07-23			ГС	JKWI CWIS-2332	-10		4090 (Cont.)		
		y law (42 USC 1395g; 42 CFR 413.20(b)) e beginning of the cost reporting period bei					FORM APPROVE OMB NO. 0938-00 EXPIRES 09-30-20	050		
		HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S			
		REPORT CERTIFICATION				FROM TO	PARTS I, II & III			
		VT SUMMARY PORT STATUS				10				
	use only	[] Electronically prepared cost	report	Date:	Time:					
		[] Manually prepared cost report [] If this is an amended report		ovider resubmitted this o	ost report					
		4. [] Medicare Utilization. Enter								
Contract	-	Cost Report Status	6. Date Received:		10. NPR Date:					
use only		As Submitted Settled without audit	7. Contractor No.: 8. [] Initial Report for t	hic Provider CCN	11. Contractor's Vend	or Code: mn 1, is 4: Enter numb	- ver of			
	`	3) Settled with audit	9. [] Final Report for the		times reopene		ici oi			
		1) Reopened			1					
		5) Amended								
		CATION BY A CHIEF FINANCIAI TION OR FALSIFICATION OF AN				CHADLE DV CDIMIN	IAL CIVIL AND ADMINIC	TD A TIME		
		D/OR IMPRISONMENT UNDER F								
THE PA	YMENT DI	RECTLY OR INDIRECTLY OF A MAY RESULT.								
	CERTIFIC	ATION BY CHIEF FINANCIAL O	FFICER OR ADMINISTRATOR	R OF PROVIDER(S)						
	I HEREBY	CERTIFY that I have read the above	e certification statement and that	I have examined the acc	companying electronical	ly filed or manually sul	bmitted cost report and			
	submitted c	ost report and the Balance Sheet and	-			_{Provider Name(s) ar	(/ /			
		ng period beginning		and to the best of my kno						
		nd prepared from the books and recor gulations regarding the provision of l								
	and regulat		nearm care services, and mai me	services identified in thi	s cost report were provi	ded in compnance with	i sucii iaws			
	SIGNAT	URE OF CHIEF FINANCIAL OFFI	CER OR ADMINISTRATOR	CHECKBOX	4	ELECTRONIC				
1	1 2 SIGNATURE STATEMENT I have read and agree with the above certification statement. I certify that									
1	I intend my electronic signature on this certification be the legally									
					binding equivalent of	-				
	·	Printed Name:						2		
	Signature of							3		
	ŭ	MENT SUMMARY								
				TITL	E XVIII					
			TITLE V	PART A	PART B	HIT	TITLE XIX			
			I	2	3	4	5	_		
1	HOSPITA	L						1		
1.01	HOSPITA	L-PARHM						1.01		
2	SUBPROV	/IDER - IPF						2		
3	SUBPROV	/IDER - IRF						3		
4	SUBPROV	VIDER (OTHER)						4		
5	SWING-B	ED SNF						5		
5.01	SWING-B	ED PARHM (CAH ONLY)					_	5.01		
6	SWING-B	ED NF						6		
7	SNF							7		
8	NF, ICF/II	D						8		
9	НОМЕ НЕ	EALTH AGENCY						9		
10	HOSPITA	L-BASED RHC						10		
11		L-BASED FQHC ENT REHABILITATION						11_		
12	PROVIDE							12		
200	TOTAL							200		

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete this information collection is estimated to be 675 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Report 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.

