary private room cost applicable to program (line 4 times line 13)			18
	program general inpatient routine service cost (line 17 plus line 18)	1 10 1; 20 C CNIE 1;	21.6 NE	19
	tal related cost allocated to inpatient routine service costs (from Wkst. B, Pt. II,	col. 18, line 30 for SNF; line	e 31 for NF; or	20
	32 for ICF/IID)			21
	liem capital related costs (line 20 divided by line 1) ram capital related cost (line 3 times line 21)			21
	ient routine service cost (line 19 minus line 22)			23
	egate charges to beneficiaries for excess costs (from provider records)			23
	program routine service costs for comparison to the cost limitation (line 23 mi	nus lina 24)		25
	the per diem limitation (1)	nuo nne 24)		26
	ient routine service cost limitation (line 3 times the per diem limitation line 26)	(1)		27
	abursable inpatient routine service costs (line 22 plus the lesser of line 25 or line			28
	asfer to Wkst. E, Pt. II, line 4) (see instructions)	. 21)		
(				
PART II - C	CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS F	OR PPS PASS-THROUGH		
1 Total	inpatient days			1
2 Progr	ram inpatient days (see instructions)			2
3 Total	nursing & allied health costs (see instructions)			3
	ing & allied health ratio (line 2 divided by line 1)			4
5 Progr	ram nursing & allied health costs for pass-through (line 3 times line 4)	5		

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 $<sup>(1) \ \</sup> Lines\ 26,27\ and\ 28\ are\ not\ applicable\ for\ title\ XVIII,\ but\ may\ be\ used\ for\ title\ V\ and\ or\ title\ XIX$ 

CALCULATION OF	PROVIDER CCN:	PERIOD :	WORKSHEET E
REIMBURSEMENT SETTLEMENT		FROM	PART I
FOR TITLE XVIII		ТО	

1	Inpatient PPS amount (see instructions)	
2	Nursing and Allied Health Education Activities (pass through payments)	
3	Subtotal (sum of lines 1 and 2)	
4	Primary payer amounts	
5	Coinsurance	
6	Allowable bad debts (from your records)	
7	Allowable bad debts for dual eligible beneficiaries (see instructions)	
8	Reimbursable bad debts (see instructions)	
9	Recovery of bad debts - for statistical records only	
10	Utilization review	
11	Subtotal (see instructions)	
12	Interim payments (see instructions)	
13	Tentative adjustment	
14	Other adjustment (see instructions)	
14.50	Demonstration payment adjustment amount before sequestration	14
14.55	Demonstration payment adjustment amount after sequestration	14
4.75	Sequestration for non-claims based amounts (see instructions)	14
4.99	Sequestration amount (see instructions)	14
15	Balance due provider/program (see instructions)	
	(Indicate overpayment in parentheses)	
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	

PART	B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ON	LY
17	Ancillary services Part B	17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)	18
19	Total reasonable costs (sum of lines 17 and 18)	19
20	Medicare Part B ancillary charges (see instructions)	20
21	Cost of covered services (lesser of line 19 or line 20)	21
22	Primary payer amounts	22
23	Coinsurance and deductibles	23
24	Allowable bad debts (from your records)	24
	Allowable bad debts for dual eligible beneficiaries (see instructions)	24.01
24.02	Reimbursable bad debts (see instructions)	24.02
25	Subtotal (sum of lines 21 and 24.02, minus lines 22 and 23)	25
26	Interim payments (see instructions)	26
27	Tentative adjustment	27
28	Other Adjustments (Specify) (see instructions)	28
	Demonstration payment adjustment amounts before sequestration	28.50
28.55	1 7 9 1	28.55
28.99	Sequestration amount (see instructions)	28.99
29	Balance due provider/program (see instructions)	29
	(indicate overpayments in parentheses)	
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	30

FORM CMS-2540-10 (06/2021) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4130)

41-346 Rev. 10

Check applicable box:		CULATION OF	PROVIDER CCN:	PERIOD :	WORKSHEET E	_
Check applicable box:				FROM	PART II	
Check applicable box:	FOR	TITLE V and TITLE XIX ONLY		TO		
Check applicable box:     SNF						
Check applicable box:		Cheek applicable have fig. Title V				_
COMPUTATION OF NET COST OF COVERED SERVICES			ICE / IID			_
Inpatient ancillary services (see instructions)		Check applicable box. [ ] SNT [ ] NT [ ]	ICF / IID			—
Inpatient ancillary services (see instructions)						
Inpatient ancillary services (see instructions)	COM	PUTATION OF NET COST OF COVERED SERVICES				_
3   A   Inpatient rorvices	1					1
4 Impatient routine services (see instructions) 5 Utilization review – physicians compensation (from provider records) 5 Utilization review – physicians compensation (from provider records) 5 Cost of covered services (sum of lines 1 - 5) 6 Cost of covered devices (sum of lines 1 - 5) 7 Differential in charges between semiprivate accommodations and less than semiprivate accommodations and less than semiprivate accommodations 8 Subtotal (line 6 minus line 7) 8 Primary payer amounts 9 Primary payer amounts 10 Total reasonable cost (line 8 minus line 9) 11 Outpatient service charges 11 Impatient ancillary service charges 12 Impatient ancillary service charges 12 Uutpatient service charges 13 Impatient routine service charges 14 Differential in charges between semiprivate accommodations 15 Total reasonable charges 15 Total reasonable charges 15 Total reasonable charges 15 Aggregate amount actually collected from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 413.13(e) 17 Amounts that would have been realized from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 413.13(e) 18 Ratio of line 16 to line 17 (not to exceed 1.000000) 19 Deductibles 10 Deductibles 10 Deductibles 11 Deductibles 12 Subtotal (line 20 minus line 21) 12 Subtotal (line 20 minus line 23)	2	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)				2
5   Utilization review - physiciants compensation (from provider records)   5   6   6   6   6   6   6   6   6   6	3	Outpatient services				3
6 Cost of covered services (sum of lines 1 - 5)         6           7 Differential in charges between semiprivate accommodations and less than semiprivate accommodations         7           8 Subtotal (line 6 minus line 7)         8           9 Primary payer amounts         9           10 Total reasonable cost (line 8 minus line 9)         10           REASONABLE CHARGES         11           11 Inpatient ancillary service charges         12           13 Inpatient routine service charges         13           14 Differential in charges between semiprivate accommodations and less than semiprivate accommodations         14           15 Total reasonable charges         13           CUSTOMARY CHARGES         15           CUSTOMARY CHARGES         15           16 Aggregate amount actually collected from patients liable for payment for services on a charge basis         15           17 Amounts that would have been realized from patients liable for payment for services on a charge basis along basis and such payment been made in accordance with 42 CFR 413.13(e)         17           18 Ratio of line 16 to line 17 (not to exceed 1 000000)         18           19 Total customary charges (see instructions)         19           COMPUTATION OF REIMBURISEMENT SETTLEMENT         20           21 Deductibles         21           22 Subtotal (line 20 minus line 21)         22	4	Inpatient routine services (see instructions)			4	4
7	5	Utilization review - physicians' compensation (from provider records)				5
than semiprivate accommodations   8   8   Subtotal (line 6 minus line 7)   8   9   Primary payer amounts   9   9   10   Total reasonable cost (line 8 minus line 9)   10   Total reasonable cost (line 8 minus line 9)   10   REASONABLE CHARGES	6	,				6
8         Subtotal (line 6 minus line 7)         8           9         Primary payer amounts         9           10         Total reasonable cost (line 8 minus line 9)         10           REASONABLE CHARGES         11         Inpatient ancillary service charges         11           12         Outpatient service charges         12           13         Inferential in charges between semiprivate accommodations and less than semiprivate accommodations         13           15         Total reasonable charges         15           CUSTOMARY CHARGES         15           16         Aggregate amount actually collected from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 413.13(e)         16           18         Ratio of line 16 to line 17 (not to exceed 1.000000)         18           19         Total customary charges (see instructions)         19           COMPUTATION OF REIMBURSEMENT SETTLEMENT         20           20         Cost ocwered services (see instructions)         20           21         Deductibles         21           22         Subtotal (line 20 minus line 21)         22           23         Coinsurance         23           24         Subtotal (line 20 minus line 23)         24	7	·			, , , , , , , , , , , , , , , , , , ,	7
9   Primary payer amounts   9   10   Total reasonable cost (line 8 minus line 9)   10   Total reasonable cost (line 8 minus line 9)   10   Total reasonable cost (line 8 minus line 9)   11   Inpatient ancillary service charges   11   Inpatient ancillary service charges   12   21   Inpatient routine service charges   13   Inpatient routine service charges   13   Inpatient routine service charges   14   Differential in charges between semiprivate accommodations and less   14   Inpatient asemiprivate accommodations   15   Total reasonable charges   16   Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)   17   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)   18   Ratio of line 16 to line 17 (not to exceed 1.000000)   18   19   Total customary charges (see instructions)   19   COMPUTATION OF REIMBURSEMENT SETTLEMENT   20   Cost of covered services (see instructions)   20   21   22   Subtotal (line 20 minus line 21)   22   23   Coinsurance   23   24   Subtotal (line 22 minus line 23)   24   25   Allowable bad debts (from your records)   25   26   Subtotal (sum of lines 24 and 25)   26   27   Unrefunded charges to beneficiaries for excess costs erroneously collected   26   27   28   Recovery of excess depreciation resulting from provider termination or a decrease   28   28   Recovery of excess depreciation resulting from provider termination or a decrease   28   28   28   Recovery of excess depreciation resulting from provider termination or a decrease   28   28   28   28   28   28   28   2						
Total reasonable cost (line 8 minus line 9)   10						
REASONABLE CHARGES						_
11   Inpatient ancillary service charges   12	_				10	0
12   Outpatient service charges   12   13   Inpatient routine service charges   13   Inpatient routine service charges   13   14   Differential in charges between semiprivate accommodations and less than semiprivate accommodations   14   15   Total reasonable charges   15   Total reasonable charges   15   Total reasonable charges   15   Total reasonable charges   16   Aggregate amount actually collected from patients liable for payment for services on a charge basis   17   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)   18   Ratio of line 16 to line 17 (not to exceed 1.000000)   18   Ratio of line 16 to line 17 (not to exceed 1.000000)   18   Total customary charges (see instructions)   19   Total customary charges (see instructions)   19   Total Customary charges (see instructions)   20   Cost of covered services (see instructions)   20   21   Deductibles   22   Subtotal (line 20 minus line 21)   22   23   Coinsurance   23   24   Subtotal (line 20 minus line 23)   24   25   Allowable bad debts (from your records)   25   Subtotal (sum of lines 24 and 25)   26   Subtotal (sum of lines 24 and 25)   27   Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit   28   Recovery of excess depreciation resulting from provider termination or a decrease   28   28   28   28   28   28   28   2						_
13 Inpatient routine service charges 14 Differential in charges between semiprivate accommodations and less than semiprivate accommodations 15 Total reasonable charges 15 Total reasonable charges 16 Aggregate amount actually collected from patients liable for payment for services on a charge basis 17 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 18 Ratio of line 16 to line 17 (not to exceed 1.000000) 19 Total customary charges (see instructions) 19 Total customary charges (see instructions) 20 Cost of covered services (see instructions) 21 Deductibles 22 Subtotal (line 20 minus line 21) 23 Coinsurance 24 Subtotal (line 22 minus line 23) 25 Allowable bad debts (from your records) 26 Subtotal (sum of lines 24 and 25) 27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit 28 Recovery of excess depreciation resulting from provider termination or a decrease		. , ,				_
Differential in charges between semiprivate accommodations and less than semiprivate accommodations  15 Total reasonable charges  CUSTOMARY CHARGES  16 Aggregate amount actually collected from patients liable for payment for services on a charge basis  17 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18 Ratio of line 16 to line 17 (not to exceed 1.000000)  19 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20 Cost of covered services (see instructions)  21 Deductibles  22 Subtotal (line 20 minus line 21)  23 Coinsurance  24 Subtotal (line 22 minus line 23)  25 Allowable bad debts (from your records)  26 Subtotal (sum of lines 24 and 25)  27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease						
than semiprivate accommodations  15 Total reasonable charges  CUSTOMARY CHARGES  16 Aggregate amount actually collected from patients liable for payment for services on a charge basis  17 Amounts that would have been realized from patients liable for payment for services on a charge basis and such payment been made in accordance with 42 CFR 413.13(e)  18 Ratio of line 16 to line 17 (not to exceed 1.000000)  19 Total customary charges (see instructions)  19 Total customary charges (see instructions)  10 COMPUTATION OF REIMBURSEMENT SETTLEMENT  20 Cost of covered services (see instructions)  21 Deductibles  22 Subtotal (line 20 minus line 21)  23 Coinsurance  24 Subtotal (line 22 minus line 23)  25 Allowable bad debts (from your records)  26 Subtotal (sum of lines 24 and 25)  27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease						_
15   Total reasonable charges   15	14	8 1			14	4
CUSTOMARY CHARGES  16 Aggregate amount actually collected from patients liable for payment for services on a charge basis  17 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18 Ratio of line 16 to line 17 (not to exceed 1.000000)  19 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20 Cost of covered services (see instructions)  21 Deductibles  22 Subtotal (line 20 minus line 21)  23 Coinsurance  24 Subtotal (line 20 minus line 23)  25 Allowable bad debts (from your records)  26 Subtotal (sum of lines 24 and 25)  27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease	15				1.	5
16       Aggregate amount actually collected from patients liable for payment for services on a charge basis       16         17       Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)       17         18       Ratio of line 16 to line 17 (not to exceed 1.000000)       18         19       Total customary charges (see instructions)       19         COMPUTATION OF REIMBURSEMENT SETTLEMENT       20         20       21       Deductibles       21         21       Deductibles       21         22       Subtotal (line 20 minus line 21)       22         23       Coinsurance       23         24       Subtotal (line 22 minus line 23)       24         25       Allowable bad debts (from your records)       25         26       Subtotal (sum of lines 24 and 25)       26         27       Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit       27         28       Recovery of excess depreciation resulting from provider termination or a decrease       28	_	ĕ			1.	
services on a charge basis  17 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18 Ratio of line 16 to line 17 (not to exceed 1.000000)  19 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20 Cost of covered services (see instructions)  21 Deductibles  22 Subtotal (line 20 minus line 21)  23 Coinsurance  24 Subtotal (line 22 minus line 23)  25 Allowable bad debts (from your records)  26 Subtotal (sum of lines 24 and 25)  27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease					1 1/	6
17 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  18 Ratio of line 16 to line 17 (not to exceed 1.000000)  19 Total customary charges (see instructions)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  20 Cost of covered services (see instructions)  21 Deductibles  22 Subtotal (line 20 minus line 21)  23 Coinsurance  24 Subtotal (line 22 minus line 23)  25 Allowable bad debts (from your records)  26 Subtotal (sum of lines 24 and 25)  27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease	10				ı,	U
on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)         18           18 Ratio of line 16 to line 17 (not to exceed 1.000000)         18           19 Total customary charges (see instructions)         19           COMPUTATION OF REIMBURSEMENT SETTLEMENT           20         20           21 Deductibles         21           22 Subtotal (line 20 minus line 21)         22           23 Coinsurance         23           24 Subtotal (line 22 minus line 23)         24           25 Allowable bad debts (from your records)         25           26 Subtotal (sum of lines 24 and 25)         25           27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit         27           28 Recovery of excess depreciation resulting from provider termination or a decrease         28	17		s		1	7
18 Ratio of line 16 to line 17 (not to exceed 1.000000)       18         19 Total customary charges (see instructions)       19         COMPUTATION OF REIMBURSEMENT SETTLEMENT       20         21 Deductibles       21         22 Subtotal (line 20 minus line 21)       22         23 Coinsurance       23         24 Subtotal (line 22 minus line 23)       23         25 Allowable bad debts (from your records)       24         26 Subtotal (sum of lines 24 and 25)       25         27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit       27         28 Recovery of excess depreciation resulting from provider termination or a decrease       28	1,					,
19   Total customary charges (see instructions)   19	18		(=)		1:	8
COMPUTATION OF REIMBURSEMENT SETTLEMENT         20           20 Cost of covered services (see instructions)         20           21 Deductibles         21           22 Subtotal (line 20 minus line 21)         22           23 Coinsurance         23           24 Subtotal (line 22 minus line 23)         24           25 Allowable bad debts (from your records)         25           26 Subtotal (sum of lines 24 and 25)         25           27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit         27           28 Recovery of excess depreciation resulting from provider termination or a decrease         28	19					_
21 Deductibles       21         22 Subtotal (line 20 minus line 21)       22         23 Coinsurance       23         24 Subtotal (line 22 minus line 23)       24         25 Allowable bad debts (from your records)       25         26 Subtotal (sum of lines 24 and 25)       25         27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit       27         28 Recovery of excess depreciation resulting from provider termination or a decrease       28		, ,				_
22 Subtotal (line 20 minus line 21)     22       23 Coinsurance     23       24 Subtotal (line 22 minus line 23)     24       25 Allowable bad debts (from your records)     25       26 Subtotal (sum of lines 24 and 25)     26       27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     27       28 Recovery of excess depreciation resulting from provider termination or a decrease     28	20	Cost of covered services (see instructions)			20	0
23 Coinsurance     23       24 Subtotal (line 22 minus line 23)     24       25 Allowable bad debts (from your records)     25       26 Subtotal (sum of lines 24 and 25)     26       27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     27       28 Recovery of excess depreciation resulting from provider termination or a decrease     28	21	Deductibles			2	1
24       Subtotal (line 22 minus line 23)       24         25       Allowable bad debts (from your records)       25         26       Subtotal (sum of lines 24 and 25)       26         27       Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit       27         28       Recovery of excess depreciation resulting from provider termination or a decrease       28		Subtotal (line 20 minus line 21)				
25 Allowable bad debts (from your records)     25       26 Subtotal (sum of lines 24 and 25)     26       27 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     27       28 Recovery of excess depreciation resulting from provider termination or a decrease     28						
26     Subtotal (sum of lines 24 and 25)     26       27     Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     27       28     Recovery of excess depreciation resulting from provider termination or a decrease     28						
27     Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     27       28     Recovery of excess depreciation resulting from provider termination or a decrease     28						
based on correction of cost limit  28 Recovery of excess depreciation resulting from provider termination or a decrease  28						
28 Recovery of excess depreciation resulting from provider termination or a decrease 28	27	ş			2'	7
, , , , , , , , , , , , , , , , , , , ,						_
in program utilization	28	,			23	8
20 101 11 11 11 11 11 11 11 11 11 11 11 1		1 6				_
29 Other adjustments (Specify) (see instructions) 29						
30 Amounts applicable to prior cost reporting periods resulting from disposition of	30				30	U
depreciable assets (if minus, enter amount in parentheses)  31 Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  31	21				3	1
31 Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)  32 Interim payments  32		1				_
32 Interim payments 32 33 Balance due provider/program (line 31 minus line 32) 33						
(indicate overpayments in parentheses) (see instructions)	55				]	_

