This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES *09-30-2025*

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

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

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

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

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

PART III - SETTLEMENT SUMMARY

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated *674* 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I

PART I - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX INDENTIFICATION DATA

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:			1
2	City:	State:	ZIP Code:	County:	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From:_____	To: _____							20
21	Type of control (see instructions)									21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.				22
22.01	Did this hospital receive interim UCPs, *including supplemental UCPs,* for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				22.01
22.02	Is this a newly merged hospital that requires *a* final *UCP* to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid HMO paid and eligible but unpaid days in column 5.							25

		1	2	3	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:_____	Ending: _____		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:_____	Ending: _____		38
		Y/N	*Y/N*		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii). Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				40

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER CCN: _____ PERIOD FROM _____ TO _____ WORKSHEET S-2 PART I (CONT.)

		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)				45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III, and Wkst. L-1, Pt. I, through Pt. III.				46
47	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no.				47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				48

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? *For cost reporting periods beginning prior to December 27, 2020, e*nter "Y" for yes or "N" for no in column 1. *For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions.* For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior year or penultimate year, and *you are* impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				56
57	*For cost reporting periods beginning prior to December 27, 2020, i*f line 56*, column 1,* is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst. E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. *For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.*				57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				59

		NAHE 413.85	NAHE MA		
		1	2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.				60

			Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1	2	3	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)				60.01

		Y/N			IME	Direct GME	
		1	2	3	4	5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						61

			IME	Direct GME	
		1	2	3	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or non-general surgery. (see instructions)				61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					61.20

		1	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions)		62
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		62.01

		1	2	3	
	Teaching Hospitals that Claim Residents in Nonprovider Settings				
63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64 through 67. (see instructions)				63

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 ÷ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	1	2	3	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 ÷ (col. 3 + col. 4))	
		1	2	3	4	5	
65	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						65

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER CCN: _____ PERIOD FROM _____ TO _____ WORKSHEET S-2 PART I (CONT.)

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 ÷ (col. 1 + col. 2))	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	1	2	3	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
67	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						67

	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)	1	
68	*For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?*		*68*

		1	2	3	
	Inpatient Psychiatric Facility PPS				
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				70
71	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(C)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

		1	2	3	
	Inpatient Rehabilitation Facility PPS				
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.				75
76	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

		1	2	
	Long Term Care Hospital PPS			
80	Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no.			80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			81

		1	2	
	TEFRA Providers			
85	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			87

		Approved for Permanent Adjustment (Y/N)	*Number of Approved Permanent Adjustments*	
		1	*2*	
88	*Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)* *Column 2: Enter the number of approved permanent adjustments.*			*88*

		Wkst. A Line No.	*Effective Date*	*Approved Permanent Adjustment Amount Per Discharge*	
		1	*2*	*3*	
89	*Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.* *Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.* *Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.*				*89*

		V	XIX	
	Title V and XIX Services	1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.			90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.			94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			98.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I (CONT.)

Rural Providers		1	2	
105	Does this hospital qualify as a CAH?			105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no.			108

		Physical	Occupational	Speech	Respiratory	
		1	2	3	4	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			111

		1	2	3	
112	Did this hospital participate in the Pennsylvania Rural Health Model *(PARHM)* demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				112

		1	*2*	*3*	
113	*Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.*				*113*

Miscellaneous Cost Reporting Information		1	2	3	
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				115

		1	
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.		118

		Premiums	Paid losses	Self insurance	
		1	2	3	
118.01	List amounts of malpractice premiums and paid losses:				118.01

		1	2	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			118.02
119	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			121
122	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			122
123	*Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no.* *If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.*			*123*

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I (CONT.)

	Certified Transplant Center Information	1	2	
125	Does this facility operate a *Medicare-certified* transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			125
126	If this is a Medicare-certified kidney transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			126
127	If this is a Medicare-certified heart transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			127
128	If this is a Medicare certified liver transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			128
129	If this is a Medicare certified lung transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			129
130	If this is a Medicare certified pancreas transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			130
131	If this is a Medicare certified intestinal transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			131
132	If this is a Medicare certified islet transplant *program* , enter the certification date in column 1 and termination date, if applicable, in column 2.			132
133	Removed and reserved			133
134	If this is *a hospital-based* organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

	All Providers	1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:		Contractor's Name: _____	Contractor's Number: _____	141
142	Street:	P. O. Box:			142
143	City:	State:	Zip Code:		143

		1	2	
144	Are provider based physicians' costs included in Worksheet A?			144
145	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			149

	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13)	Title XVIII Part A	Title XVIII Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital					155
156	Subprovider - IPF					156
157	Subprovider - IRF					157
158	Subprovider - Other					158
159	SNF					159
160	HHA					160
161	CMHC					161

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/Campus in column 5. (see instructions)						166
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act	1	2	
167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.			167
168	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yyyy)			170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART II

PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

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

COMPLETED BY ALL HOSPITALS

	Provider Organization and Operation	Y/N 1	Date 2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)				1
		Y/N 1	Date 2	V/I 3	
2	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

	Financial Data and Reports	Y/N 1	Type 2	Date 3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.				5

	Approved Educational Activities	Y/N 1	Y/N 2	
6	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?			6
7	Are costs claimed for allied health programs? If yes, see instructions.			7
8	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			8
9	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions.			9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			11

	Bad Debts	Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		13
14	If line 12 is yes, were patient deductibles and/or *coinsurance amounts* waived? If yes, see instructions.		14

	Bed Complement		
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.		15

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 Part II (CONT.)

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

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

Capital Related Cost

22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense

28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services

32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians

34	*Were* services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
	Home Office Costs	1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information

41	First name:	Last name:	Title:	41
42	Employer:			42
43	Phone number:	E-mail Address:		43

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

PART I - STATISTICAL DATA

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

HOSPITAL WAGE INDEX INFORMATION	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-3 PART II

Part II - Wage Data

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

HOSPITAL WAGE INDEX INFORMATION	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-3 PART II & III

Part II - Wage Data

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department	4						26
27	Administrative & General	5						27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7						30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10						34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13						38
39	Central Services and Supply	14						39
40	Pharmacy	15						40
41	Medical Records & Medical Records Library	16						41
42	Social Service	17						42
43	Other General Service	18						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)							3
4	Subtotal other wages and related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)							6
7	Total overhead cost (see instructions)							7

HOSPITAL WAGE RELATED COSTS	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-3 PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 through 23)		24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify) _____		25

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

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA County: _____

	Description	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week _____	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service				6
7	Nursing Supervisor				7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.		19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		20

PPS ACTIVITY

		Full Episodes				Total	
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	(columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits						21
22	Skilled Nursing Visit Charges						22
23	Physical Therapy Visits						23
24	Physical Therapy Visit Charges						24
25	Occupational Therapy Visits						25
26	Occupational Therapy Visit Charges						26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)						33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)						35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Outlier Episodes						37
38	Total Non-Routine Medical Supply Charges						38

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-5

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
	DESCRIPTION	1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

	ESRD PPS	1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)			10.02
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)			10.03

	TRANSPLANT INFORMATION		
11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

	EPOETIN		
13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

	ARANESP		
17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

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

21 MCP _____ INITIAL METHOD _____ 21

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

	LOW VOLUME	CCN 1	Treatments 2	
23	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)			23

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-6

COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Check applicable box:	[ ] CMHC	[ ] OOT
	[ ] CORF	[ ] OSP
	[ ] OPT	

Enter the number of hours in your normal workweek _____

		Staff	Contract	Total (col. 1 + col. 2)	
		1	2	3	
1	Administrator and Assistant Administrator(s)				1
2	Director(s) and Assistant Director(s)				2
3	Other Administrative Personnel				3
4	Direct Nursing Service				4
5	Nursing Supervisor				5
6	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
16	Psychiatric/Psychological Service				16
17	Psychiatric/Psychological Service Supervisor				17
18	Other (specify)				18

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

		Y/N	Date	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes and do not complete the rest of this worksheet.			1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2

	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7 (CONT.)

	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA2				63
64	IA1				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

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

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

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-8

Check applicable box:	[ ] Hospital-based RHC [ ] Hospital-based FQHC

Clinic Address and Identification:

1	Street:	1
2	City: State: Zip Code: County:	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations[1]

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation).
List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14	RHC/FQHC name: _____ CCN: _____			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA	PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-9 PARTS I THROUGH IV

PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

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

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

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 and 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

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

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

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

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

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-10 *PART I*

PART I - HOSPITAL AND HOSPITAL COMPLEX DATA

Uncompensated and Indigent Care *Cost-to-Charge Ratio*			
1	Cost to charge ratio (*see instructions*)		1
Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (*see instructions*)		8
Children's Health Insurance Program (CHIP) (see instructions for each line)			
9	Net revenue from stand-alone CHIP		9
10	Stand-alone CHIP charges		10
11	Stand-alone CHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone CHIP (*see instructions*)		12
Other state or local government indigent care program (see instructions for each line)			
13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (*see instructions*)		16
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)		19

Uncompensated *care cost* (see instructions for each line)

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured *discounts (see instructions)*				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (*see instructions*)				23

24	Does the amount on line 20, *col.* 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)		25
25.01	*Charges for insured patients' liability (see instructions)*		*25.01*
26	*Bad debt amount (see instructions)*		26
27	*Medicare reimbursable bad debts (see instructions)*		27
27.01	*Medicare allowable bad debts (see instructions)*		27.01
28	Non-Medicare bad debt *amount* (see instructions)		28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt *amounts* (see instructions)		29
30	Cost of uncompensated care (line 23, *col.* 3, plus line 29)		30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-10, PART II

PART II - HOSPITAL DATA

Uncompensated and Indigent Care Cost-to-Charge Ratio

1	Cost to charge ratio (see instructions)		1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (see instructions)		8

Children's Health Insurance Program (CHIP) (see instructions for each line)

9	Net revenue from stand-alone CHIP		9
10	Stand-alone CHIP charges		10
11	Stand-alone CHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone CHIP (see instructions)		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (see instructions)		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16)		19

Uncompensated care cost (see instructions for each line)

		Uninsured Patients	Insured Patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts (see instructions)				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (see instructions)				23

24	Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program?		24
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions)		25
25.01	Charges for insured patients' liability (see instructions)		25.01
26	Bad debt amount (see instructions)		26
27	Medicare reimbursable bad debts (see instructions)		27
27.01	Medicare allowable bad debts (see instructions)		27.01
28	Non-Medicare bad debt amount (see instructions)		28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		29
30	Cost of uncompensated care (line 23, col. 3, plus line 29)		30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31

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HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-11 PART I