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

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX IDENTIFICATION DATA

PROVIDER CCN: PERIOD WORKSHEET S-2
FROM PART I

								TO		
	- HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX INDENTIFICATION DAT	A								
Hospital	and Hospital Health Care Complex Address:									
1	Street:	P.O. Box:								1
	City:	State:	ZIP Code:	County:						2
Hospital	and Hospital-Based Component Identification:									
		Component	CCN	CBSA	Provider	Date		yment System (P, T, O,		
	Component	Name	Number	Number	Type	Certified	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										13
	Hospital-Based Hospice									14
	Hospital-Based Health Clinic-RHC									15
	Hospital-Based Health Clinic-FQHC									16
17										17
18	Renal Dialysis									18
	Other									19
		From:	To:					<u> </u>		20
	Type of control (see instructions)	1 Ioni.	10.							21
	t PPS Information	1					1	2	3	21
	Does this facility qualify and is it currently receiving payments for disproportionate share hospit	al adjustment in accords	ance with 42 CER 412 106	2 In column 1 enter "V	" for yes or "N" for no		1	2	J	22
22	Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, ent			7. III coluliii 1, cilici 1	ior yes or iv ior no.					
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting per			o for the portion of the	cost reporting period occur	rring prior to October	1			22.01
22.01	Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring			to for the portion of the	cost reporting period occu	iring prior to October	i. I			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlem			r vos or "N" for no						22.02
22.02	for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes				han 1					22.02
22.02	Did this hospital receive a geographic reclassification from urban to rural as a result of the OME									22.03
22.03										22.03
	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for y				or after October 1. (see in	structions)				
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with the first than 499 beds).				1 1 6370 0	40 m c				22.04
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revision of the									22.04
	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for y				or after October 1. (see in	structions)				
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with									
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, e				_					23
	Is the method of identifying the days in this cost reporting period different from the method used	d in the prior cost report	ing period? In column 2, o							
				In-State	In-State	Out-of State	Out-of State	Medicaid	Other	
				Medicaid	Medicaid eligible	Medicaid	Medicaid eligible	HMO	Medicaid	
				paid days	unpaid days	paid days	unpaid days	days	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 paid days in									24
	Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medica	and HMO paid and eligib	le but unpaid days in					1		1
	column 5, and other Medicaid days in column 6.			<u> </u>	1]		
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid e			[25
	Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid	id HMO paid and eligible	e but unpaid days in colum	ın 5.						
							1	2	3	
	Enter your standard geographic classification (not wage) status at the beginning of the cost repo									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	r rural.						27
	If applicable, enter the effective date of the geographic reclassification in column 2.									
	7 1 (// 1									35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of per						Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in e									37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance w									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 exce	ess of one and enter sub	sequent dates.		Beginning:	Ending:		38
		-	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		Y/N	Y/N		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals					no.				39
	Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii)									
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for	no in column 1, for disc	charges prior to October 1	. Enter "Y" for yes or "	N" for no in column 2,			1		40
	for discharges on or after October 1. (see instructions)						1	1		

							()
HOSPI	TAL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPI	LEX IDENTIFICATION DATA				FROM	PART I (CONT.)	
00					TO	1111111 (001111)	
				V		*****	_
				V	XVIII	XIX	
Prospec	tive 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							48
Teachin	g Hospitals			1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for	r no in column 1. For co	st reporting periods				56
	beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved.						
	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 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 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.	rior 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.						
57	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GMI	E programs trained at thi	s facility? Enter "Y" for	yes			57
	or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If or	column 2 is "Y", comple	te 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 41	13.77(e)(1)(iv) and (v), i	egardless of which month	n(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 I			ì			
		D-4.					
58							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	7
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 "V" are y	7011		, and the second	60
00		iv for no in column 1.	ir column r is r , are y	I			00
	impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.						
						Pass-Through	
					Worksheet A	Qualification	
					Line #	Criterion Code	
				1	2	3	
60.01	Tree: (a)					3	60.01
00.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)	77.7			n c	Discost CMII	00.01
		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	-
	T			1	Z	3	
61.01							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 year's primary care and year's primary care and year's primary care and	a 61 02) (can instruction	nc)				61.05
		e 01.03). (see ilistructio	iis)				
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
					Unweighted	Unweighted	
					IME	Direct GME	
			Program Name	Program Code	FTE Count	FTE Count	
			1	2	3	4	
(1.10	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)		1		,	-	61.10
01.10							01.10
	Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTI	E unweighted count.					
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions)				1		61.20
	Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTI	E unweighted count.	1		I		1
ACA Pr	ovisions Affecting the Health Resources and Services Administration (HRSA)		-	•		1	1
	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		instructions)					62.01
	g Hospitals that Claim Residents in Nonprovider Settings			1	2	3	
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 in	structions)					63
				Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	
				Nonprovider Site	in Hospital	(col. 1 + col. 2))	
C 4"	SSAL SAL ACA D. V. FTF D. Lat. N. W. Sala C. H. Thirle and the salar sal	010		Nonprovider Site			-
Section	5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 20			1	2	3	+
64	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.						64
	Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.		I		1		
	Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				I		1
				Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	1
		Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	1
		r rogram ivame		rionprovider site	iii i i ospitai		-1
		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				1		65
	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	I	I		1		
	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	1	1		I		1
	trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	I	I		1	1	I