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ANA	LYSIS OF PAYMENTS TO PROVIDERS SERVICES RENDERED				PROVIDER CCN:	PERIOD : FROMTO	WORKSHEET E-1	
					tient Part A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description			1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted							2
	or to be submitted to the intermediary/contractor for services							
	rendered in the cost reporting period. If none, enter zero.							
3	List separately each retroactive lump sum		.01					3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		to	.52					3.52
		Program	.53					3.53
			.54					3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99					3.99
4								4
	(Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)							
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6	Determine net settlement amount (balance	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contra	ctor Number				8

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<sup>(1)</sup> 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.

DALANCE CHEET	DDOWIDED CCM.	DEDIOD .	WORKSHEET G
BALANCE SHEET	PROVIDER CCN:	PERIOD :	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		FROM	
accounting records, complete the "General Fund" column only.)		TO	

Assets	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS					
1 Cash on hand and in banks					1
2 Temporary investments					2
3 Notes receivable				1	3
4 Accounts receivable					4
5 Other receivables					5
6 Less: allowances for uncollectible notes	( )	( )	( )	( )	6
and accounts receivable					
7 Inventory					7
8 Prepaid expenses					8
9 Other current assets					9
10 Due from other funds					10
11 TOTAL CURRENT ASSETS					11
(sum of lines 1 - 10)				+	
FIXED ASSETS					- 13
12 Land					12
13 Land improvements					13
14 Less: Accumulated depreciation	( )	( )	( )	( )	14
15 Buildings					15
16 Less Accumulated depreciation	( )	( )	( )	( )	16
17 Leasehold improvements					17
18 Less: Accumulated Amortization	( )	( )	( )	( )	18
19 Fixed equipment					19
20 Less: Accumulated depreciation	( )	( )	( )	( )	20
21 Automobiles and trucks					21
22 Less: Accumulated depreciation	( )	( )	( )	( )	22
23 Major movable equipment					23
24 Less: Accumulated depreciation	( )	( )	( )	( )	24
25 Minor equipment - Depreciable					25
26 Minor equipment nondepreciable					26
27 Other fixed assets					27
28 TOTAL FIXED ASSETS					28
(sum of lines 12 - 27)					
OTHER ASSETS					
29 Investments					29
30 Deposits on leases					30
31 Due from owners/officers					31
32 Other assets					32
33 TOTAL OTHER ASSETS					33
(sum of lines 29 - 32)					
34 TOTAL ASSETS					34
(sum of lines 11, 28 and 33)					

<sup>( ) =</sup> contra amount

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BALANCE SHEET	PROVIDER CCN:	PERIOD:	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		FROM	
accounting records, complete the "General Fund" column only.)		TO	

CURRENT LIABILITIES		Liabilities and Fund	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CURRENT LIABILITIES			rund 1				
35   Accounts payable   36   Salaries, wages & fees payable   37   Payroll taxes payable   38   Notes & Joan payable   40   Notes & Joan payable   40   Accelerated payments   41   Due to other funds   42   Other current liabilities   43   TOTAL CURRENT LIABILITIES   (sum of lines 35 - 42)   (cum of lines 34 - 49)   (cum of lines 44 - 40)   (c	CURI		1	<u> </u>	3	7	
36   Salaries, wages & fees payable							35
37 Payroll taxes payable 38 Notes & losa payable (short term) 39 Deferred income 40 Accelerated payments 41 Due to other funds 42 Other current liabilities 43 TOTAL CURRENT LIABILITIES (sum of lines 35 - 42) 44 Mortgage payable 45 Notes payable 46 Unsecured loans 47 Loans from owners: 48 Other long term liabilities 49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LONG TERM LIABILITIES (sum of lines 45 - 40) 51 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 52 General final balance - restricted 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - restricted 56 Governia body created - endowment find balance - restricted 57 Plant fund balance - reserve for plant improvement, replacement and expansion 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL LIABILITIES (sum of lines 41 - 10) 50 TOTAL LIABILITIES 51 TOTAL FUND BALANCES 52 Governia balance - reserve for plant improvement, replacement and expansion 53 TOTAL LIABILITIES AND							36
Notes & Joans payable (short term)							37
39   Deferred income							38
40   Accelerated payments							39
1   Due to other funds							40
42 Other current liabilities							41
43 TOTAL CURRENT LIABILITIES (sum of lines 35 - 42)  LONG TERM LIABILITES  44 Mortgage payable 45 Notes payable 46 Unsecured loans 47 Loans from owners: 48 Other long term liabilities 49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LABILITIES (sum of lines 43 and 50) CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance 57 Plant fund balance - invested in plant 58 Plant fund balance - invested in plant 59 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL LIABILITIES AND							42
(sum of lines 35 - 42)							43
LONG TERM LIABILITIES  44 Mortgage payable  45 Notes payable  46 Unsecured loans  47 Loans from owners:  48 Other long term liabilities  49 Other (specify)  50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)  51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance  53 Specific purpose fund 54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - invested in plant  59 TOTAL FUND BALANCES (sum of lines 52 thru 58) (sum of lines 52 thru 58)  60 TOTAL LIABILITIES	1.5						13
44 Mortgage payable 45 Notes payable 46 Unsecured loans 47 Loans from owners: 48 Other long term liabilities 49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LIABILITIES (sum of lines 43 and 50) CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance - invested in plant 57 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL LIABILITIES AND	LONG						
45 Notes payable 46 Unsecured loans 47 Loans from owners: 48 Other long term liabilities 49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LIABILITIES (sum of lines 45 and 50) CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance - unrestricted 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL LIABILITIES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							44
46 Unsecured loans 47 Loans from owners: 48 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - restricted 56 Governing body created - endowment fund balance - investricted 57 Plant fund balance - invested in plant 58 Plant fund balance - invested in plant 59 Plant fund balance - reserve for plant improvement, replacement and expansion 50 TOTAL LIABILITIES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							45
47 Loans from owners:  48 Other long term liabilities  49 Other (specify)  50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)  51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance  53 Specific purpose fund  54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance - unrestricted  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thu 58)  60 TOTAL LIABILITIES AND							46
48 Other long term liabilities 49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 -49) 51 TOTAL LIABILITIES (sum of lines 43 and 50) CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - restricted 56 Governing body created - endowment fund balance - investricted 57 Plant fund balance - invested in plant 58 Plant fund balance - invested in plant 59 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thu 58) 60 TOTAL LIABILITIES AND							47
49 Other (specify) 50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49) 51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS 52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance - unrestricted 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							48
50 TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)  51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							49
(sum of lines 44 - 49)  51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance - invested in plant  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND		TOTAL LONG TERM LIABILITIES					50
51 TOTAL LIABILITIES (sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	30						30
(sum of lines 43 and 50)  CAPITAL ACCOUNTS  52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance 57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	51						51
CAPITAL ACCOUNTS  52 General fund balance  53 Specific purpose fund  54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance - invested in plant  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	31						31
52 General fund balance 53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund balance 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND	CAPI						
53 Specific purpose fund 54 Donor created - endowment fund balance - restricted 55 Donor created - endowment fund balance - unrestricted 56 Governing body created - endowment fund fund balance 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							52
54 Donor created - endowment fund balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND							53
balance - restricted  55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND							54
55 Donor created - endowment fund balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	٥.						
balance - unrestricted  56 Governing body created - endowment fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	55						55
56 Governing body created - endowment fund balance 57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							
fund balance  57 Plant fund balance - invested in plant  58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	56						56
57 Plant fund balance - invested in plant 58 Plant fund balance - reserve for plant improvement, replacement and expansion 59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND	50						
58 Plant fund balance - reserve for plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	57						57
plant improvement, replacement and expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND							58
expansion  59 TOTAL FUND BALANCES (sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	50						30
59 TOTAL FUND BALANCES (sum of lines 52 thru 58) 60 TOTAL LIABILITIES AND							
(sum of lines 52 thru 58)  60 TOTAL LIABILITIES AND	59						59
60 TOTAL LIABILITIES AND	27						
	60		+		<del>                                     </del>		60
	00	FUND BALANCES					30
(sum of lines 51 and 59)							

<sup>( ) =</sup> contra amount

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<u> </u>			( )
STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN:	PERIOD :	WORKSHEET G - 1
		FROM	
		TO	

		Gener	al Fund	Special Pu	irpose Fund	Endown	nent Fund	Plan	t Fund	Т
		1	2	3	4	5	6	7	8	1
1	Fund balances at beginning of period									1
	Net income (loss) (from Wkst. G-3, line 31)									2
3	Total (sum of line 1 and line 2)									3
4	Additions (credit adjustments)									4
5										5
6										6
7										7
8										8
9										9
	Total additions (sum of lines 5 - 9)									10
	Subtotal (line 3 plus line 10)									11
12	Deductions (debit adjustments)									12
13										13
14										14
15										15
16										16
17										17
	Total deductions (sum of lines 13 - 17)									18
19	Fund balance at end of period per balance sheet (line 11 - line 18)									19