PART I - HOSPITAL-BASED FQHC IDENTIFICATION DATA

		Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW	
	1	2	3	4	5	
1	Site Name:					1
2	Street: P.O. Box:					2
3	City: State: ZIP Code: County: Designation - Enter "R" for rural or "U" for urban:					3
4	Is this hospital-based FQHC part of an entity that owns, leases or controls multiple FQHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below.					4
5	Name of Entity:					5
6	Street: P.O. Box: HRSA Award Number:					6
7	City: State: ZIP Code:					7

		Y/N	Date Requested	Date Approved	Number of FQHCs	
Consolidated Cost Report		1	2	3	4	
8	Is this hospital-based FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 9 beginning with line 9.01. If column 1 is no, leave line 9 blank. (see instructions)					8

		CCN	CBSA	Date Requested	Date Approved	
	1	2	3	4	5	
9	List of Consolidated Providers:					9
9.01	Site Name:					9.01

		1	2	3	
Hospital-Based FQHC Operations					
10	What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions)				10
11	Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the hospital-based FQHC reported on line 1, column 1, receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 12)				11
12	If the response to line 11 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2, and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.				12
Medical Malpractice					
13	Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.				13
Interns and Residents					
14	Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, the number of FTE residents that your hospital-based FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)				14

HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN: _____ COMPONENT CCN: _____ SUBCOMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-11 PART II

PART II - HOSPITAL-BASED FQHC CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA

	1	Date Certified 2	Type of control (see instructions) 3	Date Decertified 4	V/I Decertification 5	Date of CHOW 6	
1	Site Name:						1
2	Street: P.O. Box:						2
3	City: State: ZIP Code: County:		Designation - Enter "R" for rural or "U" for urban:				3

Hospital-Based FQHC Operations		1	2	3	
4	What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicabl alpha characters in column 2. (see instructions)				4
5	Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 6)				5
6	If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.				6

Medical Malpractice					
7	Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.				7

Interns and Residents					
8	Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)				8

HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-11 PART III

PART III - HOSPITAL-BASED FQHC STATISTICAL DATA

		COMPONENT CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
		0	1	2	3	4	5	
1	Medical Visits							1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER CCN: _____ PERIOD: FROM _____ TO _____ WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing Program								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23		Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42		Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46

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

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

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

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
102	*10200*	*Opioid Treatment Program*								*102*
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1 through 117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118 through 199)				- 0 -				200

RECLASSIFICATIONS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE [1]	INCREASES				DECREASES				WKST. A-7 REF.	
			COST CENTER	WKST. A LINE #	SALARY	OTHER	COST CENTER	WKST. A LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1												1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
30												30
31												31
32												32
33												33
34												34
35												35
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)											500

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

RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1 through 7)								8
9	Reconciling Items								9
10	Total (line 7 minus line 9)								10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total [1] (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Total (sum of lines 1 and 2)								3

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

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

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
3	Total (sum of lines 1 and 2)				1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total [2] (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Total (sum of lines 1 and 2)								3

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

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

	DESCRIPTION (1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE #	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1					12
13	Laundry and linen service						13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		26
27	Depreciation - movable equipment			Movable Equipment	2		27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
30.99	Hospice (non-distinct) (see instructions)			Adults and Pediatrics	30		30.99
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT adjustment for depreciation						32
33	Other adjustments (specify) (3)						33
50	TOTAL (sum of lines 1 through 49) (Transfer to Worksheet A, column 6, line 200)						50

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

(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 through 49 and subscripts thereof.

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

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

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

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

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

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

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

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

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

[1] Use the following symbols to indicate interrelationship to related organizations:

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

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

	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS I & II

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)		1
2	Line 1 multiplied by 15 hours per week		2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		6
7	Standard travel expense rate		7
8	Optional travel expense rate per mile		8

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked						9
10	AHSEA (see instructions)						10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)						11
12	Number of travel hours (see instructions)						12
13	Number of miles driven (see instructions)						13

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)		15
16	Assistants (column 3, line 9 times column 3, line10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 9, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20

If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 2, and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.

21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)		23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS III & IV

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance

24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28

Optional Travel Allowance and Optional Travel Expense

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

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense

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

Optional Travel Allowance and Optional Travel Expense

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

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or great than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
	CALCULATION OF LIMIT						
50	Percentage of overtime hours by category (divide the hours in each column on liine 47 by the total overtime worked in column 5, line 47.						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5, the sum of columns 1, 3, and 4, for respiratory therapy, and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35))		58
59	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)		63
64	Total cost of outside supplier services (from provider records)		64
65	Excess over limitation (line 64 minus line 63; if negative, enter zero)		65

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____ PERIOD: FROM _____ TO _____ WORKSHEET B, PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	4	4A	5	6	7	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									82
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic *HSCT* Acquisition									77
78	*CAR T-Cell Immunotherapy*									*78*
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
93.99	Partial Hospitalization Program									93.99

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	
	ANCILLARY SERVICE COST CENTERS											
50	Operating Room											50
51	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology											53
54	Radiology-Diagnostic											54
55	Radiology-Therapeutic											55
56	Radioisotope											56
57	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											82
73	Drugs Charged to Patients											73
74	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
77	Allogeneic *HSCT* Acquisition											77
78	*CAR T-Cell Immunotherapy*											*78*
	OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)											88
89	Federally Qualified Health Center (FQHC)											89
90	Clinic											90
91	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART I

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
102	*Opioid Treatment Program*										*102*
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

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

ALLOCATION OF CAPITAL-RELATED COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	2A	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic *HSCT* Acquisition									77
78	*CAR T-Cell Immunotherapy*									*78*
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
93.99	Partial Hospitalization Program									93.99

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

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

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures											1
2	Capital Related Costs-Movable Equipment											2
4	Employee Benefits Department											4
5	Administrative and General											5
6	Maintenance and Repairs											6
7	Operation of Plant											7
8	Laundry and Linen Service											8
9	Housekeeping											9
10	Dietary											10
11	Cafeteria											11
12	Maintenance of Personnel											12
13	Nursing Administration											13
14	Central Services and Supply											14
15	Pharmacy											15
16	Medical Records & Medical Records Library											16
17	Social Service											17
18	Other General Service (specify)											18
19	Nonphysician Anesthetists											19
20	Nursing Program											20
21	Intern & Res. Service-Salary & Fringes (Approved)											21
22	Intern & Res. Other Program Costs (Approved)											22
23	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											36
40	Subprovider IPF											40
41	Subprovider IRF											41
42	Subprovider (specify)											42
43	Nursery											43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

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

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
102	*Opioid Treatment Program*											*102*
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											113
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	TOTAL (sum lines 118 through 201)											202

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

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

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

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

ALLOCATION OF CAPITAL-RELATED COSTS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B, PART II

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
102	*Opioid Treatment Program*										
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										113
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

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

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

COST ALLOCATION - STATISTICAL BASIS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET B-1

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

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

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	4	5A	5	6	7	
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
102	*Opioid Treatment Program*								*102*
	SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1 through 117)								118
	NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross foot adjustments								200
201	Negative cost centers								201
202	Cost to be allocated (per Worksheet B, Part I)								202
203	Unit cost multiplier (Worksheet B, Part I)								203
204	Cost to be allocated (per Worksheet B, Part II)								204
205	Unit cost multiplier (Worksheet B, Part II)								205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)								206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207

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

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

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

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

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

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

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

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

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

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

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

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASGND TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY AND FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
102	*Opioid Treatment Program*										*102*
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)										202
203	Unit cost multiplier (Worksheet B, Part I)										203
204	Cost to be allocated (per Worksheet B, Part II)										204
205	Unit cost multiplier (Worksheet B, Part II)										205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)										206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										207

POST STEPDOWN ADJUSTMENTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET B-2

	DESCRIPTION	WORKSHEET CODE	WORKSHEET LINE NO.	AMOUNT	
	1	2	3	4	
1	Adjustment for EPO costs in Renal Dialysis cost center	1	74		1
2	Adjustment for EPO costs in Home Program Dialysis cost center	1	94		2
3	Adjustment for ARANESP costs in Renal Dialysis cost center	1	74		3
4	Adjustment for ARANESP costs in Home Program Dialysis cost center	1	94		4
5	Adjustment for ESA costs in Renal Dialysis cost center (see instructions)	1	74		5
6	Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)	1	94		6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50
51					51
52					52
53					53
54					54
55					55
56					56
57					57
58					58
59					59

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I,, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
69	Electrocardiology												69
70	Electroencephalography												70
71	Medical Supplies Charged to Patients												71
72	Implantable Devices Charged to Patients												72
73	Drugs Charged to Patients												73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
77	Allogeneic *HSCT* Acquisition												77
78	*CAR T-Cell Immunotherapy*												*78*
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic												90
91	Emergency												91
92	Observation Beds (see instructions)												92
93	Other Outpatient Service (specify)												93
93.99	Partial Hospitalization Program												93.99
	OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
102	*Opioid Treatment Program*												*102*
	SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)												200
201	Less Observation Beds												201
202	Total (see instructions)												202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET C, PART II

Check applicable box: [ ] Title V [ ] Title XIX

	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
		1	2	3	4	5	6	7	8	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Prgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic *HSCT* Acquisition									77
78	*CAR T-Cell Immunotherapy*									*78*

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET C. PART II (CONT.)

Check applicable box: [ ] Title V [ ] Title XIX

	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
		1	2	3	4	5	6	7	8	
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds (see instructions)									92
93	Other Outpatient Service (specify)									93
93.99	Partial Hospitalization Program									93.99
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
102	*Opioid Treatment Program*									*102*
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
200	Subtotal (sum of lines 50 through 199)									200
201	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART I

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*	[ ] PPS [ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30 through 199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D PART II

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] IPF [ ] IRF	[ ] Subprovider (Other) [ ] PARHM Demonstration *[ ] CHART Model*	[ ] PPS [ ] TEFRA

(A)	Cost Center Description	Capital Related Cost (from Wkst. B Part II, col. 26)	Total Charges (from Wkst. C, Pt .I, col. 8)	Ratio of Cost to Charges (col .1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catheterization						60
60	Laboratory						60
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
77	Allogeneic *HSCT* Acquisition						77
78	*CAR T-Cell Immunotherapy*						*78*
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92	Observation Beds						92
93	Other Outpatient Service (specify)						93
93.99	Partial Hospitalization Program						93.99
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET D, PART III

Check applicable boxes:
[ ] Title V
[ ] Title XVIII, Part A
[ ] Title XIX
[ ] Hospital
[ ] PARHM Demonstration
[ ] CHART Model
[ ] PPS
[ ] TEFRA
[ ] Other

		Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1, 2, and 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults & Pediatrics (General Routine Care)												30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care Unit (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
42	Subprovider (Other)												42
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
200	Total (sum of lines 30 through 199)												200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS-THROUGH COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET D, PART IV

Check applicable boxes:

[ ] Title V
[ ] Title XVIII, Part A
[ ] Title XIX

[ ] Hospital
[ ] IPF
[ ] IRF
[ ] Subprovider (Other)

[ ] SNF
[ ] NF
[ ] ICF/IID
[ ] Swing-Bed SNF

[ ] PARHM Demonstration
[ ] PARHM CAH Swing Bed-SNF
[ ] CHART Model
[ ] CHART CAH Swing Bed-SNF

[ ] PPS
[ ] TEFRA
[ ] Other

		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Serv.-Prgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Transfusing									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged To Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic *HSCT* Acquisition									77
78	*CAR T-Cell Immunotherapy*									*78*
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
93.99	Partial Hospitalization Program									93.99

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART IV (Cont.)