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サエノ	(Cont.)	1 ORIVI CIVIS-23-10-10			00-10
	TEMENT OF PATIENT REVENUES OPERATING EXPENSES	PROVIDER CCN:	PERIOD : FROM TO	WORKSHEET G - 2 PARTS I & II	
PART	I - PATIENT REVENUES				
		INPATIENT	OUTPATIENT	TOTAL	
	Revenue Center	1	2	3	
	ral Inpatient Routine Care Services				
	Skilled nursing facility				1
2	Nursing facility ICF / IID				3
	Other long term care				4
5					5
5	(sum of lines 1 - 4)				
All (	Other Care Service				
	Ancillary services				6
7	Clinic				7
8	Home health agency				8
9					9
10	· ·				10
11					11
	Hospice				12
13	Other (specify)				13 14
14	Total patient revenues (sum of lines 5 - 13) (transfer to Wkst. G-3, col. 3, line 1)				14
PAR7	TII - OPERATING EXPENSES Operating Expenses (per Wkst. A, col. 3, line 100)				1
2	Add (Specify)				2
3					3
4					4
5					5
6					6
7					7
8	Total Additions (sum of lines 2 - 7)				8
9	Deduct (Specify)				9
10					10
11					11
12					12
13					13
14	Total Deductions (sum of lines 9 - 13)				14

15 Total Operating Expenses (sum of lines 1 and 8, minus line 14)

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	TEMENT OF REVENUES EXPENSES	PROVIDER CCN:	PERIOD : FROM	WORKSHEET G-3	
			то		
			•		
1	Total patient revenues (from Wkst. G-2, Pt. I, col. 3, line 14)				1
2	Less: contractual allowances and discounts on patients accounts				2
3	Net patient revenues (line 1 minus line 2)				3
4	Less: total operating expenses (form Wkst. G-2, Pt. II, line 15)		4		
5	Net income from service to patients (line 3 minus 4)				5
	Other income:				
6	Contributions, donations, bequests, etc.				6
7	Income from investments				7
8	Revenues from communications (telephone and internet service)				8
9	Revenue from television and radio service				9
10	Purchase discounts				10
11	Rebates and refunds of expenses				11
12	Parking lot receipts				12
13	Revenue from laundry and linen service	_			13
14	Revenue from meals sold to employees and guests	_	_		14
15	Revenue from rental of living quarters	_	_		15

16 17

18 19

20 21 22

23

24 4.50

31

Revenue from rental of living quarters

Rental of vending machines Rental of skilled nursing space

Governmental appropriations

Total (line 5 plus line 25) Other expenses (specify

Other miscellaneous revenue (specify COVID-19 PHE Funding

Total other income (sum of lines 6 - 24)

30 Total other expenses (sum of lines 27 - 29)

31 Net income (or loss) for the period (line 26 minus line 30)

Revenue from sale of drugs to other than patients

Tuition (fees, sale of textbooks, uniforms, etc.)

Revenue from gifts, flower, coffee shops, canteen

Revenue from sale of medical records and abstracts

Revenue from sale of medical and surgical supplies to other than patients

16

17

20

23

24

25

28

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ANA	LYSIS OF SNF-BASED		PROVIDER CCN:		PERIOD:		WORKSHEET H					
HOM	E HEALTH AGENCY COSTS								FROM			
							HHA CCN:		то			
				TRANSPOR-							NET	
				TATION	CONTRACTED/		TOTAL		RECLASSIFIED		EXPENSES FOR	İ
			EMPLOYEE	( see	PURCHASED	OTHER	( sum of cols.	RECLASSIFI-	TRIAL BALANCE	ADJUST-	ALLOCATION	İ
		SALARIES	BENEFITS	instructions )	SERVICES	COSTS	1 thru 5 )	CATIONS	(col. 6 + col. 7)	MENTS	(col. 8 + col. 9)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	10	
GEN	ERAL 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
	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
	Drugs											13
14	DME											14
15	Telemedicine											15
HHA	NONREIMBURSABLE SERVICES											
	Home Dialysis Aide Services											16
17	Respiratory Therapy											17
	Private Duty Nursing											18
19	Clinic											19
20	Health Promotion Activities											20
21	Day Care Program											21
22	Home Delivered Meals Program											22
23	Homemaker Service											23
24	All Others											24
25	Total (sum of lines 1-24)											25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

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COST ALLOCATION - HHA GENERAL SERVICE COST	PROVIDER CCN:		PERIOD:		WORKSHEET H-1				
				HHA CCN:		FROMTO		PART I	
	NET EXPENSES FOR COST		PITAL ED COSTS						Ī
	ALLOCATION ( from Wkst. H, col. 10 )	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTAL TRATIVE (cols. 0 through 4) & GENERAL		TOTAL ( cols. 4A + 5 )	
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTERS									
1 Capital Related - Bldgs. and Fixtures									1
2 Capital Related - Movable Equipment									2
3 Plant Operation & Maintenance									3
4 Transportation (see instructions)									4
5 Administrative and General									5
HHA REIMBURSABLE SERVICES									4
6 Skilled Nursing Care									6
7 Physical Therapy									7
8 Occupational Therapy									8
9 Speech Pathology									9
10 Medical Social Services								<u> </u>	10
11 Home Health Aide									11
12 Supplies									12
13 Drugs									13
14 DME									14
15 Telemedicine									15
HHA NONREIMBURSABLE SERVICES									4
16 Home Dialysis Aide Services									16
17 Respiratory Therapy									17
18 Private Duty Nursing									18
19 Clinic									19
20 Health Promotion Activities									20
21 Day Care Program									21
22 Home Delivered Meals Program									22
23 Homemaker Service									23
24 All Others									24
25 Total (sum of lines 1-24)								4	25

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	T ALLOCATION - HHA STATISTICAL BASIS	PROVIDER CCN:		PERIOD:	WORKSHEET H-1,					
					ННА CCN:		FROMTO		PART II	
					Inter cerv.		10			
			CAP	ITAL						
				D COSTS	PLANT			ADMINIS-		
			BLDGS. &	MOVABLE	OPERATION &			TRATIVE		
		NET EXPENSES	FIXTURES	EQUIPMENT	MAINTENANCE	TRANS-	D T C C L C C C	& GENERAL		
		FOR COST	( Square	( Dollar Value	( Square	PORTATION	RECONCIL-	( Accumulated	TOT 1	
		ALLOCATION 0	Feet )	or Square Feet )	Feet )	( Mileage )	IATION	Cost )	TOTAL 6	_
GEN	ERAL SERVICE COST CENTERS	U	1	2	3	4	5A	3	0	_
UEN 1	Capital Related - Bldgs. and Fixtures							1		
2	Capital Related - Movable Equipment							2		
	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
- 5	Administrative and General									5
	REIMBURSABLE SERVICES									
6										6
7	Physical Therapy									7
- 8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
14	DME									14
15										15
	NONREIMBURSABLE SERVICES									
	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
	Private Duty Nursing									18
	Clinic									19
	Health Promotion Activities									20
	Day Care Program									21
	Home Delivered Meals Program									22
	Homemaker Service									23
	All Others									24
	Total (sum of lines 1-24)									25
	Cost to be allocated									26
27	Unit Cost Multiplier									27

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	OCATION OF GENERAL SERVICE	VI CIVIS 23 10	PROVIDER CCN:		PERIOD:	WORKSHEET H-2, PART I					
COST	S TO HHA COST CENTERS					HHA CCN:		FROM TO		PARTI	
-		From Wkst.	ННА		PITAL ED COSTS						
		H-1, Pt. I, col. 6,	TRIAL BALANCE (1)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL ( cols. 0 through 3 )	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	HHA COST CENTER	line	0	1	2	3	3A	4	5	6	1
	Administrative and General	5	Ů,	1		,	311	· ·	J	•	1
	Skilled Nursing Care	6									2
	Physical Therapy	7									3
4	Occupational Therapy	8									4
	Speech Pathology	9									5
	Medical Social Services	10									6
7	Home Health Aide	11									7
8	Supplies	12									8
	Drugs	13									9
	DME	14									10
	Telemedicine	15									11
	Home Dialysis Aide Services	16									12
	Respiratory Therapy	17									13
	Private Duty Nursing	18									14
	Clinic	19									15
	Health Promotion Activities	20									16
	Day Care Program	21									17
	Home Delivered Meals Program	22									18
	Homemaker Service	23									19
	All Others	24									20
	Totals (sum of lines 1-20) (2)										21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places										22

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<sup>(1)</sup> Column 0, line 21 must agree with Wkst. A, col. 7, line 70.(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

T12	o (Cont.)	TORN	1 CN15-25-0-1	. 0		11-12				
ALL	OCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET H-2,		
COS	TS TO HHA COST CENTERS					FROM		PART I		
				HHA CCN:		ТО				
				NURSING	CENTRAL		MEDICAL			
		HOUSE		ADMINIS-	SERVICES &		RECORDS &	SOCIAL		
		KEEPING	DIETARY	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE		
	HHA COST CENTER	7	8	9	10	11	12	13	1	
1	Administrative and General								1	
	Skilled Nursing Care								2	
3	Physical Therapy								3	
4	Occupational Therapy								4	
5	Speech Pathology								5	
6	Medical Social Services								6	
7	Home Health Aide								7	
8	Supplies								8	
	Drugs								9	
	DME								10	
	Telemedicine								11	
	Home Dialysis Aide Services								12	
	Respiratory Therapy								13	
	Private Duty Nursing								14	
	Clinic								15	
	Health Promotion Activities								16	
	Day Care Program								17	
	Home Delivered Meals Program								18	
	Homemaker Service								19	
	All Others								20	
	Totals (sum of lines 1-20) (2)								21	
22	Unit Cost Multiplier: column 18, line 1								22	
	divided by the sum of column 18,									
	line 21, minus column 18, line 1,									
	rounded to 6 decimal places.									

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<sup>(2)</sup> Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

11-1	2	FORM	l CMS-2540-1		4190 (Cont.)				
	OCATION OF GENERAL SERVICE TS TO HHA COST CENTERS			PROVIDER CCN: HHA CCN:		PERIOD : FROM TO		WORKSHEET H-2 PART I	,
	HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE 15	SUBTOTAL ( sum of cols. 3A through 15 )	POST STEPDOWN ADJUSTMENTS	SUBTOTAL ( cols. 16 ± 17 ) 18	ALLOCATED HHA A&G ( see Pt. II )	TOTAL HHA COSTS 20	
1	Administrative and General								1
	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
	Drugs								9
	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
	Respiratory Therapy								13
	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1								22
	divided by the sum of column 18,								
	line 21, minus column 18, line 1,								
	rounded to 6 decimal places.								

<sup>(2)</sup> Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

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ALLO	OCATION OF GENERAL SERVICE IS TO HIA COST CENTERS			PROVIDER CCN:		PERIOD : FROM		WORKSHEET H-2, PART II	
	TISTICAL BASIS			HHA CCN:		TO		TAKT II	
			PITAL					1	T
			ED COSTS			ADMINIS-		LAUNDRY	
		BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	OPERATION	& LINEN	
		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	OF PLANT	SERVICE	
		( Square	( Dollar Value	( Gross	RECONCIL-	( Accumulated	( Square	( Pounds of	
		Feet )	or Square Feet )	Salaries )	IATION	Cost )	Feet )	Laundry)	_
	HHA COST CENTER	1	2	3	4A	4	5	6	
1	Administrative and General								1
2	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
	Medical Social Services								6
	Home Health Aide								7
8	Supplies								8
	Drugs								9
10	DME								10
11	Telemedicine								11
	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program							1	17
18	Home Delivered Meals Program							1	18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier							1	23

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11-12	/I CMS-2540-1			4190 (Cont.)				
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET H-2, PART II	
HHA COST CENTER	HOUSE- KEEPING ( Hours of Service )	DIETARY ( Meals Served )	NURSING ADMINIS- TRATION ( Direct Nursing Hrs. )	CENTRAL SERVICES & SUPPLY ( Costed Requis.)	PHARMACY ( Costed Requis. )	MEDICAL RECORDS & LIBRARY ( Time Spent )	SOCIAL SERVICE ( Time Spent )	
1 Administrative and General		o	9	10	11	12	13	+-
2 Skilled Nursing Care								2
3 Physical Therapy								3
4 Occupational Therapy								4
5 Speech Pathology						<u> </u>		5
6 Medical Social Services						<u> </u>		6
7 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Telemedicine								11
12 Home Dialysis Aide Services								12
13 Respiratory Therapy								13
14 Private Duty Nursing								14
15 Clinic								15
16 Health Promotion Activities								16
17 Day Care Program								17
18 Home Delivered Meals Program								18
19 Homemaker Service								19
20 All Others								20
21 Totals (sum of lines 1-20)								21
22 Total cost to be allocated								22
23 Unit Cost Multiplier								23