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other)	[ ] SNF [ ] NF [ ] ICF/IID [ ] Swing-Bed SNF	[ ] PARHM Demonstration [ ] PARHM CAH Swing-Bed SNF *[ ] CHART Model* *[ ] CHART CAH Swing Bed-SNF*	[ ] PPS [ ] TEFRA [ ] Other

		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
200	Total (sum of lines 50 through 199)									200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART IV (Cont.)

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other)	[ ] SNF [ ] NF [ ] ICF/IID [ ] Swing-Bed SNF	[ ] PARHM Demonstration [ ] PARHM CAH Swing-Bed SNF *[ ] CHART Model* *[ ] CHART CAH Swing Bed-SNF*	[ ] PPS [ ] TEFRA [ ] Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Delivery Room and Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic *HSCT* Acquisition								77
78	*CAR T-Cell Acquisition*								*78*
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
93.99	Partial Hospitalization Program								93.99

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART IV (Cont.)

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other)	[ ] SNF [ ] NF [ ] ICF/IID [ ] Swing-Bed SNF	[ ] PARHM Demonstration [ ] PARHM CAH Swing Bed-SNF *[ ] CHART Model* *[ ] CHART CAH Swing Bed-SNF*	[ ] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
200	Total (sum of lines 50 through 199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D, PART V

Check applicable boxes:	[ ] Title V - O/P	[ ] Hospital	[ ] Subprovider (Other)	[ ] Swing-Bed SNF	[ ] PARHM Demonstration
	[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing-Bed NF	[ ] PARHM CAH Swing-Bed SNF
	[ ] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID	*[ ] CHART Model*
					[ ] CHART CAH Swing-Bed SNF

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

			Program Charges			Program Cost			
		Cost to Charge Ratio from Wkst. C, Pt. I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)	PPS Services (see (see inst.)	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic *HSCT* Acquisition								77
78	*CAR T-Cell Immunotherapy*								*78*
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed								92
93	Other Outpatient Service (specify)								93
93.99	Partial Hospitalization Program								93.99
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PART I

Check applicable boxes:	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (other) [ ] SNF	[ ] NF [ ] ICF/IID [ ] PARHM Demonstration *[ ] CHART Model*	[ ] PPS [ ] TEFRA [ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)		1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		2
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed and observation bed days)		4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PART II

Check applicable boxes:	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (other)	[ ] PARHM Demonstration [ ] CHART Model	[ ] PPS [ ] TEFRA [ ] Other

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)		38
39	Program general inpatient routine service cost (line 9 x line 38)		39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)		41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47

		1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)		48
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49	Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)		49
	PASS-THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59
60	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60
61	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PARTS III & IV

Check applicable boxes:	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other)	[ ] SNF [ ] NF	[ ] ICF/IID	[ ] PPS [ ] TEFRA [ ] Other

PART III - SNF, NF, AND ICF/IID ONLY

70	SNF / NF / ICF/IID routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing Program cost						91
92	Allied Health cost						92
93	All other Medical Education						93

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

PART I - NOT IN APPROVED TEACHING PROGRAM

	Cost Centers	Percent of Assigned Time	Expense Allocation	Total Inpatient Days All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			1
	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care)				2
3	Intensive care unit				3
4	Coronary care unit				4
5	Burn Intensive Care Unit				5
6	Surgical Intensive Care Unit				6
7	Other Special Care (specify)				7
8	Nursery				8
9	Subtotal (sum of lines 2 through 8)				9
10	IPF - Inpatient routine service				10
11	IRF - Inpatient routine service				11
12	Subprovider (Other) - Inpatient routine service				12
13	Skilled Nursing Facility				13
14	Nursing Facility				14
15	Other Long Term Care				15
16	Home Health Agency				16
17	Outpatient Rehabilitation Providers				17
18	Ambulatory Surgical Center				18
19	Hospice				19
20	Subtotal (sum of lines 9 through 19)				20
	Hospital Outpatient Services:			Total Charges (from Wkst. C, Pt. I, col. 8, lines 88 through 93)	
21	Rural Health Clinic (RHC)				21
22	Federally Qualified Health Center (FQHC)				22
23	Clinic				23
24	Emergency				24
25	Observation beds				25
26	Other Outpatient Service (specify)				26
27	Subtotal (sum of lines 21 through 26)				27
28	Total (sum of lines 20 and 27)	100.00			28

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

	Hospital Inpatient Routine Services:	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Swing Bed Amount	Net Cost (col. 1 plus col. 2)	
		1	2	3	
29	Adults & Pediatrics (general routine care)				29
30	Swing Bed - SNF				30
31	Swing Bed - NF				31
32	Intensive care unit				32
33	Coronary care unit				33
34	Burn Intensive Care Unit				34
35	Surgical Intensive Care Unit				35
36	Other Special Care (specify)				36
37	Subtotal (sum of lines 29, and 32 through 36)				37
38	IPF - Inpatient routine service				38
39	IRF - Inpatient routine service				39
40	Subprovider (Other)- Inpatient routine service				40
41	Skilled Nursing Facility				41
42	Total (sum of lines 37 through 41)				42

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

	Hospital	Not In Approved Teaching Program (from Part I)	Amount	
		1	2	
43	Inpatient	col. 9, line 9		43
44	Outpatient	col. 9, line 27		44
45	Total Hospital (sum of lines 43 and 44)			45
46	IPF - Inpatient routine service	col. 9, line 10		46
47	IRF - Inpatient routine service	col. 9, line 11		47
48	Subprovider (Other)- Inpatient routine service	col. 9, line 12		48
49	Skilled Nursing Facility	col. 9, line 13		49

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

PART I - NOT IN APPROVED TEACHING PROGRAM

	Average Cost Per Day	Health Care Program Inpatient Days			Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
		Title V	Title XVIII, Part B	Title XIX				
	4	5	6	7	8	9	10	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20

	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges			Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title V	Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)				
	4	5	6	7				
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42								42

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

	In Approved Teaching Program		Total Title XVIII Costs					
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				
	3	4	5	6				
43	line 37							43
44								44
45			line 22					45
46	line 38		line 22					46
47	line 39		line 22					47
48	line 40		line 22					48
49	line 41		line 22					49

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-3

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other)	[ ] SNF [ ] NF [ ] Swing-Bed SNF [ ] Swing-Bed NF	[ ] ICF/IID [ ] PARHM Demonstration [ ] PARHM CAH Swing-Bed SNF *[ ] CHART Model* *[ ] CHART CAH Swing-Bed SNF*	[ ] PPS [ ] TEFRA [ ] Other

	COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults and Pediatrics (General Routine Care)				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify)				42
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room				50
51	Recovery Room				51
52	Labor Room and Delivery Room				52
53	Anesthesiology				53
54	Radiology-Diagnostic				54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan				57
58	Magnetic Resonance Imaging (MRI)				58
59	Cardiac Catheterization				59
60	Laboratory				60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy				64
65	Respiratory Therapy				65
66	Physical Therapy				66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients				72
73	Drugs Charged to Patients				73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
77	Allogeneic *HSCT* Acquisition				77
78	*CAR T-Cell Immunotherapy*				*78*
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
93.99	Partial Hospitalization Program				93.99
	OTHER REIMBURSABLE COST CENTERS				
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50 through 94 and 96 through 98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM	PROVIDER CCN: _____ OPO CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-4, PART I

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)

	Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition	Inpatient Routine Organ Charges		Per Diem Costs (from Wkst. D-1, Part II)	Organ Acquisition Days	Cost (col. 2 x col. 3)	
		1	D	2	3	4	
1	Adults and Pediatrics		38				1
2	Intensive Care		43				2
3	Coronary Care		44				3
4	Burn Intensive Care Unit		45				4
5	Surgical Intensive Care Unit		46				5
6	Other Special Care (specify)		47				6
7	TOTAL (sum of lines 1 through 6)						7

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

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM	PROVIDER CCN: _____ OPO CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-4, PART II

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICE COSTS)

	Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program	Average Cost Per Day (from Wkst. D-2, Part I, col. 4)		Organ Acquisition Days	Organ Acquisition Costs (col. 1 x col. 2)	
		D	1	2	3	
42	Adults & Pediatrics (General routine care)	2				42
43	Intensive Care Unit	3				43
44	Coronary Care Unit	4				44
45	Burn Intensive Care Unit	5				45
46	Surgical Intensive Care Unit	6				46
47	Other Special Care (specify)	7				47
48	TOTAL (sum of lines 42 through 47)					48

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

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM	PROVIDER CCN: _____ OPO CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-4, PARTS III & IV

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

PART III - SUMMARY OF COSTS AND CHARGES

		Cost		Charges		
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct organ acquisition (see instructions)					59
60	Cost of physicians' services in a teaching hospital (see instructions)					60
61	Total (sum of lines 56 through 60)					61

			Usable Organs			
		1	*2*	*3*	*4*	
62	Total usable organs (see instructions)					62
63	Medicare usable organs (see instructions)					63
64	Ratio of Medicare usable organs to total usable organs (*see instructions*)					64

		Cost		*Charges*		
		Part A	*Part B*	*Part A*	*Part B*	
		1	*2*	*3*	*4*	
65	Medicare Cost *and* Charges (see instructions)					65
66	Revenue for organs sold *(see instructions)*					66
66.01	*Partial primary payor amounts applicable to organ acquisition*					*66.01*
66.02	*Partial primary payor amounts applicable to transplants (informational only)*					*66.02*
67	Subtotal (*see instructions*)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69

PART IV - STATISTICS

		Living Related	Cadaveric	Revenue	
		1	2	3	
70	Organs excised in provider [1]				70
71	Organs purchased from other transplant hospitals [2]				71
72	Organs purchased from non-transplant hospitals				72
73	Organs purchased from OPOs *(see instructions)*				73
74	Total (sum of lines 70 through 73)				74
75	Organs transplanted				75
75.01	*Organs transplanted into Medicare beneficiaries*				*75.01*
75.02	*Kidneys transplanted into MA beneficiaries*				*75.02*
75.03	*Organs transplanted, Medicare secondary payer*				*75.03*
75.04	*Organs transplanted, Other (see instructions)*				*75.04*
76	Organs sold to other hospitals				76
77	Organs sold to OPOs				77
78	Organs sold to transplant hospitals				78
79	Organs sold to *MRTC without an agreement* or VA hospitals				79
79.01	*Kidneys sold to MRTC with an agreement*				*79.01*
80	Organs sold outside the U.S.				80
81	Organs sent outside the U.S. (no revenue received)				81
82	Organs used for research				82
83	Unusable/Discarded organs *(see instructions)*				83
84	Total (*see instructions*)				84

[1] Organs procured outside your center by a procurement team from your center are not included in the count.
[2] Organs procured outside your center by a procurement team from your center are included in the count.

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-5, PART I

Check applicable box: [ ] Hospital Staff [ ] Medical Staff

PART I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ENDING BEFORE JUNE 30, 2014

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

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

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-5, PART II

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF

PART II - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL FOR COST REPORTING PERIODS ENDING BEFORE JUNE 30, 2014

		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)	
		1	2	3	
1	Adjusted Cost of Physician's Direct Medical and Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days				2
3	Average Per Diem (line 1 ÷ line 2)				3
	HEALTH CARE PROGRAM REIMBURSABLE DAYS				
4	Title V - Inpatient				4
5	Title V - Outpatient				5
6	Title XVIII - Part A				6
7	Title XVIII - Part B				7
8	Title XIX - Inpatient				8
9	Title XIX - Outpatient				9
10	Inpatient and Outpatient Kidney Acquisition				10
11	Inpatient and Outpatient Liver Acquisition				11
12	Inpatient and Outpatient Heart Acquisition				12
13	Inpatient and Outpatient Lung Acquisition				13
14	Inpatient and Outpatient Pancreas Acquisition				14
15	Inpatient and Outpatient Intestine Acquisition				15
16	Inpatient and Outpatient Islet Acquisition				16
17	Other Organ Acquisition				17
	HEALTH CARE PROGRAM REIMBURSABLE COST				
18	Title V - Inpatient (line 3 x line 4)				18
19	Title V - Outpatient (line 3 x line 5)				19
20	Title XVIII - Part A (line 3 x line 6)				20
21	Title XVIII - Part B (line 3 x line 7)				21
22	Title XIX - Inpatient (line 3 x line 8)				22
23	Title XIX - Outpatient (line 3 x line 9)				23
24	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)				24
25	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)				25
26	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)				26
27	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)				27
28	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)				28
29	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)				29
30	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)				30
31	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)				31

Transfer the amounts in column 3 as follows:
- Add lines 18 and 19, and transfer to Worksheet E-3, Part VII
- Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate
- Line 21 to Worksheet E, Part B
- Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate
- Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET D-5, PART III

PART III - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ENDING ON OR AFTER JUNE 30, 2014

	Wkst. A Line #	Cost Center / Physician Identifier	Total Remuneration	Professional Component	RCE Amount	Physician/ Professional Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total							200

	Wkst. A Line #	Cost Center / Physician Identifier	Cost of Membership & Continuing Education	Professional Component Share of Column 11	Cost of Physician Malpractice Insurance	Professional Component Share of Column 13	Adjusted RCE Limit	Adjust Cost of Physician's Direct Medical & Surgical Services	
	9	10	11	12	13	14	15	16	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total (transfer the amount in column 16, line 200, to Part IV, line 1)							200

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-5, PART IV

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF

PART IV - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL FOR COST REPORTING PERIODS ENDING ON OR AFTER JUNE 30, 2014

1	Adjusted cost of physicians' direct medical and surgical services		1
2	Total inpatient days and outpatient visit days		2
3	Average per diem (line 1 ÷ line 2)		3

HEALTH CARE PROGRAM REIMBURSABLE DAYS

4	Title V - Inpatient		4
5	Title V - Outpatient		5
6	Title XVIII - Part A		6
7	Title XVIII - Part B		7
8	Title XIX - Inpatient		8
9	Title XIX - Outpatient		9
10	Inpatient and outpatient kidney acquisition		10
11	Inpatient and outpatient liver acquisition		11
12	Inpatient and outpatient heart acquisition		12
13	Inpatient and outpatient lung acquisition		13
14	Inpatient and outpatient pancreas acquisition		14
15	Inpatient and outpatient intestine acquisition		15
16	Inpatient and autpatient islet acquisition		16
17			17
17.01	*Inpatient allogeneic HSCT acquisition*		*17.01*
17.02	*Outpatient allogeneic HSCT acquisition*		*17.02*

HEALTH CARE PROGRAM REIMBURSABLE COST

18	Title V - Inpatient (line 3 x line 4)		18
19	Title V - Outpatient (line 3 x line 5)		19
20	Title XVIII - Part A (line 3 x line 6)		20
21	Title XVIII - Part B (line 3 x line 7)		21
22	Title XIX - Inpatient (line 3 x line 8)		22
23	Title XIX - Outpatient (line 3 x line 9)		23
24	Inpatient and outpatient kidney acquisition (line 3 x line 10)		24
25	Inpatient and outpatient liver acquisition (line 3 x line 11)		25
26	Inpatient and outpatient heart acquisition (line 3 x line 12)		26
27	Inpatient and outpatient lung acquisition (line 3 x line 13)		27
28	Inpatient and outpatient pancreas acquisition (line 3 x line 14)		28
29	Inpatient and outpatient intestine acquisition (line 3 x line 15)		29
30	Inpatient and outpatient islet acquisition (line 3 x line 16)		30
31			31
31.01	*Inpatient allogeneic HSCT acquisition (line 3 x line 17.01)*		*31.01*
31.02	*Outpatient allogeneic HSCT acquisition (line 3 x line 17.02)*		*31.02*

Transfer amounts as follows:
- Add lines 18 and 19, and transfer to Worksheet E-3, Part VII, line 20 (title V hospital or component)
- Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF); Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (cost reimbursement)
- Line 21 to Worksheet E, Part B , line 23 (Medicare Part B Medical and Other Health Services)
- Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, line 20 (title XIX hospital or component)
- Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60
- *Line 31.01 to Worksheet D-6, Part III, line 5, col. 1*
- *Line 31.02 to Worksheet D-6, Part III, line 5, col. 2*

COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-6, PARTS I & II

PART I - INPATIENT ROUTINE AND ANCILLARY SERVICES CELLULAR THERAPY ACQUISITION COSTS

	Inpatient Routine Services Acquisition Costs	Routine Services Acquisition Charges		Per Diem Costs (see instructions)	Inpatient Acquisition Days	Acquisition Costs (col. 2 x col. 3)			
		1	D-1	2	3	4			
1	Adults and Pediatrics		38						1
2	Intensive Care		43						2
3	Coronary Care		44						3
4	Burn Intensive Care Unit		45						4
5	Surgical Intensive Care Unit		46						5
6	Other Special Care (specify)		47						6
7	Total (sum of lines 1 through 6)								7

	Ancillary Services Acquisition Costs		Ratio of Cost to Charges (from Wkst. C, Pt. I, col. 9)	Inpatient Ancillary Services Acquistion Charges	Outpatient Ancillary Services Acquistion Charges	Inpatient Ancillary Services Acquistion Cost	Outpatient Ancillary Services Acquistion Cost	
		C	1	2	3	4	5	
8	Operating Room	50						8
9	Recovery Room	51						9
10	Labor Room & Delivery Room	52						10
11	Anesthesiology	53						11
12	Radiology-Diagnostic	54						12
13	Radiology-Therapeutic	55						13
14	Radioisotope	56						14
15	Computed Tomography (CT) Scan	57						15
16	Magnetic Resonance Imaging (MRI)	58						16
17	Cardiac Catheterization	59						17
18	Laboratory	60						18
19	PBP Clinical Laboratory Services-Program Only	61						19
20	Whole Blood & Packed Red Blood Cells	62						20
21	Blood Storage, Processing, & Transfusing	63						21
22	IV Therapy	64						22
23	Electrocardiology	69						23
24	Medical Supplies Charged to Patients	71						24
25	Drugs Charged to Patients	73						25
26	ASC (non-distinct part)	75						26
27	Other Ancillary (specify)	76						27
28	Total (sum of lines 8 through 27)							28

PART II - INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING PROGRAM CELLULAR THERAPY ACQUISITION COSTS

	Interns and Residents Not in Approved Teaching Program Acquisition Costs	Average Cost Per Day (from Wkst. D-2, Pt. I, col. 4)		Inpatient Acquisition Days	Inpatient Part B Acquisition Costs (col. 1 x col. 2)			
		D-2	1	2	3			
1	Adults & Pediatrics	2						1
2	Intensive Care Unit	3						2
3	Coronary Care Unit	4						3
4	Burn Intensive Care Unit	5						4
5	Surgical Intensive Care Unit	6						5
6	Other Special Care (specify)	7						6
7	Total (sum of lines 1 through 6)							7

COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-6, PART III

PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS

		Amount		
1	Acquisition cost from Worksheet B, col. 26 (see instructions)			1

	Acquisition Services Total Costs	Inpatient 1	Outpatient 2	
2	Routine and ancillary			2
3	Interns and residents			3
4	Apportionment of acquisition cost from line 1			4
5	Cost of physicians' services in a teaching hospital (see instructions)			5
6	Total acquisition cost (sum of lines 2 through 5)			6

	Determine Ratio of Medicare Transplants to Total Transplants	Inpatient 1	Outpatient 2	Total 3	
7	Total transplants (see instructions)				7
8	Medicare transplants (see instructions)				8
9	Medicare ratio (line 8 ÷ line 7)				9
10	Medicare cost (see instructions)				10