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ALLOCATION OF GENERAL SERVICE OCSTS TO THA COST CENTERS STATISTICAL BASIS    NURSING	4190 (Cont.)	FORM	CIVIS-2340-1	Ū		11-12			
STATISTICAL BASIS	ALLOCATION OF GENERAL SERVICE		PROVIDER CCN:						
STATISTICAL BASIS	COSTS TO HHA COST CENTERS					FROM		PART II	
AND ALLIED   HEALTH   EDUCATION   CASIGNAT   CONTRACTOR	STATISTICAL BASIS			HHA CCN:		TO			
AND ALLIED   HEALTH   EDUCATION   CASIGNAT   CONTRACTOR									
HEALTH EDUCATION GENERAL (sum of length (specified)   File (specifie									
EDUCATION   GENERAL   (sum of SERVICE   cols. 3A   SERVICE   cols. 3A   STEPDOWN   SUBTOTAL   HINA A&G   TOTAL   G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&G   TOTAL   HINA A&									
Cassigned   SERVICE   cols. 3A   STEPDOWN   SUBTOTAL   HHA A&G   TOTAL   Time   (SPECIFY   through 15)   ADJUSTMENTS   (cols. 16 ± 17)   (see Pt. 11)   HHA COSTS			OTHER	SUBTOTAL					
Time   (SPECIFY   through 15)   ADJUSTMENTS   (cols. 16 ± 17)   (see Pt. II)   HHA COSTS		EDUCATION	GENERAL	( sum of	POST		ALLOCATED		
HHA COST CENTER		( Assigned	SERVICE	cols. 3A	STEPDOWN	SUBTOTAL	HHA A&G	TOTAL	
1   Administrative and General		Time )	(SPECIFY)	through 15)	ADJUSTMENTS	$( cols. 16 \pm 17 )$	( see Pt. II )	HHA COSTS	
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       6         8 Supplies       8         9 Drugs       8         10 DME       9         11 Telemedicine       10         12 Home Dialysis Aide Services       11         13 Respiratory Therapy       9         14 Private Duty Nursing       13         15 Clinic       16         16 Health Promotion Activities       16         17 Day Care Program       17         18 Home Delivered Meals Program       17         19 Home maker Service       9         21 Totals (sum of lines 1-20)       20         22 Total cost to be allocated       22	HHA COST CENTER	14	15	16	17	18	19	20	1
3 Physical Therapy	1 Administrative and General								1
4   Occupational Therapy									2
5 Speech Pathology         5           6 Medical Social Services         6           7 Home Health Aide         7           8 Supplies         8           9 Drugs         8           10 DME         9           11 Telemedicine         10           12 Home Dialysis Aide Services         11           13 Respiratory Therapy         12           14 Private Duty Nursing         13           15 Clinic         15           16 Health Promotion Activities         16           17 Day Care Program         16           18 Home Delivered Meals Program         18           19 Homemaker Service         19           20 All Others         20           21 Total cost to be ailocated         22									3
6 Medical Social Services 6 6 7 Home Health Aide 7 7 8 Supplies 8 8 9 Drugs 8 9 Drugs 9 9 10 DME 9 9 11 Telemedicine 9 10 12 Home Dialysis Aide Services 9 9 12 13 Respiratory Therapy 9 14 Private Duty Nursing 9 15 Clinic 9 16 Health Promotion Activities 9 16 Health Promotion Activities 9 17 Day Care Program 9 18 Home Delivered Meals Program 9 19 Homemaker Service 9 19 All Others 9 19 All Others 9 19 20 All Others 9 22 Totals (sum of lines 1-20) 9 21 Totals (sum of lines 1-20) 9 21 Total cost to be allocated 9 19 Care Program 9 22 2 Total cost to be allocated 9 19 All Others 9 20 All Others 9 22 2 Total cost to be allocated 9 19 All Others 9 20 Al									4
7 Home Health Aide	5 Speech Pathology								5
8 Supplies       8         9 Drugs       9         10 DME       10         11 Telemedicine       10         12 Home Dialysis Aide Services       11         13 Respiratory Therapy       13         14 Private Duty Nursing       13         15 Clinic       15         16 Health Promotion Activities       15         17 Day Care Program       16         18 Home Delivered Meals Program       18         19 Homemaker Service       19         20 All Others       20         21 Total cost to be allocated       22									6
9 Drugs 9 10 DME 9 11 Telemedicine 10 12 Home Dialysis Aide Services 9 13 Respiratory Therapy 13 14 Private Duty Nursing 14 15 Clinic 15 16 Health Promotion Activities 15 17 Day Care Program 16 18 Home Delivered Meals Program 18 19 Homemaker Service 19 20 All Others 19 21 Total cost to be allocated 19 22 Total cost to be allocated 19 25 All Oster to Service 19 26 All Others 19 27 Total cost to be allocated 19 28 All Oster to Service 19 29 Total cost to be allocated 19 20 Total cost to be allocated 19 20 Total cost to be allocated 19 21 Total cost to be allocated 19 20 Total cost to be allocated 19 21 Total cost to be allocated 19 21 Total cost to be allocated 19 22 Total cost to be allocated 19 28 Total cost to be allocated 19 29 20 Total cost to be allocated 19 21 Total cost to be allocated 19 22 Total cost to be allocated 19 22 Total cost to be allocated 19 25 Total cost to be allocated 19 26 Total cost to be allocated 19 27 Total cost to be allocated 19 28 Total cost to be allocated 19 29 20 Total cost to be allocated 19 21 Total cost to be allocated 19 21 Total cost to be allocated 19 22 Total cost to be allocated 19 23 Total cost to be allocated 19 24 25 Total cost to be allocated 19 25 Total cost to be allocated 19 26 Total cost to be allocated 19 27 Total cost to be allocated 19 28 Total cost to be allocated 19 28 Total cost to be allocated 19 29 Total cost to be allocated 19 20 Total cost to be allocated 19 20 Total cost									7
10 DME									
Telemedicine									_
12 Home Dialysis Aide Services       12         13 Respiratory Therapy       13         14 Private Duty Nursing       14         15 Clinic       15         16 Health Promotion Activities       16         17 Day Care Program       17         18 Home Delivered Meals Program       18         19 Homemaker Service       18         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
13 Respiratory Therapy       13         14 Private Duty Nursing       14         15 Clinic       15         16 Health Promotion Activities       16         17 Day Care Program       17         18 Home Delivered Meals Program       18         19 Homemaker Service       18         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
14 Private Duty Nursing       14         15 Clinic       15         16 Health Promotion Activities       16         17 Day Care Program       17         18 Home Delivered Meals Program       18         19 Homemaker Service       18         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
15   Clinic   15   16   Health Promotion Activities   16   16   17   Day Care Program   17   18   Home Delivered Meals Program   18   Home Delivered Meals Program   18   19   Homemaker Service   19   19   19   19   19   19   19   1	13 Respiratory Therapy								
16 Health Promotion Activities       16         17 Day Care Program       17         18 Home Delivered Meals Program       18         19 Homemaker Service       19         20 All Others       20         21 Totals (sum of lines 1-20)       20         22 Total cost to be allocated       22	, 6								
17 Day Care Program       17         18 Home Delivered Meals Program       18         19 Homemaker Service       19         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
18 Home Delivered Meals Program       18         19 Homemaker Service       19         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
19 Homemaker Service       19         20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
20 All Others       20         21 Totals (sum of lines 1-20)       21         22 Total cost to be allocated       22									
21       Totals (sum of lines 1-20)       21         22       Total cost to be allocated       22									
22 Total cost to be allocated 22									
23 Unit Cost Multiplier 23									
	23 Unit Cost Multiplier								23

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APPO	APPORTIONMENT OF PATIENT SERVICE COSTS								PROVIDER CCN HHA CCN:	<b>1</b> :	PERIOD : FROM TO		WORKSHEET H-3, Parts I & II		
	Check applicable box:		[] Title V	[] Title	XVIII	[] Title XIX									
PART	I - COMPUTATION OF							T				~ ~~ .			
Cost I	Per Visit Computation	From,	Facility	Shared	Total		Average		Program Visits	_		Cost of Services			
		Wkst.	Costs	Ancillary	HHA		Cost		Part I				Part B	Total	
		H-2,	( from	Costs	Costs		Per Visit		Not Subject	Subject		Not Subject	Subject	Program Cost	
		Pt. I,	Wkst. H-2.	( from	( col. 1 +	Total	( col. 3		to Deductibles	to Deductibles		to Deductibles	to Deductibles	( sum of	
		col. 20,	Pt. I )	Pt. II )	col 2)	Visits	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	& Coinsurance	& Coinsurance	cols. 9-10)	
	Patient Services	line -	1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
3	Occupational Therapy	4													3
4	Speech Pathology	5													4
5	Medical Social Services	6													5
6	Home Health Aide	7													6
7	Total (sum of lines 1-6)														7
									1						
Patient	t Services by CBSA												Program Visits		
1 441011	which services by CBS/1													Part B	
													Not Subject	Subject	
											CBSA		to Deductibles	to Deductibles	
											No. (1)	Part A	& Coinsurance	& Coinsurance	
											100. (1)	2 Part A	3	& Comsurance	
0	Claille 4 Name in a Casa										1	2	3	4	0
	Skilled Nursing Care Physical Therapy														8
	Occupational Therapy														10
	Speech Pathology														11
	Medical Social Services														12
	Home Health Aide														13
14	Total (sum of lines 8-13)														14
	es and Drugs Cost			Facility					Pro	gram Covered Cha			Cost of Services		
Comp	utations			Costs	Shared		Total			Part			Part I		
			From	( from	Ancillary	Total	Charges			Not Subject	Subject		Not Subject	Subject	
			Wkst. H-2,	Wkst.	Costs	HHA	( from	Ratio		to	to		to	to	
			Pt. I,	H-2,	( from	Cost	HHA	( col. 3		Deductibles &	Deductibles &		Deductibles &	Deductibles &	
			col. 20,	Pt. I)	Pt. II )	( cols. $1 + 2 )$	records)	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	
	Other Patient Services		line -	1	2	3	4	5	6	7	8	9	10	11	
15	Cost of Medical Supplies		8												15
16	Cost of Drugs		9												16
PART	II - APPORTIONMENT	OF COS	T OF HHA S	ERVICES F	JRNISHED	BY SHARED	SKILLED N	JRSING FACIL	ITY DEPARTME	NTS					
							From	Cost to		Total HHA	Charges	HHA Shared A	Ancillary Costs	Transfer to	
							Wkst. C,		itio	( from provid		( col. 1 x	•	Pt. 1 -	
							col. 3, line -	1		2		3		4	1
1 Physical Therapy							44	·		<del>-</del>				col. 2, line 2	1
2 Occupational Therapy							45							col. 2, line 3	2
3 Speech Pathology						46							col. 2, line 4	3	
4 Cost of Medical Supplies						48							col. 2, line 4	4	
	4 Cost of Medical Supplies 5 Cost of Drugs						49			1		}		col. 2, line 15	5
Э	Cost of Drugs				49	]						coi. 2, line 10	3		

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<sup>(1)</sup> The CBSA numbers flow from Wkst. S-4, line 22, and subscripts as indicated should be replicated on lines 8-13.

4190	(Cont.) FORM	4 CMS-2540-10			11-19
CALCU	JLATION OF SNF-BASED HHA	PROVIDER CCN:	PERIOD:	WORKSHEET H-4,	
REIME	SURSEMENT SETTLEMENT		FROM	Parts I & II	
		HHA CCN:	TO		
	Check applicable box: [] Title V [] Title XVIII	[ ] Title XIX			
PART	I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU	JSTOMARY CHARGES			_
				art B	_
			Not Subject to	Subject to	
		Boot A	Deductibles & Coinsurance	Deductibles & Coinsurance	
	Description	Part A	& Consurance	& Comsurance	_
Resons	ible Cost of Part A & Part B Services	1	2	3	
	Reasonable cost of services (see instructions)		T	T	1
	Total charges				2
	ary Charges				
	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
DADT	II - COMPUTATION OF SNF-BASED HHA REIMBURSEMENT SETTLE	MENIT			
PARI	II - COMPUTATION OF SNF-DASED HHA REINIBURSEMENT SETTLE	VIEN I	Part A Services	Part B Services	
	Description		1	2	-
10	Total reasonable cost (see instructions)		1	2	10
	Total PPS Reimbursement - Full Episodes without Outliers				11
12	Total PPS Reimbursement - Full Episodes with Outliers				12
	Total PPS Reimbursement - LUPA Episodes				13
	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
	DME Payments				18
	Oxygen Payments				19
20	Prosthetic and Orthotic Payments				20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)				21
22	Subtotal (sum of lines 10 through 20 minus line 21)				22
23	Excess reasonable cost (from line 8)				23
24	Subtotal (line 22 minus line 23)				24
25	Coinsurance billed to program patients (from your records)				25 26
	Net cost (line 24 minus line 25)				_
27 28	Allowable bad debts (from your records)  Allowable bad debts for dual eligible beneficiaries (see instructions)		+	+	27 28
	Total costs - current cost reporting period (line 26 plus line 27)				29
30	Other adjustments (see instructions) (specify)				30
	Demonstration payment adjustment amount before sequestration				30.50
	Demonstration payment adjustment amount after sequestration				30.55
	Sequestration amount (see instructions)				30.99
31	Subtotal (see instructions)				31
32	Interim payments (see instructions)				32
33	Tentative settlement (for contractor use only)				33
34	Balance due provider/program (see instructions)				34
35	Protested amounts (nonallowable cost report items) in accordance with				35
	CMS Pub. 15-2, section 115.2				

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ANALYSIS OF PAYMENTS TO SNF-BASED HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	*			PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-5	<u>· ()</u>
				Part A		Part B	
			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Description			1	2	3	4	
1 Total interim payments paid to provider							1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
3 List separately each retroactive lump sum							3.01
adjustment amount based on subsequent revision of	Program	.02					3.02
the interim rate for the cost reporting period	to	.03					3.03
Also show date of each payment.	Provider	.04					3.04
If none, write "NONE," or enter a zero. (1)		.05					3.05
		.50					3.50
	Provider	.51					3.51
	to	.52					3.52
	Program	.53					3.53
		.54					3.54
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)	•	.99					3.99
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)							4
TO BE COMPLETED BY CONTRACTOR							
5 List separately each tentative settlement	Program	.01					5.01
payment after desk review. Also show	to	.02					5.02
date of each payment.	Provider	.03					5.03
If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
	to	.51					5.51
	Program	.52					5.52
SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6 Determine net settlement amount (balance	Program to Provider	.01					6.01
due) based on the cost report (1)	Provider to Program	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		T =					7
8 Name of Contractor		Contra	ictor Number				8

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

ANALYSIS OF SNF-BASED RHC/FQHC COSTS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET I-1		
				RHC/FQHC CCN:		то	_		
	Check applicable box: [ ] RHC	[ ] FQHC							
				1		RECLASSIFIED		NET EXPENSES	т
		COMPEN- SATION	OTHER COSTS	TOTAL ( col. 1 + col. 2 )	RECLASSIFI- CATIONS	TRIAL BALANCE ( col. 3 +/- col. 4 )	ADJUSTMENTS	FOR ALLOCATION ( col. 5 +/- col.6 )	
		1	2	3	4	5	6	7	†
	TH CARE STAFF COSTS								
	Physician								1
	Physician Assistant								2
	Nurse Practitioner								3
	Visiting Nurse								4
	Other Nurse								5
	Clinical Psychologist								6
	Clinical Social Worker								7
	Laboratory Technician								8
	Other health care staff costs								9
	Subtotal (sum of lines 1 - 9)								10
	IS UNDER AGREEMENT								
	Physician Services Under Agreement								11
	Physician Supervision Under Agreement								12
	Other costs under agreement								13
	Subtotal (sum of lines 11 - 13)								14
	ER HEALTH CARE COSTS								
	Medical Supplies								15
	Transportation (Health Care Staff)								16
	Depreciation - Medical Equipment								17
	Professional Liability Insurance								18
	Other health care costs								19
	Subtotal (sum of lines 15 - 19)								21
22	Total cost of health care services								22
COC	(sum of lines 10, 14, and 21)								
	TS OTHER THAN RHC / FQHC SERVICES								- 22
	Pharmacy								23
	Dental								24
	Optometry								25
	All other non reimbursable costs								26
28 DHC	Total nonreimbursable costs (sum of lines 23 - 26)								28
	FQHC OVERHEAD								20
	RHC/FQHC costs								29
	Administrative costs Total RHC/FQHC overhead (sum of lines 29-30)								30
	Total RHC/FQHC overhead (sum of lines 29-30)								21

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

16

18

19

Total RHC/FQHC overhead (from Wkst. I-1, col. 7, line 31)

Total overhead (sum of lines 16 and 17)

17 Parent provider overhead allocated to RHC/FQHC (see instructions)

Overhead applicable to RHC/FQHC services (lines 15 X line 18)
 Total allowable cost of RHC/FQHC services (sum of lines 12 and 19)

16

18

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<sup>(1)</sup> Productivity standards established by CMS are: 4200 visits for each physician, and 2100 visits for each nonphysician practitioner.

24.50

24.55

25 25.01

26 27

29

24.50

25

26

27

25.01

Demonstration payment adjustment amount before sequestration

29 Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2

24.55 Demonstration payment adjustment amount after sequestration

Net reimbursable amount (see instructions)

Sequestration amount (see instructions)

Interim payments (from Wkst. I-5, line 4)

Tentative settlement (for contractor use only)
Balance due RHC/FQHC/Program (see instructions)

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				,	,
	PUTATION OF SNF-BASED RHC/FQHC PNEUMOCOCCAL INFLUENZA VACCINE COST	PROVIDER CCN:	PERIOD : FROM	WORKSHEET I-4	
		RHC/FQHC CCN:	то		
	Check applicable box: [ ] Title V [ ] Title XVIII [ ]	Title XIX			
	Check applicable box: [ ] RHC [ ] FQ	HC			
CALC	CULATION OF COST		PNEUMOCOCCAL	INFLUENZA	
			1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)				1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff ti	me			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)				3
_				i	-

CALC	CULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22)			6
7	Total overhead (from Wkst. I-2, line 19)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and their administration (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of			15
	cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of			16
	cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			

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7170 (Cont.)	1 OKWI CWI5-25-0-10			00-10
ANALYSIS OF PAYMENTS TO	PROVIDER CCN:	PERIOD:	WORKSHEET I - 5	
SNF-BASED RHC/FQHC FOR SERVICES RENDERED		FROM		
	RHC/FQHC CCN:	ТО		
Check applicable box: [ ] RHC	[ ] FQHC			
		mm/dd/yyyy	Amount	
Description		1	2	_
1 Total interim payments paid to RHC/FQHC				1
2 Interim payments payable on individual bills, either sub	mitted			2
or to be submitted to the intermediary/contractor for ser	vices			
rendered in the cost reporting period. If none, enter zer	0.			
3 List separately each retroactive lump sum		.01		3.01
adjustment amount based on subsequent revision of	Program	.02		3.02
the interim rate for the cost reporting period	to	.03		3.03
Also show date of each payment.	RHC/FQHC	.04		3.04
If none, write "NONE," or enter a zero. (1)		.05		3.05
		.50		3.50
	RHC/FQHC	.51		3.51
	to	.52		3.52
	Program	.53		3.53
		.54		3.54
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lin		.99		3.99
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2, ar	id 3.99)			4
(Transfer to Wkst. I-3, line 26)				
TO BE COMPLETED BY CONTRACTOR				
5 List separately each tentative settlement	Program	.01		5.01
payment after desk review. Also show	to	.02		5.02
date of each payment.	RHC/FQHC	.03		5.03
If none, write "NONE," or enter a zero. (1)	RHC/FQHC	.50		5.50
	to	.51		5.51
CUIDTOTAL ( CV 501 540 : CV	Program	.52		5.52
SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lin		.99		5.99
6 Determine net settlement amount (balance	Program to RHC/FQHC	.01		6.01
due) based on the cost report (1)  7 TOTAL MEDICARE PROGRAM LIABILITY (see ins	RHC/FQHC to Program	.02		6.02
8 Name of Contractor	uucuons)	Contractor Number		7 8
o mame of Contractor		Contractor Number		8

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<sup>(1)</sup> On lines 3, 5, and 6, where an amount is due "RHC/FQHC to Program," show the amount and date on which the RHC/FQHC agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC			PROVIDER CCN:  COMPONENT CCN:		PERIOD: FROM TO		WORKSHEET J-1 PART I	
		NET			1		ADMINIS-	$\overline{\top}$
		EXPENSES FOR COST ALLOCATION	CAPITAL REI BUILDS. & FIXTURES	LATED COST  MOVABLE  EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL ( cols. 0 through 3 )	TRATIVE & GENERAL	
	COMPONENT COST CENTER	0	1	2	3	3A	4	7
	Administrative and General							1
	Skilled Nursing Care							2
	Physical Therapy							3
	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13

14

15

16 17

18

19

Appr. Patient Training & Education

Prosthetic and Orthotic Devices

19 Durable Medical Equipment - Rented

20 Durable Medical Equipment - Sold

22 Totals (sum of lines 1-21) (1)
23 Unit Cost Multiplier (see instructions)

16 Drugs and Biologicals

17 Medical Supplies18 Medical Appliances

21 All Other

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<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC			PROVIDER CCN:  COMPONENT CCN:		PERIOD: FROM TO		WORKSHEET J-1 PART I	
	COMPONENT COST CENTER	PLANT OPERATION MAINTENANC & REPAIRS 5		HOUSE - KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9		
1	Administrative and General				T		1	
	Skilled Nursing Care						2	
3	Physical Therapy						3	
	Occupational Therapy						4	
	Speech Pathology						5	
	Medical Social Services						6	
	Respiratory Therapy						7	
	Psychiatric/Psychological Services						8	
9	Individual Therapy						9	
10	Group Therapy						10	
	Individualized Activity Therapy						11	
	Family Counseling						12	
	Diagnostic Services						13	
	Appr. Patient Training & Education						14	
	Prosthetic and Orthotic Devices						15	
16	Drugs and Biologicals						16	
17	Medical Supplies						17	
18	Medical Appliances						18	
	Durable Medical Equipment - Rented						19	
	Durable Medical Equipment - Sold						20	
21	All Other						21	
22	Totals (sum of lines 1-21) (1)						22	
23	Unit Cost Multiplier (see instructions)						23	

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<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC			PROVIDER CCN:		PERIOD : FROM	WORKSHEET J-1 PART I		
10 0			COMPONENT CCN:		TO			
						NURSING &		$\overline{\mathbf{T}}$
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	
	COMPONENT COST CENTER	10	11 11	12	13	14	15	-
1 1	Administrative and General	10	11	12	13	17	13	1
	Skilled Nursing Care							2
	Physical Therapy							3
	Occupational Therapy	i						4
	Speech Pathology							5
	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
	Appr. Patient Training & Education							14
	Prosthetic and Orthotic Devices							15
	Drugs and Biologicals							16
	Medical Supplies							17
18	Medical Appliances							18
	Durable Medical Equipment - Rented							19
	Durable Medical Equipment - Sold							20
	All Other							21
	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

	OCATION OF GENERAL SERVICE COSTS COST CENTERS FOR CMHC	PROVIDER CCN:  COMPONENT CCN:		PERIOD : FROM TO	WORKSHEET J-1 PART I		
	COMPONENT COST CENTER	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	SUBTOTAL 18	ALLOCATED A & G ( see Pt. II )	TOTAL ( sum of cols. 18 and 19 ()	
1	Administrative and General						1
	Skilled Nursing Care						2
	Physical Therapy						3
	Occupational Therapy						4
	Speech Pathology						5
	Medical Social Services						6
	Respiratory Therapy						7
	Psychiatric/Psychological Services						8
	Individual Therapy						9
	Group Therapy						10
	Individualized Activity Therapy						11
	Family Counseling						12
	Diagnostic Services						13
	Appr. Patient Training & Education						14
	Prosthetic and Orthotic Devices						15
	Drugs and Biologicals						16
	Medical Supplies						17
	Medical Appliances						18
	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20

22 Totals (Sum of lines 1-21) (1) 23 Unit Cost Multiplier (see instructions)

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<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

			. ,
ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-1
TO COST CENTERS FOR CMHC		FROM	PART II
	COMPONENT CCN:	ТО	
			•
	CAPITAL RELATED		ADMINIS-
	MOVABLE	T	TRATIVE

		CAPITAL	RELATED			ADMINIS-	T
			MOVABLE			TRATIVE	
		BUILDS.	EQUIPMENT	EMPLOYEE		& GENERAL	
		& FIXTURES	( Dollar Value or	BENEFITS	RECONCIL-	( Accumulated	
		( Square Feet )	Square Feet )	( Gross Salaries )	IATION	Cost )	
	COMPONENT COST CENTER	1	2	3	4A	4	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
	Psychiatric/Psychological Services						8
	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	11 8						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21							21
22	Totals (sum of lines 1-21)						22
23							23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC		PROVIDER	CCN:		PERIOD :	WORKSHEET J-1 PART II		
10 (	COST CLAVERS FOR CAME	COMPONE	T CCN:	FROM TO				
		PLAN	т І і	AUNDRY	Ι	I	NURSING	
		OPERA'		& LINEN	HOUSE -		ADMINIS-	
		MAINTEN		SERVICE	KEEPING	DIETARY	TRATION	
		& REP	AIRS (	Pounds of	( Hours of	( Meals	( Direct Nursing	
		( Square	Feet ) I	Laundry)	Service )	Served)	Hours of Service)	
	COMPONENT COST CENTER	5		6	7	8	9	1
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
	Speech Pathology							5
	Medical Social Services							6
	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
	Individual Therapy							9
	Group Therapy							10
	Individualized Activity Therapy							11
	Family Counseling							12
	Diagnostic Services							13
	App. 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 Other							21
	Totals (sum of lines 1-21)							22
	Total cost to be allocated  Unit Cost Multiplier							23
2/	Limit Cost Multiplior				1		i e	2/

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ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC		1 312.	PROVIDER CCN:		PERIOD :	WORKSHEET J-1 PART II		
ТО	COST CENTERS FOR CMHC		COMPONENT CCN:		FROM TO			
		CENTRAL	1	ı	1	NURSING &	<del></del>	
		SERVICES & SUPPLY ( Costed Requisitions )	PHARMACY ( Costed Requisitions )	MEDICAL RECORDS & LIBRARY ( Time Spent )	SOCIAL SERVICES ( Time Spent )	ALLIED HEALTH EDUCATION ( Assigned Time )	OTHER GENERAL SERVICE	
	COMPONENT COST CENTER	10	11	12	13	14	15	1
	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
	Occupational Therapy							4
	Speech Pathology							5
	Medical Social Services							6
	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
	All Other							21
22	Totals (sum of lines 1-21)							22
23	Total cost to be allocated							23
24	Unit Cost Multiplier						Ί	24

4190 (Cont.)	FORM CMS-2540-10	11-12
7170 (Cont.)	1 OKWI CWIS-23-10-10	11-1.