PART IV - STATISTICS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A

Check applicable box: [ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

1	DRG amounts other than outlier payments		1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		1.04
2	Outlier payments for discharges (see instructions)		2
2.01	Outlier reconciliation amount		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		2.04
3	Managed care simulated payments		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)		4
	Indirect Medical Education Adjustment Calculation for Hospitals		
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)		5
5.01	*FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)*		*5.01*
6	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6
6.26	*Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)*		*6.26*
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)		7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.		7.01
7.02	*Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)*		*7.02*
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)		8.02
8.21	*The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)*		*8.21*
9	Sum of lines 5 *and 5.01,* plus *line* 6*, plus lines 6.26 through 6.49* , minus lines 7 and 7.01, *plus or minus line 7.02,* plus/minus line 8, plus lines *8.01 through 8.27* (see instructions)		9
10	FTE count for allopathic and osteopathic programs in the current year from your records		10
11	FTE count for residents in dental and podiatric programs		11
12	Current year allowable FTE (see instructions)		12
13	Total allowable FTE count for the prior year		13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.		14
15	Sum of lines 12 through 14 divided by 3		15
16	Adjustment for residents in initial years of the program *(see instructions)*		16
17	Adjustment for residents displaced by program or hospital closure		17
18	Adjusted rolling average FTE count		18
19	Current year resident to bed ratio (line 18 divided by line 4)		19
20	Prior year resident to bed ratio (see instructions)		20
21	Enter the lesser of lines 19 or 20 (see instructions)		21
22	IME payment adjustment (see instructions)		22
22.01	IME payment adjustment - Managed Care (see instructions)		22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA		
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		23
24	IME FTE resident count over cap (see instructions)		24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		25
26	Resident to bed ratio (divide line 25 by line 4)		26
27	IME payments adjustment factor (see instructions)		27
28	IME add-on adjustment amount (see instructions)		28
28.01	IME add-on adjustment amount - Managed Care (see instructions)		28.01
29	Total IME payment (sum of lines 22 and 28)		29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		29.01
	Disproportionate Share Adjustment		
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		30
31	Percentage of Medicaid patient days to total patient days (see instructions)		31
32	Sum of lines 30 and 31		32
33	Allowable disproportionate share percentage (see instructions)		33
34	Disproportionate share adjustment (see instructions)		34

		Prior to October 1	On or after October 1	
	Uncompensated Care *Payment* Adjustment			
35	Total uncompensated care amount (see instructions)			35
35.01	Factor 3 (see instructions)			35.01
35.02	Hospital *UCP, including supplemental UCP* (If line 34 is zero, enter zero on this line) (see instructions)			35.02
35.03	Pro rata share of the hospital *UCP, including supplemental UCP* (see instructions)			35.03
35.04	Pro rata share of the *MDH's UCP, including supplemental UCP* (see instructions)			35.04
35.05	Pro rata share of the *SCH's UCP, including supplemental UCP* (see instructions)			35.05
36	Total *UCP adjustment* (sum of columns 1 and 2 on line 35.03)			36

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A (Cont.)

Check applicable box: [ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)

Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A

Check applicable box: [ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)

	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			90
91	Capital outlier from Wkst. L, Pt. I, line 2			91
92	Operating outlier reconciliation adjustment amount (see instructions)			92
93	Capital outlier reconciliation adjustment amount (see instructions)			93
94	The rate used to calculate the time value of money (see instructions)			94
95	Time value of money for operating expenses (see instructions)			95
96	Time value of money for capital related expenses (see instructions)			96
	HSP Bonus Payment Amount	Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100
	HVBP Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)			101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102
	HRR Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)			103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200
	Cost Reimbursement			
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201
202	Medicare discharges (see instructions)			202
203	Case-mix adjustment factor (see instructions)			203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204	Medicare target amount			204
205	Case-mix adjusted target amount (line 203 times line 204)			205
206	Medicare inpatient routine cost cap (line 202 times line 205)			206
	Adjustment to Medicare Part A Inpatient Reimbursement			
207	Program reimbursement under the §410A Demonstration (see instructions)			207
208	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208
209	Adjustment to Medicare IPPS payments (see instructions)			209
210	Reserved for future use			210
211	Total adjustment to Medicare IPPS payments (see instructions)			211
	Comparison of PPS versus Cost Reimbursement			
212	Total adjustment to Medicare Part A IPPS payments (from line 211)			212
213	Low-volume adjustment (see instructions)			213
218	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218

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CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART B

Check applicable box: [ ] Hospital [ ] Subprovider (Other) *[ ] CHART Model* [ ] IPF [ ] SNF [ ] IRF [ ] PARHM Demonstration

	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1	Medical and other services (see instructions)		1
2	Medical and other services reimbursed under OPPS (see instructions)		2
3	OPPS payments		3
4	Outlier payment (see instructions)		4
4.01	Outlier reconciliation amount (see instructions)		4.01
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of lines 3, 4, and 4.01, divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12	Ancillary service charges		12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14	Total reasonable charges (sum of lines 12 and 13)		14
	Customary charges		
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)		18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (see instructions)		21
22	Interns and residents (see instructions)		22
23	Cost of physicians' services in a teaching hospital (see instructions)		23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	Deductibles and coinsurance amounts (see instructions)		25
26	Deductibles and Coinsurance amounts relating to amount on line 24 (see instructions)		26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)		30
31	Primary payer payments		31
32	Subtotal (line 30 minus line 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	Composite rate ESRD (from Wkst. I-5, line 11)		33
34	Allowable bad debts (see instructions)		34
35	Adjusted reimbursable bad debts (see instructions)		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		36
37	Subtotal (see instructions)		37
38	MSP-LCC reconciliation amount from PS&R		38
39	Other adjustments (specify) (see instructions)		39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration		39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99	Recovery of Accelerated depreciation		39.99
40	Subtotal (see instructions)		40
40.01	Sequestration adjustment (see instructions)		40.01
40.02	Demonstration payment adjustment amount after sequestration		40.02
40.03	Sequestration adjustment-PARHM *or CHART* pass-throughs		40.03
41	Interim payments		41
41.01	Interim payments-PARHM *or CHART*		41.01
42	Tentative settlement (for contractors use only)		42
42.01	Tentative settlement-PARHM *or CHART* (for contractors use only)		42.01
43	Balance due provider/program (see instructions)		43
43.01	Balance due provider/program-PARHM *or CHART* (see instructions)		43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		44

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART B (Cont.)

Check applicable box:	[ ] Hospital	[ ] Subprovider (Other)	*[ ] CHART Model*
	[ ] IPF	[ ] SNF	
	[ ] IRF	[ ] PARHM Demonstration	

PART B - MEDICAL AND OTHER HEALTH SERVICES

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-1, PART I

Check applicable box:

[ ] Hospital [ ] Subprovider (Other) [ ] PARHM Demonstration
[ ] IPF [ ] SNF [ ] PARHM CAH Swing-Bed SNF
[ ] IRF [ ] Swing-Bed SNF *[ ] CHART Model*
[ ] CHART CAH Swing-Bed SNF

	Description			Inpatient Part A mm/dd/yyyy 1	Inpatient Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01- 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. E or Wkst. E-3, line and column as appropriate)							4
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-1, PART II

Check applicable box:	[ ] Hospital [ ] CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)		1
2	Medicare days (*see instructions*)		2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (*see instructions*)		4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-2

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

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	Inpatient routine services - swing bed-SNF (see instructions)			1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A; and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)			3
3.01	Nursing and allied health payment-PARHM *or CHART* (see instructions)			3.01
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days			5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)			10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (see instructions)			15
16	Other adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)			16.55
16.99	Demonstration payment adjustment amount before sequestration			16.99
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)			19
19.01	Sequestration adjustment (see instructions)			19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
19.03	Sequestration adjustment-PARHM *or CHART* pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)			19.25
20	Interim payments			20
20.01	Interim payments-PARHM *or CHART*			20.01
21	Tentative settlement (for contractor use only)			21
21.01	Tentative settlement-PARHM *or CHART* (for contractor use only)			21.01
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)			22
22.01	Balance due provider/program-PARHM *or CHART* (see instructions)			22.01
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			23
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200
	Cost Reimbursement			
201	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201
202	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202
203	Total (sum of lines 201 and 202)			203
204	Medicare swing-bed SNF discharges (see instructions)			204
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205	Medicare swing-bed SNF target amount			205
206	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207	Program reimbursement under the §410A Demonstration (see instructions)			207
208	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208
209	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209
210	Reserved for future use			210
	Comparison of PPS versus Cost Reimbursement			
215	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215

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

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART II

Check applicable box:	[ ] Hospital [ ] Subprovider IPF

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)		1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)		9
10	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		10
11	Teaching Adjustment (line 1 multiplied by line 10).		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3, and 11)		12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)		16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17).		18
19	Deductibles		19
20	Subtotal (line 18 minus line 19)		20
21	Coinsurance		21
22	Subtotal (line 20 minus line 21)		22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)		26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
30.99	Demonstration payment adjustment amount before sequestration		30.99
31	Total amount payable to the provider (see instructions)		31
31.01	Sequestration adjustment (see instructions)		31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments		32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32, and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III

Check applicable box:	[ ] Hospital [ ] Subprovider IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	Net Federal PPS payment (see instructions)		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)		2
3	Inpatient Rehabilitation LIP payments (see instructions)		3
4	Outlier payments		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2)		5.01
6	New teaching program adjustment (see instructions)		6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see isntructions)		7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a “new teaching program” (see isntructions)		8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)		9
10	Average daily census (see instructions)		10
11	Teaching Adjustment Factor (see instructions)		11
12	Teaching Adjustment (see instructions)		12
13	Total PPS Payment (see instructions)		13
14	Nursing and allied health managed care payments (see instructions)		14
15	Organ acquisition DO NOT USE THIS LINE		15
16	Cost of physicians' services in a teaching hospital (see instructions)		16
17	Subtotal (see instructions)		17
18	Primary payer payments		18
19	Subtotal (line 17 less line 18)		19
20	Deductibles		20
21	Subtotal (line 19 minus line 20)		21
22	Coinsurance		22
23	Subtotal (line 21 minus line 22)		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)		24
25	Adjusted reimbursable bad debts (see instructions)		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)		26
27	Subtotal (sum of lines 23 and 25)		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)		28
29	Other pass through costs (see instructions)		29
30	Outlier payments reconciliation		30
31	Other adjustments (specify) (see instructions)		31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		31.50
31.99	Demonstration payment adjustment amount before sequestration		31.99
32	Total amount payable to the provider (see instructions)		32
32.01	Sequestration adjustment (see instructions)		32.01
32.02	Demonstration payment adjustment amount after sequestration		32.02
33	Interim payments		33
34	Tentative settlement (for contractor use only)		34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		36

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART IV

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

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

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART V

Check applicable box:	[ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services		1
2	Nursing and allied health managed care payment (see instructions)		2
3	Organ acquisition		3
3.01	*Cellular therapy acquisition cost (see instructions)*		*3.01*
4	Subtotal (sum of lines 1 through *3.01*)		4
5	Primary payer payments		5
6	Total cost (see instructions)		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	Customary charges		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)		13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)		19
20	Deductibles (exclude professional component)		20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus lines 20 and 21)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)		25
26	Adjusted reimbursable bad debts (see instructions)		26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 25 or 26)		28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
29.99	Demonstration payment adjustment amount before sequestration		29.99
30	Subtotal (see instructions)		30
30.01	Sequestration adjustment (see instructions)		30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
30.03	Sequestration adjustment-PARHM *or CHART*		30.03
31	Interim payments		31
31.01	Interim payments-PARHM *or CHART*		31.01
32	Tentative settlement (for contractor use only)		32
32.01	Tentative settlement-PARHM *or CHART* (for contractor use only)		32.01
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		33
33.01	Balance due provider/program-PARHM *or CHART* (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART VII

Check applicable boxes:	[ ] Title V [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/IID	[ ] PPS [ ] TEFRA [ ] Other

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

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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-4

Check applicable box:	[ ] Title V	[ ] Hospital	[ ] CAH-Based IPF
	[ ] Title XVIII	[ ] PARHM Demonstration	[ ] CAH-Based IRF
	[ ] Title XIX	*[ ] CHART Model*	

	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996		1
1.01	*FTE cap adjustment under §131 of the CAA 2021 (see instructions)*		*1.01*
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)		2
2.26	*Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)*		*2.26*
3	Amount of reduction to Direct GME cap under §422 of MMA		3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)		3.01
3.02	*Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)*		*3.02*
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)		4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)		4.02
4.21	*The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)*		*4.21*
5	FTE adjusted cap (line 1 plus *and 1.01,* plus line 2 *plus lines 2.26 through 2.49,* minus lines 3 and 3.01, *plus or minus line 3.02,* plus or minus line 4, plus lines *4.01 through 4.27*		5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		6
7	Enter the lesser of line 5 or line 6		7

		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year				8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. *For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.*				9
10	Weighted dental and podiatric resident FTE count for the current year				10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count				11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)				12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instr.)				13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)				14
15	Adjustment for residents in initial years of new programs				15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure				16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count				17
18	Per resident amount				18
18.01	*Per resident amount under §131 of the CAA 2021*				*18.01*
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 time line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25

	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1	2	2.01	3	
26	Inpatient days (see instructions)					26
27	Total inpatient days (see instructions)					27
28	Ratio of inpatient days to total inpatient days					28
29	Program direct GME amount					29
29.01	Percent reduction for MA DGME					29.01
30	Reduction for direct GME payments for Medicare Advantage					30
31	Net Program direct GME amount					31

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		34
35	Medicare outpatient ESRD charges (see instructions)		35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		36

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-4

Check applicable box:	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*	[ ] CAH-Based IPF [ ] CAH-Based IRF

	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME		
	Part A Reasonable Cost		
37	Reasonable cost (see instructions)		37
38	Organ acquisition costs Wkst. D-4, Pt. III, col. 1, line 69)		38
39	Cost of physicians' services in a teaching hospital (see instructions)		39
40	Primary payer payments (see instructions)		40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		41
	Part B Reasonable Cost		
42	Reasonable cost (see instructions)		42
43	Primary payer payments (see instructions)		43
44	Total Part B reasonable cost (line 42 minus line 43)		44
45	Total reasonable cost (sum of lines 41 and 44)		45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48	Total program GME payment (line 31)		48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		50

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-5

TO BE COMPLETED BY CONTRACTOR

1	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		1
2	Capital outlier from Wkst. L, Pt. I, line 2		2
3	Operating outlier reconciliation adjustment amount (see instructions)		3
4	Capital outlier reconciliation adjustment amount (see instructions)		4
5	The rate used to calculate the time value of money (see instructions)		5
6	Time value of money for operating expenses (see instructions)		6
7	Time value of money for capital related expenses (see instructions)		7

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

	Assets (Omit cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1 through 10)					11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12 through 29)					30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31 through 34)					35
36	Total assets (sum of lines 11, 30, and 35)					36

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

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable					37
38	Salaries, wages, and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)					45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)					59
60	Total liabilities and fund balances (sum of lines 51 and 59)					60

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net income (loss) (from Worksheet G-3, line 29)									2
3	Total (sum of line 1 and line 2)									3
4	Additions (credit adjustments) (specify)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4 through 9)									10
11	Subtotal (line 3 plus line 10)									11
12	Deductions (debit adjustments) (specify)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12 through 17)									18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)									19

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

PART I - PATIENT REVENUES

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

PART II - OPERATING EXPENSES

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

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET G-3

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

OTHER INCOME

6	Contributions, donations, bequests, etc		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.50	COVID-19 PHE Funding		24.50
25	Total other income (sum of lines 6-24)		25
26	Total (line 5 plus line 25)		26
27	Other expenses (specify)		27
28	Total other expenses (sum of line 27 and subscripts)		28
29	Net income (or loss) for the period (line 26 minus line 28)		29

ANALYSIS OF HOSPITAL-BASED
HOME HEALTH AGENCY COSTS

PROVIDER CCN: _____
HHA CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H

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

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

COST ALLOCATION - HHA GENERAL SERVICE COST

PROVIDER CCN: _____
HHA CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-1
PART I

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

COST ALLOCATION - HHA STATISTICAL BASIS

PROVIDER CCN: _____
HHA CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-1, PART II

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART I

	HHA COST CENTER (omit cents)	From Wkst. H-1 Part I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
			0	1	2	4	4A	5	6	7	8	
1	Administrative and General	5										1
2	Skilled Nursing Care	6										2
3	Physical Therapy	7										3
4	Occupational Therapy	8										4
5	Speech Pathology	9										5
6	Medical Social Services	10										6
7	Home Health Aide	11										7
8	Supplies	12										8
9	Drugs	13										9
10	DME	14										10
11	Home Dialysis Aide Services	15										11
12	Respiratory Therapy	16										12
13	Private Duty Nursing	17										13
14	Clinic	18										14
15	Health Promotion Activities	19										15
16	Day Care Program	20										16
17	Home Delivered Meals Program	21										17
18	Homemaker Service	22										18
19	All Others	23										19
20	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1, divided by the sum of column 26, line 20, minus column 26, line 1, rounded to 6 decimal places.											21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART I (CONT.)

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART I

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART II

	HHA COST CENTER	CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)						
		1	2	4	4A	5	6	7	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Home Dialysis Aide Services								11
12	Respiratory Therapy								12
13	Private Duty Nursing								13
14	Clinic								14
15	Health Promotion Activities								15
16	Day Care Program								16
17	Home Delivered Meals Program								17
18	Homemaker Service								18
19	All Others								19
20	Totals (sum of lines 1-19)								20
21	Total cost to be allocated								21
22	Unit Cost Multiplier								22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART II (CONT.)

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART II (CONT.)

	HHA COST CENTER	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS		PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)	
						SALARY & FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)		
		17	18	19	20	21	22	23	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Home Dialysis Aide Services								11
12	Respiratory Therapy								12
13	Private Duty Nursing								13
14	Clinic								14
15	Health Promotion Activities								15
16	Day Care Program								16
17	Home Delivered Meals Program								17
18	Homemaker Service								18
19	All Others								19
20	Totals (sum of lines 1-19)								20
21	Total cost to be allocated								21
22	Unit Cost Multiplier								22

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-3, Parts I & II

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								Program Visits			Cost of Services				
									Part B			Part B			
	Patient Services	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (sum of col. 1 + col. 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)	
			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 through 6)														7

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

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

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

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

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-4, Parts I & II

Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX

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

	Description	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-5

	Description			Part A mm/dd/yyyy 1	Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero.(1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 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 INTERMEDIARY

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor	Contractor Number			NPR Date: Month, Day, Year			8

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

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET I-1

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

		TOTAL COSTS	BASIS	STATISTICS	FTEs per 2080 Hours	
		1	2	3	4	
1	Registered Nurses		Hours of Service			1
2	Licensed Practical Nurses		Hours of Service			2
3	Nurses Aides		Hours of Service			3
4	Technicians		Hours of Service			4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary		Accumulated Cost			8
9	Subtotal (sum of lines 1-8)					9
10	Employee Benefits		Salary			10
11	Capital Related Costs-Bldgs. & Fixtures		Square Feet			11
12	Capital Related Costs-Mov. Equip.		Percentage of Time			12
13	Machine Costs & Repairs		Percentage of Time			13
14	Supplies		Requisitions			14
14.01	*Pediatric Medical Supplies*		*Requisitions*			*14.01*
15	Drugs		Requisitions			15
16	Other		Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*					17
18	Capital Related Costs-Bldgs. & Fixtures		Square Feet			18
19	Capital Related Costs-Mov. Equip.		Percentage of Time			19
20	Employee Benefits Department		Salary			20
21	Administrative and General		Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping		Square Feet			22
23	Medical Education Program Costs					23
24	Central Services & Supplies		Requisitions			24
25	Pharmacy		Requisitions			25
26	Other Allocated Costs		Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*					27
28	Laboratory (see instructions)		Charges			28
29	Respiratory Therapy (see instructions)		Charges			29
30	Other (see instructions)		Charges			30
31	Total costs (sum of lines 27-30)					31

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET I-2

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS DEPARTMENT	DRUGS	MEDICAL SUPPLIES	*PEDIATRIC MEDICAL SUPPLIES*	ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
		BUILDING	EQUIPMENT	RNs	OTHER									
		1	2	3	4	5	6	7	*7.01*	8	9	10	11	
1	Total Renal Department Costs													1
	MAINTENANCE													
2	Hemodialysis													2
2.01	AKI-Hemodialysis													2.01
2.02	*Hemodialysis-Pediatric*													*2.02*
3	Intermittent Peritoneal													3
3.01	AKI-Intermittent Peritoneal													3.01
3.02	*IPD-Pediatric*													*3.02*
	TRAINING													
4	Hemodialysis													4
4.01	*Hemodialysis-Pediatric*													*4.01*
5	Intermittent Peritoneal													5
5.01	*IPD-Pediatric*													*5.01*
6	CAPD													6
6.01	*CAPD-Pediatric*													*6.01*
7	CCPD													7
7.01	*CCPD-Pediatric*													*7.01*
	HOME													
8	Hemodialysis													8
8.01	*Hemodialysis-Pediatric*													*8.01*
9	Intermittent Peritoneal													9
9.01	*IPD-Pediatric*													*9.01*
10	CAPD													10
10.01	*CAPD-Pediatric*													*10.01*
11	CCPD													11
11.01	*CCPD-Pediatric*													*11.01*
	OTHER BILLABLE SERVICES													
12	Inpatient Dialysis													12
13	Method II Home Patient													13
14	ESAs (included in Renal Department)													14
15	ARANESP (see instructions)													15
16	Other													16
17	Total (sum of lines 2 through 16)													17
18	Medical Educational Program Costs													18
19	Total Renal Costs (line 17 plus line 18)													19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET I-3