	1170 (Cont.)	1 01011 01115 23 10 10		11 12
•	COMPUTATION OF CMHC	PROVIDER CCN:	PERIOD:	WORKSHEET J-2
	REHABILITATION COSTS		FROM	PART I
		COMPONENT CCN:	то	

PART I - APPORTIONMENT	OF CMHC COST CENTERS
	T.4

	Total Costs		Ratio of	Title V		Title XVIII		Title	e XIX	
	( from Wkst. J-1,	Total	Costs to		Costs		Costs		Costs	1
	Pt. I, col. 20)	Charges	Charges	Charges	(col. 3 x col. 4)	Charges	(col. 3 x col. 6)	Charges	(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										(
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapy										11
12 Family Counseling										12
13 Diagnostic Services										13
14 App. Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment - Rented										19
20 Durable Medical Equipment - Sold										20
21 All Other										21
22 Totals (sum of lines 2-21)										22

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REHABILITATION COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-2 PART II
			-

PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED BY	Y SHARED DEPARTMENTS							
	Ratio of	Titl	e V	Title	XVIII	Title XIX		
	Costs to		Costs		Costs		Costs	1
	Charges	Charges	(col. 3 x col. 4)	Charges	(col. 3 x col. 6)	Charges	(col. 3 x col. 8)	
	3	4	5	6	7	8	9	1
23 Oxygen (Inhalation) Therapy								23
24 Physical Therapy								24
25 Occupational Therapy								25
26 Speech Pathology								20
27 Medical Supplies Charged to Patients								27
28 Drugs Charged to Patients								28
29 Other Costs Furnished by shared Departments								29
30 Total (sum of lines 23 through 29)								30
31 Total component cost (sum of Pt. I, line 22 and Pt. II, line 30)								31
(Transfer to Wkst I_3)								I

<sup>(1)</sup> Part II - From Wkst. C, col. 3, lines as applicable

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4130 (	Cont.)	OKW CW3-2340-10			10-19
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET J-3	
FOR SNI	F-BASED COMMUNITY MENTAL HEALTH CENTER		FROM		
SERVIC	ES	COMPONENT CCN:	ТО		
-	Check applicable box: [] Title V [] Title XVIII []	Title XIX			
				PROGRAM	
				COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 31)				1
2	PPS payments received excluding outliers				2
3	Outlier payments				3
4	Primary payer payments				4
5	Total reasonable cost (see instructions)				5
	MARY CHARGES				
6	Total charges for program services				6
7	Excess of customary charges over reasonable cost (see instructions)				7
	Excess of reasonable cost over customary charges (see instructions)				8
COMPU'	TATION OF REIMBURSEMENT SETTLEMENT				
9	Total reasonable cost (see instructions)				9
10	Part B deductible billed to program patients				10
11	Part B coinsurance billed to program patients (from provider records)				11
12	Net cost (line 9 minus lines 10 and 11)				12
13	Allowable bad debts (from provider records) (see instructions)				13
13.01	Reimbursable bad debts (see instructions)				13.01
14	Allowable bad debts for dual eligible beneficiaries (see instructions)				14
15	Net reimbursable amount (see instructions)				15
16	Other adjustments (see instructions) (specify)				16
16.50	Demonstration payment adjustment amount before sequestration				16.50
16.55	Demonstration payment adjustment amount after sequestration				16.55
17	Total cost (see instructions)				17
17.01	Sequestration amount (see instructions)				17.01
18	Interim payments (see instructions)				18
19	Tentative settlement (for contractor use only)				19
20	Balance due component/program (see instructions)				20
21	Protested amounts (nonallowable cost report items) in accordance with C	MS Pub. 15-2 section 115.2			21

 $FORM\ CMS-2540-10\ (10/2019)\ (INSTRUCTIONS\ FOR\ THIS\ WORKSHEET\ ARE\ PUBLISHED\ IN\ CMS\ PUB.\ 15-2,\ SECTION\ 4155)$ 

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00-1	0 101	CIVI CIVID-23-10-10	,		7170	(Cont.)
ANA	LYSIS OF PAYMENTS TO	PROVIDER CCN:		PERIOD:	WORKSHEET J-4	
SNF-l	BASED CMHC			FROM		
FOR :	SERVICES RENDERED	COMPONENT CCN:		ТО		
TO P	ROGRAM BENEFICIARIES					
		Ш		mm/dd/yyyy	Amount	
	Description			1	2	
1	Total interim payments paid to CMHC					1
2	Interim payments payable on individual bills, either submitted					2
	or to be submitted to the intermediary/contractor for services					
	rendered in the cost reporting period. If none, enter zero.					
3	List separately each retroactive lump sum		.01			3.01
	adjustment amount based on subsequent revision of	Program	.02			3.02
	the interim rate for the cost reporting period	to	.03			3.03
	Also show date of each payment.	Provider	.04			3.04
	If none, write "NONE," or enter a zero. (1)		.05			3.05
			.50			3.50
		Provider	.51			3.51
		to	.52			3.52
		Program	.53			3.53
		Į ,	.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 Wkst. J-3: Pt. I, line 18)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative	Program	.01			5.01
	settlement payment after desk review.	to	.02			5.02
		Provider	.03			5.03
	Also show date of each payment.	Provider	.50			5.50
	If none, write "NONE," or enter a 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 (balance	Program to Provider	.01			6.01
	due) based on the cost report (1)	Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contr	actor Number		8
			1			

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

ANALYSIS OF HOSPICE COSTS								N:	PERIOD:		WORKSHEET K	
									FROM TO			
							HOSPICE CCN:		то			
		1	1	1	CON-	1		ı		I		
			EMPLOYEE		TRACTED							
		SALARIES	BENEFITS	TRANSPOR-	SERVICES		TOTAL		SUBTOTAL		TOTAL	
		( from	( from	TATION	( from		( cols. 1	RECLASSI-	( col. 6	ADJUST-	( col. 8	
		Wkst. K-1)	Wkst. K-2)	( see instruct. )	Wkst. K-3)	OTHER	through 5)	FICATION	± col. 7)	MENTS	± col. 9)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	10	ł
GENE	ERAL SERVICE COST CENTERS	1	2	3	1	J	Ü	,	Ů		10	
	Capital Related Costs-Bldg. and Fixt.											1
	Capital Related Costs-Movable Equip.											2
	Plant Operation and Maintenance											3
	Transportation - Staff											4
	Volunteer Service Coordination											5
	Administrative and General											6
	TIENT CARE SERVICE											
	Inpatient - General Care											7
	Inpatient - Respite Care											8
	TING SERVICES											
	Physician Services											9
	Nursing Care											10
	Nursing Care-Continuous Home Care											11
	Physical Therapy											12
	Occupational Therapy											13
	Speech/ Language Pathology											14
	Medical Social Services											15
	Spiritual Counseling											16
	Dietary Counseling											17
	Counseling - Other											18
	Home Health Aide and Homemaker											19
	HH Aide & Homemaker-Cont. Home Care											20
	Other											21
OTH	ER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
	Analgesics											23
24	Sedatives / Hypnotics											24
25	Other - Specify											25
26	Durable Medical Equipment/Oxygen											26
	Patient Transportation											27
28	Imaging Services											28
	Labs and Diagnostics											29
30	Medical Supplies											30
31	Outpatient Services (including E/R Dept.)											31
32	Radiation Therapy											32
33	Chemotherapy											33
34	Other											34
HOSE	ICE NONREIMBURSABLE SERVICE											
35	Bereavement Program Costs											35
	Volunteer Program Costs											36
37	Fundraising											37
	Other Program Costs											38
30	Total (sum of lines 1 through 38)			-								30

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	PICE COMPENSATION ANALYSIS  ARIES AND WAGES					HOSPICE CCN:	:	FROMTO		WORKSHEET K-	·1
		ADMINIS- TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	I	2	3	4	5	6	7	8	9	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
5											5
	Administrative and General										6
INPA	TIENT CARE SERVICE										
7											7
8	Inpatient - Respite Care										8
	TING SERVICES										
9	Physician Services										9
	Nursing Care										10
	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
	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker-Cont. Home Care										20
21	Other										21
OTH	ER HOSPICE SERVICE COSTS										
	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
	Other										34
	PICE NONREIMBURSABLE SERVICE										J-4
	Bereavement Program Costs										35
36	· ·	+				+	1				36
	Fundraising						+				37
	Other Program Costs						+				38
	Total (sum of lines 1 through 29)				-	+	+	+	+	+	20

<sup>(1)</sup> Transfer the amount in column 9 to Wkst. K, col. 1

2   Capital Related Costs-Movable Equip.		OYEE BENEFITS (PAYROLL RELATED)					HOSPICE CCN:		FROMTO		WORKSHEET K-2	:
Capital Related Costs-Mely, and Fixt				DIRECTOR			NURSES		AIDES	ALL OTHER	TOTAL (1)	
1 Cripal Related Costs-Bolds and Fixt.			1	2	3	4	5	6	7	8	9	1
2   Cignal Related Costs-Noveble Equip.   3   3   Plant Operation and Maintenance   3   3   1   Transportation and Maintenance   1   4   4   4   4   5   5   5   5   5   5												
3   Plats Operation and Maintenance	1	Capital Related Costs-Bldg. and Fixt.										1
4   Transportation - Staff												
S Volunter Service Coordination												3
6 Administrative and General	4	Transportation - Staff										4
NPATIENT CARE SERVICE												5
7   Inputient - General Carce												6
8   Inpatient - Respite Care	INPA	TIENT CARE SERVICE										
VISITING SERVICES												7
9 Physician Services   9 9 19 10 Nutsing Care   11 Nutsing Cares Continuous Home Care   11 Nutsing Cares Continuous Home Care   11	8	Inpatient - Respite Care										8
10   Nursing Care	VISIT	TING SERVICES										
11 Nursing Care-Continuous Horse Care												9
11 Nursing Care-Continuous Horse Care	10	Nursing Care										10
13   Sepect N. Language Pathology												11
14   Speech Language Pathology												12
15   Medical Social Services	13	Occupational Therapy										13
15   Medical Social Services	14	Speech/ Language Pathology										14
17   Dietary Counseling	15	Medical Social Services										15
17   Dietary Counseling	16	Spiritual Counseling										16
18   Counseling - Other												17
20												18
21 Other	19	Home Health Aide and Homemaker										19
OTHER HOSPICE SERVICE COSTS         22         Drugs, Biological and Infusion Therapy         22         23         Analgasics         23         24         24         24         24         24         25         Other - Specify         25         25         0ther - Specify         25         25         26         27         27         27         27         28         18         27         27         28         18         29         29         28         28         29         28         28         28         28         28         28         29         29         28         28         29         28         28         28         28         29         28         28         29         29         28         28         29         28         28         28         28         28         29         28         28         29         28         28         29         28         28         29         28         28         29         28         28         29         29         30         Medical Supplies         30         30         30         30         30         30         30         30         30         30         30         30         30         30	20	HH Aide & Homemaker-Cont. Home Care										20
22   Drugs, Biological and Infusion Therapy   22   23   Analgesics   24   Sedatives / Hyprotics   24   Sedatives / Hyprotics   25   25   26   Durable Medical Equipment/Oxygen   26   27   Patient Transportation   27   28   Imaging Services   28   29   Labs and Diagnostics   29   Labs and Diagnostics   29   30   Medical Supplies   31   32   Radiation Therapy   31   32   Radiation Therapy   32   33   Chemotherapy   34   34   Other Hospitcal Note of the program Costs   35   36   Volunteer Program Costs   36   37   Fundraising   37   Sucher Program Costs   38   38   38   39   30   30   30   30   30   30   30												21
23   Analgesics	OTH	ER HOSPICE SERVICE COSTS										
23   Analgesics	22	Drugs, Biological and Infusion Therapy										22
24       Sedatives / Hypnotics       24         25       Other - Specify       25         26       Durable Medical Equipment/Oxygen       26         27       Patient Transportation       27         28       Imaging Services       28         29       Labs and Diagnostics       29         30       Medical Supplies       30         31       Outpatient Services (including E/R Dept.)       30         32       Radiation Therapy       32         33       Chemotherapy       33         34       Other       34         HOSPICE NONREIMBURSABLE SERVICE       35         35       Bereavement Program Costs       36         37       Fundraising       37         38       Other Program Costs       37         39       Other Program Costs       37	23	Analgesics										
25   Other - Specify   25   26   Durable Medical Equipment/Oxygen   26   26   27   Patient Transportation   27   28   Imaging Services   29   Labs and Diagnostics   29   29   20   20   20   20   20   20												
26   Durable Medical Equipment/Oxygen   26   27   28   27   28   27   28   29   28   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   29   28   28												
27   Patient Transportation   27   28   Imaging Services   28   29   Labs and Diagnostics   29   29   29   20   20   20   20   20												
28 Imaging Services       28         29 Labs and Diagnostics       29         30 Medical Supplies       30         31 Outpatient Services (including E/R Dept.)       31         32 Radiation Therapy       32         33 Chemotherapy       33         34 Other       33         HOSPICE NONREIMBURSABLE SERVICE       34         35 Bereavement Program Costs       35         36 Volunteer Program Costs       36         37 Fundraising       37         38 Other Program Costs       38         38 Other Program Costs       38												
29 Labs and Diagnostics       29         30 Medical Supplies       30         31 Outpatient Services (including E/R Dept.)       31         32 Radiation Therapy       31         33 Chemotherapy       32         34 Other       33         HOSPICE NONREIMBURSABLE SERVICE       34         35 Bereavement Program Costs       35         36 Volunteer Program Costs       35         37 Fundraising       37         38 Other Program Costs       38         39 Other Program Costs       38												
30   Medical Supplies   30   31   32   31   32   32   32   33   Chemotherapy   33   34   Other   34   35   35   36   36   37   Fundraising   36   37   38   Other Program Costs   38   39   Other Program Costs   39   30   30   30   30   30   30   30												
31   Outpatient Services (including E/R Dept.)   31   32   Radiation Therapy   32   33   Chemotherapy   33   34   Other   34   Other   34   35   35   36   Seravement Program Costs   35   Seravement Program Costs   36   Other Program Costs   37   Fundraising   38   Other Program Costs   38   Other Program Costs   39   Other Program Costs   39   31   31   32   33   Other Program Costs   31   32   33   Other Program Costs   31   32   33   Other Program Costs   32   33   Other Program Costs   33   Other Program Costs   34   35   36   37   37   38   Other Program Costs   38   38   Other Program Costs   38   38   Other Program Costs   38												
32       Radiation Therapy       32         33       Chemotherapy       33         34       Other       34         HOSPICE NONREIMBURSABLE SERVICE       34         35       Bereavement Program Costs       35         36       Volunteer Program Costs       35         37       Fundraising       37         38       Other Program Costs       38												
33       Chemotherapy       33         34       Other       34         HOSPICE NONREIMBURSABLE SERVICE       34         35       Bereavement Program Costs       35         36       Volunteer Program Costs       35         37       Fundraising       37         38       Other Program Costs       38												
34 Other         34           HOSPICE NONREIMBURSABLE SERVICE         35           35 Bereavement Program Costs         35           36 Volunteer Program Costs         36           37 Fundraising         37           38 Other Program Costs         38           38 Other Program Costs         38												
HOSPICE NONREIMBURSABLE SERVICE												
35         Bereavement Program Costs         35           36         Volunteer Program Costs         36           37         Fundraising         37           38         Other Program Costs         38												Ť
36       Volunteer Program Costs       36         37       Fundraising       37         38       Other Program Costs       38												3.5
37 Fundraising       37         38 Other Program Costs       38			†	<del> </del>			1	†				
38 Other Program Costs 38			<del> </del>				+	<b>†</b>				
		ë	<del> </del>				+	<b>†</b>				
			†	<del> </del>			1	†				39