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

	COMPOSITE PAYMENT SERVICES	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS							
		BUILDING (SQUARE FEET)	EQUIPMENT (% OF TIME)	RNs (HOURS)	OTHERS (HOURS)	DEPARTMENT (SALARY)	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	*PEDIATRIC MEDICAL SUPPLIES (REQUIST.)*	ROUTINE ANCILLARY SERVICES (CHARGES)	SUB-TOTAL	OVERHEAD (ACCUM. COST)	
		1	2	3	4	5	6	7	*7.01*	8	9	10	
1	Total Renal Department Costs												1
	MAINTENANCE												
2	Hemodialysis												2
2.01	AKI-Hemodialysis												2.01
2.02	*Hemodialysis-Pediatric*												*2.02*
3	Intermittent Peritoneal												3
3.01	AKI- Intermittent Peritoneal												3.01
3.02	*IPD-Pediatric*												*3.02*
	TRAINING												
4	Hemodialysis												4
4.01	*Hemodialysis-Pediatric*												*4.01*
5	Intermittent Peritoneal												5
5.01	*IPD-Pediatric*												*5.01*
6	CAPD												6
6.01	*CAPD-Pediatric*												*6.01*
7	CCDP												7
7.01	*CCPD-Pediatric*												*7.01*
	HOME												
8	Hemodialysis												8
8.01	*Hemodialysis-Pediatric*												*8.01*
9	Intermittent Peritoneal												9
9.01	*IPD-Pediatric*												*9.01*
10	CAPD												10
10.01	*CAPD-Pediatric*												*10.01*
11	CCDP												11
11.01	*CCPD-Pediatric*												*11.01*
	OTHER BILLABLE SERVICES												
12	Inpatient Dialysis Treatments _____												12
13	Method II Home Patient												13
14	ESAs												14
15	ARANESP (see instructions)												15
16	Other												16
17	Total Statistical Basis												17
18	Unit Cost Multiplier (line 1 ÷ line 17)												18

COMPUTATION OF AVERAGE COST PER TREATMENT
FOR OUTPATIENT RENAL DIALYSIS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET I-4

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments	Number of Program Treatments	Total Program Expenses (see instructions)	Total Program Payment	Total Program Payment	Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02)	
		1	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	
1	Maintenance - Hemodialysis														1
1.01	*Maintenance - AKI Hemodialysis*														*1.01*
2	Maintenance - Peritoneal Dialysis														2
2.01	*Maintenance - AKI Peritoneal Dialysis*														*2.01*
3	Training - Hemodialysis														3
4	Training - Peritoneal Dialysis														4
5	Training - CAPD														5
6	Training - CCPD														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis														8
9	Home Program - CAPD	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
10	Home Program - CCPD														10
11	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instructions)														11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)														12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET I-5

	Description			
1	Total expenses related to care of program beneficiaries (see instructions)			1

		1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)			2
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments			2.04
3	Deductibles billed to Medicare (Part B) patients (see instructions)			3
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)			3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)			4
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)			4.03
5	Bad debts for deductibles and coinsurance, net of bad debt recoveries			5
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014			5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)			5.05
6	Adjusted reimbursable bad debts (see instructions)			6
7	Allowable bad debts for dual eligible beneficiaries (see instructions)			7
8	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)			8
9	Program payment (see instructions)			9
10	Unrecovered from Medicare (Part B) patients (see instructions)			10
11	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12	Total allowable expenses (see instructions)		12
13	Total composite costs (from Wkst. I-4, col. 2, line 11)		13
14	Facility specific composite cost percentage (line 13 divided by line 12)		14

PART III - ESRD PAYMENTS - INFORMATION ONLY			
15	*Low volume payment amount (see instructions)*		*15*
16	*TDAPA*		*16*
17	*TPNIES*		*17*
18	*CRA TPNIES*		*18*
19	*HDPA*		*19*
20	*PPA*		*20*

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

	COMPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	4	4A	5	6	7	8	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART I (CONT.)

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

	COMPONENT COST CENTER (omit cents)	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
17	Medical Supplies												17
18	Medical Appliances												18
19	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others												21
22	Totals (sum of lines 1-21)(1)												22
23	Unit Cost Multiplier (see instructions)												23

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

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

	COMPONENT COST CENTER (omit cents)	NURSING PROGRAM	INTERNS & RESIDENTS		PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 4A-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJ.	SUBTOTAL (sum of cols. 24 ± 25)	ALLOCATED COMPONENT A&G (see Part II) (2)	TOTAL (sum of cols. 26 ± 27)	
			SALARY & FRINGES	PROGRAM COSTS							
		20	21	22	23	24	25	26	27	28	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

	CMHC COST CENTER (omit cents)		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)							
		0	1	2	4	4A	5	6	7	8	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)										22
23	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART II (CONT.)

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

	CORF COST CENTER (omit cents)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)*	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME)	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
17	Medical Supplies												17
18	Medical Appliances												18
19	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others												21
22	Totals (sum of lines 1-21)												22
23	Total Cost to be Allocated												23
24	Unit Cost Multiplier (see instructions)												24

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART II (CONT.)

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

	CORF COST CENTER (omit cents)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)						
		20	21	22	23	24	25	26	27	28	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)										22
23	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-2, PART I

PART I - APPORTIONMENT OF CMHC COST CENTERS

		(From Wkst. J-1, Pt. I, col. 28)	Total Component Charges	Ratio of Costs to Charges (col. 1 ÷ col. 2)	Title V Component Charges	Title V Component Costs (col. 3 x col. 4)	Title XVIII Component Charges	Title XVIII Component Costs (col. 3 x col. 6)	Title XIX Component Charges	Title XIX Component Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	All Others (1)										19
20	Totals (sum of lines 1 through19)										20

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

COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET J-2, PART II

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

		(From Wkst. J-1, Pt. I, col. 29)	Total Component Charges	Ratio of Costs to Charges (1)	Title V Component Charges (2)	Title V Component costs (col. 3 x col. 4)	Title XVIII Component Charges (2)	Title XVIII Component costs (col. 3 x col. 6)	Title XIX Component Charges (2)	Title XIX Component costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
21	Respiratory Therapy										21
22	Physical Therapy										22
23	Occupational Therapy										23
24	Speech Pathology										24
25	Medical Supplies Charged to Patients										25
26	Implantable Devices Charged to Patients										26
27	Drugs Charged to Patients										27
28	Total (sum of lines 21-28)										28
29	Total component costs. Add the amount from Pt. I, line 20, and the amounts from line 28, columns 5, 7, and 9. (3)										29

(1) From Worksheet C, Part I, column 9, lines as appropriate
(2) Charges for columns 4 and 8 are obtained from your records.
(3) Transfer the amounts on line 28, columns 5, 7, and 9, as appropriate, to Worksheet J-3, line 1.

CALCULATION OF REIMBURSEMENT SETTLEMENT COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET J-3

Check applicable box: [ ] Title V [ ] Title VIII [ ] Title XIX

		PROGRAM COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 29)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
6	Total charges for program services		6
	CUSTOMARY CHARGES		
7	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		8 8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
10	Total customary charges (see instructions)		10
11	Excess of customary charges over reasonable cost (see instructions)		11
12	Excess of reasonable cost over customary charges (see instructions)		12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
13	Total reasonable cost (from line 5)		13
14	Part B deductible billed to program patients		14
15	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Allowable bad debts (from provider records) (see instructions)		21
22	Adjusted reimbursable bad debts (see instructions)		22
23	Allowable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		25.50
25.99	Demonstration payment adjustment amount before sequestration		25.99
26	Total cost (see instructions)		26
26.01	Sequestration adjustment (see instructions)		26.01
26.02	Demonstration payment adjustment amount after sequestration		26.02
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		29
30	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)		30

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET J-4

Check applicable boxes: [ ] Title XVIII

	DESCRIPTION			Part B 1 mm/dd/yyyy	Part B 2 Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1).	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet J-3, line 27)					4

TO BE COMPLETED BY INTERMEDIARY

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	Total Medicare liability (see instructions)					7

8	Name of Contractor	Contractor Number	NPR Date (Month, Day, Year)	8

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR-TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	TOTAL (cols. 1-5)	RECLASSI-FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance											3
4	Transportation - Staff											4
5	Volunteer Service Coordination											5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
10	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
12	Physical Therapy											12
13	Occupational Therapy											13
14	Speech/ Language Pathology											14
15	Medical Social Services											15
16	Spiritual Counseling											16
17	Dietary Counseling											17
18	Counseling - Other											18
19	Home Health Aide and Homemaker											19
20	HH Aide & Homemaker - Cont. Home Care											20
21	Other											21
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
23	Analgesics											23
24	Sedatives / Hypnotics											25
25	Other - Specify											25
26	Durable Medical Equipment/Oxygen											26
27	Patient Transportation											27
28	Imaging Services											28
29	Labs and Diagnostics											29
30	Medical Supplies											30
31	Outpatient Services (including E/R Dept.)											31
32	Radiation Therapy											32
33	Chemotherapy											33
34	Other											34
	HOSPICE NONREIMBURSABLE SERVICE											
35	Bereavement Program Costs											35
36	Volunteer Program Costs											36
37	Fundraising											37
38	Other Program Costs											38
39	Total (sum of lines 1 thru 38)											39

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
15	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total (sum of lines 1 thru 38)										39

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
15	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total (sum of lines 1 thru 38)										39

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

HOSPICE COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
15	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total (sum of lines 1 thru 38)										39

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-4, PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICES COORDI-NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS-TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	5	5A	6	7	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
15	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total (sum of lines 1 thru 38)										39

COST ALLOCATION - HOSPICE STATISTICAL BASIS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-4, PART II

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

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

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET K-5, PART I (Cont.)

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	
1	Administrative and General											1
2	Inpatient - General Care											2
3	Inpatient - Respite Care											3
4	Physician Services											4
5	Nursing Care											5
6	Nursing Care-Continuous Home Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech/ Language Pathology											9
10	Medical Social Services											10
11	Spiritual Counseling											11
12	Dietary Counseling											12
13	Counseling - Other											13
14	Home Health Aide and Homemaker											14
15	HH Aide & Homemaker - Cont. Home Care											15
16	Other											16
17	Drugs, Biological and Infusion Therapy											17
18	Analgesics											18
19	Sedatives / Hypnotics											19
20	Other - Specify											20
21	Durable Medical Equipment/Oxygen											21
22	Patient Transportation											22
23	Imaging Services											23
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (including E/R Dept.)											26
27	Radiation Therapy											27
28	Chemotherapy											28
29	Other											29
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
32	Fundraising											32
33	Other Program Costs											33
34	Totals (sum of lines 1-33) (2)											34
35	Unit Cost Multiplier (see instructions)											35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART I (Cont.)

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

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

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)	
		17	18	19	20	21	22	23	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care-Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemaker								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biological and Infusion Therapy								17
18	Analgesics								18
19	Sedatives / Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (including E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1-33) (2)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier (see instructions)								36

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

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	66				1
2	Occupational Therapy	67				2
3	Speech/ Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73				4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60				6
7	Medical Supplies	71				7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	76				10
11	Totals (sum of lines 1-10)					11

CALCULATION OF HOSPICE PER DIEM COST	PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET K-6

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)					4
5	Aggregate Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)					6
7	Aggregate Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10
11	Aggregate NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)					12
13	Aggregate cost for other days (line 3 times line 12)					13

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

CALCULATION OF CAPITAL PAYMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L

Check applicable boxes:	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] PARHM Demonstration *[ ] CHART Model*	[ ] PPS [ ] Cost Method

PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12
PART II - PAYMENT UNDER REASONABLE COST			
1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 x line 4)		5
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment		11
	(from prior year Worksheet L, Part III, line 14)		
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I

	Cost Center Descriptions	EXTRA-ORDINARY CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	2A	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
61	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic *HSCT* Acquisition									77
78	*CAR T-Cell Immunotherapy*									*78*
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient (specify)									93
93.99	Partial Hospitalization Program									93.99

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

	Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
102	*Opioid Treatment Program*											*102*
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	Total (sum of line 118 and lines 190 through 201)											202
203	Total Statistical Basis											203
204	Unit Cost Multiplier											204

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
102	*Opioid Treatment Program*										*102*
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	Total (sum of line 118 and lines 190 through 201)										202
203	Total Statistical Basis										203
204	Unit Cost Multiplier										204

COMPUTATION OF PROGRAM INPATIENT ROUTINE SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L-1, PART II

Check applicable box:
[ ] Title V
[ ] Title XVIII, Part A
[ ] Title XIX

(A)	Cost Center Description	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) 1	Swing Bed Adjustment 2	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2) 3	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4) 5	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6) 7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
200	Total (sum of lines 30-199)								200

(A) Worksheet A line numbers

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L-1, PART III

Check applicable boxes: [ ] Hospital [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX

(A)	Cost Center Description	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catherization						59
60	Laboratory						60
61	PBP Clinical Laboratory Service-Program Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Trans.						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
77	Allogeneic Stem Cell Acquisition						77

(A) Worksheet A line numbers

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L-1, PART III (CONT.)

Check applicable boxes: [ ] Hospital [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX

(A)	Cost Center Description	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)	
		1	2	3	4	5	
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92	Observation Beds						92
93	Other Outpatient (specify)						93
93.99	Partial Hospitalization Program						93.99
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)						200

(A) Worksheet A line numbers

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET M-1

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

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

ALLOCATION OF OVERHEAD TO HOSPTIAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-2

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard [1]	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1 through 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)						8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES

10	Total costs of health care services (from Worksheet M-1, column 7, line 22)		10
11	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		12
13	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)		13
14	Total hospital-based RHC/FQHC overhead (from Worksheet M-1, column 7, line 31)		14
15	Parent provider overhead allocated to facility (see instructions)		15
16	Total overhead (sum of lines 14 and 15)		16
17	Allowable Direct GME overhead (see instructions)		17
18	Enter the amount from line 16		18
19	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)		19
20	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)		20

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-3

Check applicable boxes:	[ ] Hospital-based RHC [ ] Hospital-based FQHC	[ ] Title V [ ] Title XVIII [ ] Title XI

	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1	Total allowable cost of hospital-based RHC/FQHC services (from Worksheet M-2, line 20)		1
2	Cost of injections/infusions and their administration (from Worksheet M-4, line 15)		2
3	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3
4	Total visits (from Worksheet M-2, column 5, line 8)		4
5	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

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

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

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-4

Check applicable boxes:	[ ] Hospital-based RHC [ ] Hospital-based FQHC	[ ] Title V [ ] Title XVIII [ ] Title XI

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1	2	2.01	2.02	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)					1
2	Ratio of injection/infusion staff time to total health care staff time					2
3	Injection/infusion health care staff cost (line 1 x line 2)					3
4	Injections/infusions and related medical supplies costs (from your records)					4
5	Direct cost of injections/infusions (line 3 plus line 4)					5
6	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, column 7, line 22)					6
7	Total overhead (from Worksheet M-2, line 19)					7
8	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)					8
9	Overhead cost - injection/infusion (line 7 x line 8)					9
10	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from your records)					11
12	Cost per injection/infusion (line 10/line 11)					12
13	Number of injection/infusion administered to Program beneficiaries					13
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees					13.01
14	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)					14
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Worksheet M-3, line 2)					15
16	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Worksheet M-3, line 21)					16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-5

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

	DESCRIPTION			Part B 1 mm/did/ivy	Part B 2 Amount	
1	Total interim payments paid to hospital-based RHC/FQHC					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1).	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	Total Medicare liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
FOR HOSPITAL-BASED FQHC

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET N-1

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
FOR HOSPITAL-BASED FQHC

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET N-1

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
REIMBURSABLE PASS THROUGH COSTS									
47	Pneumococcal Vaccines & Med Supplies								47
48	Influenza Vaccines & Med Supplies								48
48.10	COVID-19 Vaccine & Med Supplies								48.10
48.11	Monoclonal Antibody Products								48.11
49	Subtotal - Reimbursable Pass through Costs								49
OTHER FQHC SERVICES									
60	Medicare Excluded Services								60
61	Diagnostic & Screening Lab Tests								61
62	Radiology - Diagnostic								62
63	Prosthetic Devices								63
64	Durable Medical Equipment								64
65	Ambulance Services								65
66	Telehealth								66
67	Drugs Charged to Patients								67
68	Chronic Care Management								68
69	Other								69
70	Subtotal - Other FQHC Services								70
NONREIMBURSABLE COST CENTERS									
77	Retail Pharmacy								77
78	Other Nonreimbursable								78
79	Subtotal - Non-Reimbursable Costs								79
100	TOTAL (sum of lines 13, 37, 49, 70, and 79)								100

CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET N-2

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

COMPUTATION OF HOSPITAL-BASED FQHC VACCINE COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET N-3

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

CALCULATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET N-4

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERED	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET N-5

	Description			Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to hospital-based FQHC					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.5
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01 through 3.49 minus sum of lines 3.50 through 3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. N-4, line 17)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.5
			.51			5.51
			.52			5.52
	Subtotal (sum of lines 5.01 through 5.49 minus sum of lines 5.50 through 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to provider	.01			6.01
		Provider to program	.02			6.02
7	Total Medicare program liability (see instructions)					7

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

ANALYSIS OF HOSPITAL-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	
GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs-Bldg & Fixt*								1
2	Cap Rel Costs-Mvble Equip*								2
3	Employee Benefits Department*								3
4	Administrative & General *								4
5	Plant Operation and Maintenance*								5
6	Laundry & Linen Service*								6
7	Housekeeping*								7
8	Dietary*								8
9	Nursing Administration*								9
10	Routine Medical Supplies*								10
11	Medical Records*								11
12	Staff Transportation*								12
13	Volunteer Service Coordination*								13
14	Pharmacy*								14
15	Physician Administrative Services*								15
16	Other General Service*								16
17	Patient/Residential Care Services								17
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

* 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.

ANALYSIS OF HOSPITAL-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	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)									
40	Imaging Services**								40
41	Labs and Diagnostics**								41
42	Medical Supplies-Non-routine**								42
42.50	Drugs Charged to Patients**								42.50
43	Outpatient Services**								43
44	Palliative Radiation Therapy**								44
45	Palliative Chemotherapy**								45
46	Other Patient Care Services**								46
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
100	Total								100

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-1

		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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-2

		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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

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

ANALYSIS OF HOSPITAL-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)	
		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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

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

ANALYSIS OF HOSPITAL-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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION	PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET O-5	
Descriptions	HOSPICE DIRECT EXPENSES (see instructions) 1	GENERAL SERVICE EXPENSES FROM WKST B, PART I (see instructions) 2	TOTAL EXPENSES (sum of cols. 1 + 2) 3	
GENERAL SERVICE COST CENTERS				
1 Cap Rel Costs-Bldg & Fixt				1
2 Cap Rel Costs-Mvble Equip				2
3 Employee Benefits				3
4 Administrative & General				4
5 Plant Operation and Maintenance				5
6 Laundry & Linen Service				6
7 Housekeeping				7
8 Dietary				8
9 Nursing Administration				9
10 Routine Medical Supplies				10
11 Medical Records				11
12 Staff Transportation				12
13 Volunteer Service Coordination				13
14 Pharmacy				14
15 Physician Administrative Services				15
16 Other General Service				16
17 Patient/Residential Care Services				17
LEVEL OF CARE				
50 Hospice Continuous Home Care				50
51 Hospice Routine Home Care				51
52 Hospice Inpatient Respite Care				52
53 Hospice General Inpatient Care				53
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
100 Total				100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART I

	Descriptions	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	
		0	1	2	3	3A	4	5	6	7	8	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
	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
100	Total											100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART I

	Descriptions	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT / RESIDENT CARE SVCS	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS												
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service (specify)											16
17	Patient/Residential Care Services											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 (specify)											71
99	Negative Cost Center											99
100	Total											100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART II

	Cost Center Descriptions	CAP REL BLDG & FIX (Square Feet)	CAP REL MVBLE EQUIP (Dollar Value)	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT (Square Feet)	LAUNDRY & LINEN (In-Facil-ity Days)	HOUSE-KEEPING (Square Feet)	DIETARY (In-Facil-ity Days)	
		1	2	3	4A	4	5	6	7	8	
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs-Bldg & Fixt										1
2	Cap Rel Costs-Mvble Equip										2
3	Employee Benefits										3
4	Administrative & General										4
5	Plant Operation and Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping										7
8	Dietary										8
9	Nursing Administration										9
10	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation										12
13	Volunteer Service Coordination										13
14	Pharmacy										14
15	Physician Administrative Services										15
16	Other General Service										16
17	Patient/Residential Care Services										17
	LEVEL OF CARE										
50	Hospice Continuous Home Care										50
51	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
53	Hospice General Inpatient Care										53
	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
100	Cost to be allocated (per Wkst. O-6, Part I)										100
101	Unit cost multiplier										101

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART II

	Cost Center Descriptions	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS-PORTATION (Mileage)	VOLUNTEER SVC COOR-DINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMIN SERVICES (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENT CARE SVCS (In-Facil-ity Days)	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	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
100	Cost to be allocated (per Wkst. O-6, Part I)											100
101	Unit cost multiplier											101

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-7

	Cost Center Descriptions	Wkst. C, Pt. I, col. 9, line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				Shared Service Costs by LOC				
				HCHC	HRHC	HIRC	HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		0	1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS											
1	Physical Therapy	66										1
2	Occupational Therapy	67										2
3	Speech/ Language Pathology	68										3
4	Drugs, Biological and Infusion Therapy	73										4
5	Durable Medical Equipment/Oxygen	96										5
6	Labs and Diagnostics	60										6
7	Medical Supplies	71										7
8	Outpatient Services (including E/R Dept.)	93										8
9	Radiation Therapy	55										9
10	Other	76										10
11	Totals (sum of lines 1 through 10)											11

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