<sup>(1)</sup> Transfer the amounts in column 9 to Wkst. K, col. 2

	TRATED SERVICES / PURCHASED SERVIC	ES				HOSPICE CCN:		FROM TO		WORKSHEET K-3	,
		ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
INPA	TIENT CARE SERVICE										
	Inpatient - General Care										7
8	Inpatient - Respite Care										8
VISIT	TING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
	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
	HH Aide & Homemaker-Cont. Home Care										20
	Other										21
OTHI	ER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services										28
	Labs and Diagnostics										29
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy					+	<del> </del>				32
	Chemotherapy										33
	Other										34
	PICE NONREIMBURSABLE SERVICE										<del></del>
	Bereavement Program Costs										35
	Volunteer Program Costs	+	<del> </del>				<del> </del>				36
	Fundraising	+	<del> </del>				<del> </del>				37
	Other Program Costs	+	<del> </del>				<del> </del>				38
	Total (sum of lines 1 through 38)	1	<b>†</b>			1	<b>†</b>				39
27	(sum or miss r unough so)		•	1	1		1	1		1	57

<sup>(1)</sup> Transfer the amounts in column 9 to Wkst. K, col. 4

	`ALLOCATION - HOSPICE					PROVIDER CCN:		PERIOD:		WORKSHEET K-	4
GENI	ERAL SERVICE COST							FROM		PART I	
						HOSPICE CCN:		ТО			
		NET EXPENSES							1	4	
		NET EXPENSES					LOLIBERED				
		FOR COST	CARITAL DEL	ATTEN COST	DI ANIT		VOLUNTEER	GLIDTOT I	, D) (D) IG		
		ALLOC. (1)	CAPITAL REI		PLANT		SERVICE	SUBTOTAL	ADMINIS-		
		( from	BUILDS. &	MOVABLE	OPERATION	TRANS-	COORDI-	( cols. 0	TRATIVE &		
		Wkst. K, col. 10)	FIXTURES	EQUIPMENT	& MAINT.	PORTATION	NATOR	through 5)	GENERAL	TOTAL	_
	COST CENTER DESCRIPTIONS	0	1	2	3	4	5	5A	6	7	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
	TIENT CARE SERVICE										
	Inpatient - General Care										7
	Inpatient - Respite Care										8
VISIT	TNG SERVICES										
	Physician Services										9
	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services									1	15
16	Spiritual Counseling									1	16
17	Dietary Counseling									1	17
18	Counseling - Other									1	18
19	Home Health Aide and Homemaker									1	19
20	HH Aide & Homemaker-Cont. Home Care									1	20
21	Other									1	21
OTH	ER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy									1	22
	Analgesics									1	23
24	Sedatives / Hypnotics									1	24
	Other - Specify									1	25
26	Durable Medical Equipment/Oxygen									1	26
	Patient Transportation									1	27
28	Imaging Services									1	28
	Labs and Diagnostics									1	29
30	Medical Supplies									1	30
31	Outpatient Services (including E/R Dept.)									1	31
	Radiation Therapy									1	32
	Chemotherapy									1	33
	Other									1	34
	ICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs										35
	Volunteer Program Costs										36
	Fundraising									1	37
	Other Program Costs									1	38
	Total (sum of lines 1 through 38)	1			Ì	1					39

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COST ALLOCATION - HOSPICE STATISTICAL BASIS					HOSPICE CCN:		FROMTO		WORKSHEET K-4 PART II	
	COST CENTER DESCRIPTIONS	BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT ( Dollar Value or Square Feet )	PLANT OPERATION & MAINT. ( Square Feet )	TRANS- PORTATION ( Mileage )	VOLUNTEER SERVICE COORDINATOR (Hours)	RECONCI- LIATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	TOTAL 7	
CENI	COST CENTER DESCRIPTIONS ERAL SERVICE COST CENTERS	1	2	3	4	5	6A	6	/	_
	Capital Related Costs-Bldg. and Fixt.									1
	Capital Related Costs-Blog. and Fixt.  Capital Related Costs-Movable Equip.									1 2
	Plant Operation and Maintenance									3
	Transportation - Staff									4
5										5
	Administrative and General									6
	TIENT CARE SERVICE									
	Inpatient - General Care									7
	Inpatient - General Care									8
	TNG SERVICES									Ů
	Physician Services									9
	Nursing Care									10
	Nursing Care-Continuous Home Care									11
	Physical Therapy									12
	Occupational Therapy									13
14	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									21
OTHE	ER HOSPICE SERVICE COSTS									
22	Drugs, Biological and Infusion Therapy									22
	Analgesics									23
	Sedatives / Hypnotics									24
25	Other - Specify									25
	Durable Medical Equipment/Oxygen									26
	Patient Transportation									27
	Imaging Services									28
	Labs and Diagnostics									29
	Medical Supplies									30
	Outpatient Services (including E/R Dept.)									31
	Radiation Therapy									32
	Chemotherapy									33
	Other									34
	ICE NONREIMBURSABLE SERVICE									
	Bereavement Program Costs				ļ					35
	Volunteer Program Costs									36
	Fundraising									37
	Other Program Costs									38
39	Cost to be allocated (per Wkst. K-4, Pt. I) Unit Cost Multiplier									39 40
40	Unit Cost Multiplier	1	ı			1		I		40

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

	OCATION OF GENERAL SERVICE TS TO HOSPICE COST CENTERS			PROVIDER CCN:		PERIOD : FROM		WORKSHEET K-5, PART I	
				HOSPICE CCN:		то	_		
		From Wkst. K-4,	HOSPICE	CAPITAL			SUBTOTAL	ADMINIS-	
		Pt. I,	TRIAL	BLDGS. &	MOVABLE	EMPLOYEE	( cols. 0	TRATIVE &	
		col. 7,	BALANCE	FIXTURES	EQUIPMENT	BENEFITS	through 3)	GENERAL	
	HOSPICE COST CENTER (1)	line -	0	1	2	3	3A	4	<u> </u>
	Administrative and General	6							1
	Inpatient - General Care	7							2
	Inpatient - Respite Care	8							3
	Physician Services	9							4
	Nursing Care	10							5
	Nursing Care- Continuous Home Care	11							6
	Physical Therapy	12							7
	Occupational Therapy	13							8
9	Speech/ Language Pathology	14							9
	Medical Social Services - Direct	15							10
	Spiritual Counseling	16							11
	Dietary Counseling	17							12
	Counseling - Other	18							13
	Home Health Aide and Homemakers	19							14
	HH Aide & Homemaker - Cont. Home Care	20							15
	Other	21							16
	Drugs, Biologicals and Infusion	22							17
	Analgesics	23							18
	Sedative/Hypnotics	24							19
	Other - Specify	25							20
	Durable Medical Equipment/Oxygen	26							21
	Patient Transportation	27							22
	Imaging Services	28							23
	Labs and Diagnostics	29							24
	Medical Supplies	30							25
	Outpatient Services (incl. E/R Dept.)	31							26
	Radiation Therapy	32							27
	Chemotherapy	33							28
29		34							29
	Bereavement Program Costs	35							30
	Volunteer Program Costs	36							31
	Fundraising	37							32
	Other Program Costs	38							33
34	Totals (sum of lines 1 through 33)								34
2.5	III S.C. AM R. P.								2.5

<sup>(1)</sup> Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLO	OCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET K-5	
	IS TO HOSPICE COST CENTERS					FROM		Part I	
				HOSPICE CCN:		то			
		PLANT							П
		OPERATION	LAUNDRY			NURSING	CENTRAL		
		MAINTENANCE	& LINEN	HOUSE-		ADMINIS-	SERVICES &		
		& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	SUPPLY	PHARMACY	
	HOSPICE COST CENTER (1)	5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
	Other								29
30	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1 through 33)								34
2.5	Unit Cost Multiplior								2.5

<sup>(1)</sup> Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

	OCATION OF GENERAL SERVICE TS TO HOSPICE COST CENTERS			PROVIDER CCN: HOSPICE CCN:		PERIOD : FROM	_	WORKSHEET K-5 Part I	
				HOSPICE CCN:		то			
	HOCDIGE COST CENTED (1)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL ( sum of cols. 3A through 15 )	ALLOCATED HOSPICE A & G ( see Pt. II )	TOTAL HOSPICE COSTS	
	HOSPICE COST CENTER (1)  Administrative and General	12	13	14	15	16	17	18	1
	Inpatient - General Care								2
	Inpatient - General Care  Inpatient - Respite Care							<del> </del>	3
	Physician Services								4
	Nursing Care								5
	Nursing Care- Continuous Home Care							<del> </del>	6
	Physical Therapy							<del> </del>	7
	Occupational Therapy							-	8
	Speech/ Language Pathology							<del> </del>	9
10	Medical Social Services - Direct							+	10
	Spiritual Counseling							+	11
	Dietary Counseling							<del> </del>	12
	Counseling - Other							<del> </del>	13
	Home Health Aide and Homemakers								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biologicals and Infusion								17
	Analgesics								18
	Sedative/Hypnotics								19
	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
2.5	III 's C - M IS II								2.5

<sup>(1)</sup> Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

11-1	2	1 OKWI CWIS-2340-10				4190 (0	cont.
ALLC	OCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:		PERIOD:		WORKSHEET K-5,	
TO H	HOSPICE COST CENTERS - STATISTICAL BASIS			FROM		PART II	
		HOSPICE CCN:		ТО	_		
		CAPITAL	CAPITAL			ADMINIS-	
		RELATED	RELATED			TRATIVE &	
		BLDGS. &	MOVABLE	EMPLOYEE		GENERAL	
		FIXTURES	EQUIPMENT	BENEFITS	RECONCIL-	( Accumulated	
		( Square Feet )	( Dollar Value )	( Gross Salaries )	IATION	Cost )	
	HOSPICE COST CENTER (1)	1	2	3	4a	4	-
	Administrative and General						_
	Inpatient - General Care						_
	Inpatient - Respite Care						+-
	Physician Services						+
	Nursing Care						
	Nursing Care- Continuous Home Care						-
	Physical Therapy						+
- 8	Occupational Therapy						-
	Speech/ Language Pathology						
	Medical Social Services - Direct						1
	Spiritual Counseling						1
	Dietary Counseling						1
12	Counseling - Other						1
	Home Health Aide and Homemakers						1.
	HH Aide & Homemaker - Cont. Home Care						1:
	Other						10
	Drugs, Biologicals and Infusion						1
	Analgesics			+		+	13
	Sedative/Hypnotics			+		+	1
20	Other - Specify			+		+	20
20	Durable Medical Equipment/Oxygen			+		+	2
21	Patient Transportation			+		+	2:
22	Imaging Services						2:
23	Labs and Diagnostics						2.
	Medical Supplies						2:
	Outpatient Services (incl. E/R Dept.)						2.
	Radiation Therapy						2
							2
28	Chemotherapy						29
	Other Control of the						30
30	Bereavement Program Costs Volunteer Program Costs						3
	Fundraising			1		+	3:
	Other Program Costs						33
	Totals (sum of lines 1 through 33)						3,
	Total cost to be allocated						3:
36	Unit Cost Multiplier						30

	J (Cont.)		1 Oldvi	CW13-2340-10					11-12
ALLO	OCATION OF GENERAL SERVICE COSTS HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN:		PERIOD:		WORKSHEET K-5		
TO I	HOSPICE COST CENTERS - STATISTICAL BASIS				FROM		PART II		
			HOSPICE CCN:		то				
		PLANT	LAUNDRY			NURSING	CENTRAL		
		OPERATION	& LINEN	HOUSE		ADMINIS-	SERVICES &		
		MAINTENANCE	SERVICE	KEEPING		TRATION	SUPPLY	PHARMACY	
		& REPAIRS	( Pounds of	( Hours of	DIETARY	( Direct Nursing	( Costed	( Costed	
		( Square Feet )	Laundry )	Service)	( Meals Served )	Hours)	Requisitions )	Requisitions )	
	HOSPICE COST CENTER (1)	5	6	7	8	9	10	11	-
	Administrative and General			,					1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
	Physician Services								4
	Nursing Care								5
	Nursing Care- Continuous Home Care				+	-	+		6
	Physical Therapy								- 0
									8
	Occupational Therapy								
	Speech/ Language Pathology								9
	Medical Social Services - Direct								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
14	Home Health Aide and Homemakers								14
	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (incl. E/R Dept.)								26
	Radiation Therapy								27
	Chemotherapy								28
	Other		1	<del> </del>					29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising Fundraising		-	+					32
									33
	Other Program Costs								
	Totals (sum of lines 1 through 33)								34
	Total cost to be allocated								35
36	Unit Cost Multiplier				1		1		36

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	ALLOCATION OF GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD:	WORKSHEET K-5		
TO I	HOSPICE COST CENTERS - STATISTICAL BASIS					FROM		PART II	
				HOSPICE CCN:		то			
		MEDICAL RECORDS & LIBRARY ( Time Spent )	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION ( Assigned Time )	OTHER GENERAL SERVICE ( Specify )	SUBTOTAL	ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS	Τ
	HOSPICE COST CENTER (1)	12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
	Inpatient - Respite Care								3
4	Physician Services								4
	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
	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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier				•				36

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET K-5
		FROM	Part III
	HOSPICE CCN:	TO	

PART	III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS	S				
	COST CENTER	Wkst. C, col. 3, line:	Cost to Charge Ratio	Total Hospice Charges ( from provider records )	Hospice Shared Ancillary Costs ( col. 1 x col. 2 )	
		0	1	2	3	
ANCI	LLARY SERVICE COST CENTERS					
1	Physical Therapy	44				1
2	Occupational Therapy	45				2
3	Speech/ Language Pathology	46				3
4	Drugs, Biologicals and Infusion	49				4
5	Labs and Diagnostics	41				5
6	Medical Supplies	48				6
7	Radiation Therapy	40				7
8	Other	52				8
9	Total (sum of lines 1-8)					9

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	CALCULATION OF HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD :	WORKSHEET K-6	(Cont.)
			HOSPICE CCN:	FROMTO		
		Tittle XVIII	Title XIX	Other	Total	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Wkst. S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Wkst. S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Wkst. S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Wkst. S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Wkst. S-8, line 5, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other unduplicated days (Wkst. S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13

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ANALYSIS OF SNF-	BASED HOSPICE COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET O	
							FROM		
						HOSPICE CCN:	то		
-				SUBTOTAL		-			$\overline{}$
				( col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(\text{col. } 5 \pm \text{col. } 6)$	
		1	2	3	4	5	6	7	+
GENERAL SERVICE	COST CENTERS	1	2	,	,	<u> </u>	Ů	,	_
	Rel Costs-Bldg & Fixt*								1
	Rel Costs-Myble Equip*								2
	loyee Benefits Department*								3
	inistrative & General *	1							4
	Operation & Maintenance*								5
	dry & Linen Service*								6
	sekeeping*								7
8 0800 Dieta									8
	ing Administration*								9
	ine Medical Supplies*								10
11 1100 Medi									11
	Transportation*								12
	nteer Service Coordination*								13
14 1400 Phara									14
15 1500 Physi	ician Administrative Services*								15
	r General Service*								16
17 1700 Patie	nt/Residential Care Services								17
DIRECT PATIENT C	ARE SERVICE COST CENTERS								
25 2500 Inpat	tient Care-Contracted**								25
	ician Services**								26
27 2700 Nurs	e Practitioner**								27
28 2800 Regis	stered Nurse**								28
29 2900 LPN/	/LVN**								29
30 3000 Physi	ical Therapy**								30
31 3100 Occu	pational Therapy**								31
32 3200 Spee	ch/ Language Pathology**								32
33 3300 Medi	ical Social Services**								33
	tual Counseling**								34
35 3500 Dieta	nry Counseling**								35
36 3600 Coun	seling - Other**								36
37 3700 Hosp	ice Aide and Homemaker Services**								37
	ble Medical Equipment/Oxygen**								38
39 3900 Patie	nt Transportation**								39

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164)

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ANALYSIS OF SNF-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )	
	1	2	3	4	5	6	7	1
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)								
40 4000 Imaging Services**								40
41 4100 Labs and Diagnostics**								41
42 4200 Medical Supplies-Non-routine**								42
43 4300 Outpatient Services**								43
44 4400 Palliative Radiation Therapy**								44
45 4500 Palliative Chemotherapy**								45
46 Other Patient Care Services **								46
NONREIMBURSABLE COST CENTERS								
60 6000 Bereavement Program *								60
61 6100 Volunteer Program *								61
62 6200 Fundraising*								62
63 6300 Hospice/Palliative Medicine Fellows*								63
64 6400 Palliative Care Program*								64
65 6500 Other Physician Services*								65
66 6600 Residential Care *								66
67 6700 Advertising*								67
68 6800 Telehealth/Telemonitoring*								68
69 6900 Thrift Store*								69
70 7000 Nursing Facility Room & Board*								70
71 7100 Other Nonreimbursable*								71
100 Total	1			1				100

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate. 
\*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164)

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ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE CONTINUOUS HOME CARE								
-	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	$\prod$
DIRECT PATIENT CARE SERVICE COST CENTERS		_			-	The state of the s	·	_
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy								45
46 Other Patient Care Services								46
100 Total *								100

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 50

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ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE ROUTINE HOME CARE	PICE ROUTINE HOME CARE HOSE							SHEET O-2	
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )		
DIDLOW BURNESS OF SERVICE COOK OF SERVICE	1	2	3	4	5	6	7	_	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25 Inpatient Care - Contracted								25	
26 Physician Services									
27 Nurse Practitioner								27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								31	
32 Speech/ Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								35	
36 Counseling - Other								36	
37 Hospice Aide and Homemaker Services								37	
38 Durable Medical Equipment/Oxygen								38	
39 Patient Transportation								39	
40 Imaging Services								40	
41 Labs and Diagnostics								41	
42 Medical Supplies-Non-routine								42	
43 Outpatient Services								43	
44 Palliative Radiation Therapy	-							44	
45 Palliative Chemotherapy								45	
46 Other Patient Care Services								46	
100 Total *								100	

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

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

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

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

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

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4190 (Cont.)	FORM CMS-2540-1	0		11-19
COST ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET EXPENSES FOR ALLOCATION		FROM		
	HOSPICE CCN:	то		
	HOSPICE	GENERAL		
	DIRECT	SERVICE EXPENSES	TOTAL	
	EXPENSES	FROM WKST B	EXPENSES	
	( see instructions )	( see instructions )	( sum of cols. 1 + 2 )	
Descriptions	( see instructions )	2	3	-
GENERAL SERVICE COST CENTERS		-	3	
1 Cap Rel Costs-Bldg & Fixt				1
2 Cap Rel Costs-Myble Equip				2
3 Employee Benefits				3
4 Administrative & General				4
5 Plant Operation and Maintenance				5
6 Laundry & Linen Service				6
7 Housekeeping				7
8 Dietary				8
9 Nursing Administration				9
10 Routine Medical Supplies				10
11 Medical Records				11
12 Staff Transportation				12
13 Volunteer Service Coordination				13
14 Pharmacy 15 Physician Administrative Services				14
16 Other General Service				16
17 Patient/Residential Care Services				17
LEVEL OF CARE				17
50 Hospice Continuous Home Care				50
51 Hospice Routine Home Care				51
52 Hospice Inpatient Respite Care				52
53 Hospice General Inpatient Care				53
NONREIMBURSABLE COST CENTERS				
60 Bereavement Program				60
61 Volunteer Program				61
62 Fundraising				62
63 Hospice/Palliative Medicine Fellows				63
64 Palliative Care Program				64
65 Other Physician Services				65
66 Residential Care				66
67 Advertising				67
68 Telehealth/Telemonitoring				68
69 Thrift Store				69

<b>03</b> -	-18	FORM CMS-2540-10	4190	) (C	101	nt	1

COST	` ALLOCATION - SNF-BASED HOSPICE C		PROVIDER CCN:		PERIOD: FROM							
-		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	$\overline{L}$
	Descriptions	0	1	2	3	3A	4	5	6	7	8	
GENE	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
	Volunteer Service Coordination											13
	Pharmacy											14
	Physician Administrative Services											15
	Other General Service											16
17	Patient/Residential Care Services											17
LEVE	EL OF CARE											
50	Hospice Continuous Home Care											50
	Hospice Routine Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care											53
	REIMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center											99
	Total											100

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

COST	ALLOCATION - SNF-BASED HOSPICE OF	GENERAL SERVICE C	COSTS				PROVIDER CCN:		PERIOD:		WORKSHEET O-	6
							HOSPICE CCN:		FROM		Part I	
									TO			
		NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /		
		ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
		TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS	TOTAL	
	Descriptions	9	10	11	12	13	14	15	16	17	18	
	ERAL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance											5
	Laundry & Linen Service											6
7	Housekeeping											7
	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											12
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
LEVE	EL OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
NONI	REIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
65	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center											99
	Total											100

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COS	ST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COST STATIST		ST STATISTICAL BASIS			PROVIDER CCN:HOSPICE CCN:		PERIOD: FROM_ TO		WORKSHEET O-6 PART II	
		CAP REL BLDG & FIX ( Square	CAP REL MVBLE EQUIP ( Dollar	EMPLOYEE BENEFITS DEPARTMENT ( Gross	RECONCIL-	ADMINIS- TRATIVE & GENERAL ( Accum.	PLANT OP & MAINT ( Square	LAUNDRY & LINEN ( In-Facility	HOUSE- KEEPING ( Square	DIETARY  ( In-Facility	
		Feet )	Value)	Salaries )	IATION	Cost )	Feet )	Days )	Feet )	Days )	
	Cost Center Descriptions	1	2	3	4A	4	5	6	7	8	
	ERAL SERVICE COST CENTERS										
	Cap Rel Costs-Bldg & Fixt										1
	Cap Rel Costs-Mvble Equip										2
	Employee Benefits										3
	Administrative & General							_			4
	Plant Operation and Maintenance										5
	Laundry & Linen Service										6
	Housekeeping										7
	Dietary										8
	Nursing Administration										9
	Routine Medical Supplies										10
	Medical Records										11
12											12
	Volunteer Service Coordination										13
14											14
	Physician Administrative Services										15
	Other General Service										16
	Patient/Residential Care Services										17
	EL OF CARE										
	Hospice Continuous Home Care										50
	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
53	Hospice General Inpatient Care										53
	REIMBURSABLE COST CENTERS										
	Bereavement Program										60
	Volunteer Program										61
	Fundraising										62
	Hospice/Palliative Medicine Fellows										63
	Palliative Care Program										64
	Other Physician Services										65
	Residential Care										66
	Advertising										67
	Telehealth/Telemonitoring										68
	Thrift Store										69
	Nursing Facility Room & Board										70
	Other Nonreimbursable										71
	Negative Cost Center										99
	Cost to be allocated (per Wkst. O-6, Part I)										101
102	Unit cost multiplier										102

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

COST ALLOCATION - SNF-BASED HOSPICE G	ENERAL SERVIC	E COST STATIST	ICAL BASIS			PROVIDER CCN	J:	PERIOD:		WORKSHEET	O-6
						HOSPICE CCN:		FROM		Part II	
								ТО			
	NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /		T
	ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
	TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS		
	( Direct	( Patient	( Patient		( Hours of		( Patient	( Specify	( In-Facility		
	Nurs. Hrs. )	Days )	Days )	( Mileage )	Service)	( Charges )	Days )	Basis )	Days )	TOTAL	
Cost Center Descriptions	9	10	11	12	13	14	15	16	17	18	1
GENERAL SERVICE COST CENTERS											
1 Cap Rel Costs-Bldg & Fixt											1
2 Cap Rel Costs-Mvble Equip											2
3 Employee Benefits	1										
4 Administrative & General											4
5 Plant Operation and Maintenance	1										5
6 Laundry & Linen Service											3 4 5 6 7
7 Housekeeping											7
8 Dietary	1										8
9 Nursing Administration											9
10 Routine Medical Supplies											9
11 Medical Records											11
12 Staff Transportation											12
13 Volunteer Service Coordination											13
14 Pharmacy											14
15 Physician Administrative Services								1			11 12 13 14 15
16 Other General Service											16
17 Patient/Residential Care Services										7	17
LEVEL OF CARE											
50 Continuous Home Care											50
51 Routine Home Care											51
52 Inpatient Respite Care											52
53 General Inpatient Care											53
NONREIMBURSABLE COST CENTERS											
60 Bereavement Program											60
61 Volunteer Program											61
62 Fundraising											62
63 Hospice/Palliative Medicine Fellows											63
64 Palliative Care Program											64
65 Other Physician Services											65
66 Residential Care											66
67 Advertising											67
68 Telehealth/Telemonitoring											68
69 Thrift Store											69
70 Nursing Facility Room & Board											70
71 Other Nonreimbursable											71
99 Negative Cost Center											99
101 Cost to be allocated (per Wkst. O-6, Part I)											101
102 Unit cost multiplier											102

				( )
APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY	LEVEL OF CARE	PROVIDER CCN:	PERIOD:	WORKSHEET O-7
		HOSPICE CCN:	FROM	
			TO	

	Wkst. C,	Cost to	Char	Charges by LOC (from Provider Records)			Shared Service Costs by LOC				
	col. 3,	Charge					HCHC	HRHC	HIRC	HGIP	1
	line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	1
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	44										
2 Occupational Therapy	45										
3 Speech/ Language Pathology	46										
4 Drugs, Biological and Infusion Therapy	49										1
5 Durable Medical Equipment/Oxygen	51										
6 Labs and Diagnostics	41										
7 Medical Supplies	48										
8 Outpatient Services (including E/R Dept.)	63										
9 Radiation Therapy	40										1
10 Other	52										
11 Totals (sum of lines 1 through 10)											

4190 (Cont.) FORM CMS-2540-10 08-16

+170 (Cont.)	TORWI CIVIS 2540 I			00 10
CALCULATION OF SNF-BASED HOSPICE PER DIEM COST	PROVIDER CCN:	PERIOD:	WORKSHEET O	-8
		FROM		
	HOSPICE CCN:	ТО		
	TITLE XVIII	TITLE XIX		1
	MEDICARE	MEDICAID	TOTAL	
	1	2	3	7
HOSPICE CONTINUOUS HOME CARE	-	_		
1 Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 11)				1
2 Total unduplicated days (Wkst. S-8, col. 4, line 10)				2
3 Total average cost per diem (line 1 divided by line 2)				3
4 Unduplicated program days (Wkst. S-8, col. as appropriate, line 10)				4
5 Program cost (line 3 times line 4)				5
HOSPICE ROUTINE HOME CARE				
6 Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)				6
7 Total unduplicated days (Wkst. S-8, col. 4, line 11)				7
8 Total average cost per diem (line 6 divided by line 7)				8
9 Unduplicated program days (Wkst. S-8, col. as appropriate, line 11)				9
10 Program cost (line 8 times line 9)				10
HOSPICE INPATIENT RESPITE CARE				
11 Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)				11
12 Total unduplicated days (Wkst. S-8, col. 4, line 12)				12
13 Total average cost per diem (line 11 divided by line 12)				13
14 Unduplicated program days (Wkst. S-8, col. as appropriate, line 12)				14
15 Program cost (line 13 times line 14)				15
HOSPICE GENERAL INPATIENT CARE				
16 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)				16
17 Total unduplicated days (Wkst. S-8, col. 4, line 13)				17
18 Total average cost per diem (line 16 divided by line 17)				18
19 Unduplicated program days (Wkst. S-8, col. as appropriate, line 13)				19
20 Program cost (line 18 times line 19)				20
TOTAL HOSPICE CARE				
21 Total cost (sum of line 1 + line 6 + line 11 + line 16)				21
22 Total unduplicated days (Wkst. S-8, col. 4, line 14)				22
23 Average cost per diem (line 21 divided by line 22)				23

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