HOSPI	AL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPL	EX IDENTIFICATION DATA				FROM	PART I (CONT.)	
				Unweighted FTEs	TO Unweighted FTEs	Ratio (col. 1 ÷	1
				Nonprovider Site	in Hospital	(col. 1 + col. 2))	
Section	5504 of the ACA Current Year FTE Residents in Nonprovider SettingsEffective 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 FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	r of unweighted non-prii	nary care resident				66
	1 TES that trained in your nospital. Either in commin 5, the fatho of (Commin 1 divided by (Commin 1 * Commin 2)). (see instructions)			Unweighted FTEs	Unweighted FTEs	Ratio (col. 3/	1
		Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	
		1	2	3	4	5	67
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						67
	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)						
	ME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		•	•	•	1	
	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 20	23 IPPS Final Rule, 87 F	R 49065-49072 (August	10, 2022)?			68
	I Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			1	2	3	70
71	If line 70 is ves:						71
	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 n	io. (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.						
Innation	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Rehabilitation Facility PPS			1	2	2	ļ
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.			1	2	3	75
76	If line 75 is yes:						76
	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)					<u> </u>	
Long Te	rm Care Hospital PPS				1	2	1
	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
TEED	Providers				1	1 2	1
	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				1	2	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	Number of	
					Permanent Adjustment (Y/N)	Approved Permanent Adjustments	
					1	2	1
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	s)				88
	Column 2: Enter the number of approved permanent adjustments.						
						Approved Permanent Adjustment Amount	
				Wkst. A Line No.	Effective Date	Per Discharge	
				1	2	3	1
89	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.	•					89
	Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.						
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.				V	XIX	<u> </u>
Title V	and XIX Services				1	2	1
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							92 93
93							93
95					†	1	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 co		n 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 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		2 for title XIX		+	+	98.01 98.02
98.03	Does tille V or XIX follow Medicare (tilte XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1				†	1	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, a		IIX.		<u> </u>	<u> </u>	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 co	oiumn 2 for title XIX.				I	98.06

02-24 FORM CMS-2552-10 4000 (Cont.)

02-24 FORM CMS-2332-10				4090	(Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE		PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPLEX IDENTIFICATION DATA			FROM	PART I (CONT.)	
			то	, ,	
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)					107
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 i	nstructions)			
107.01 If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for l&R training programs? Enter "Y" for yes or "N" for no. (see instructions,					107.01
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
	DI : 1		0 1		_
	Physical	Occupational	Speech	Respiratory	_
100 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	2	3	4	100
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	$\overline{}$
110 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes o	or "N" for no.			 	110
If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					
			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					111
If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance	ce services; "B" for additional beds; and/or "C" for	tele-health services.			
THE DOLL THE STATE OF THE PARTY OF THE STATE	NY 10 C	. 1	2	3	112
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		r in			112
column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable	<u> </u>				
Miscellaneous Cost Reporting Information		1	2	3	$\overline{}$
115 II sthis an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2.		•		 	115
If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term care (includes psychiatric, rehabilitation a	enitale				115
providers) based on the definition in CMS Pub. 15-1, chapter 22, \$208.1.	spitals				
providers) oased on the deminion in Cwis 1 do:15-1, chapter 22, §2206.1.					
				1	\top
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
				0.10:	
		Premiums	Paid losses	Self insurance	_
118.01 List amounts of malpractice premiums and paid losses:		1		3	118.01
116.01 List amounts of marphaetice premiums and pare rosses.					110.01
			1	2	7
118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers an	nd 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				120
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	2, "Y" for yes or "N" for no.				
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
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 1.					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/or	consulting services, from an unrelated organization	? In column 1,		1	123
enter "Y" for yes or "N" for no.	and the space of the state of t	Da			
If column 1 is "V", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations	s located in a CBSA outside of the main hospital C	BSA? In column 2,			
enter "Y" for yes or "N" for no.			1	I	1

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090 (Cont.)	FORM CMS	S-2552-10						02-24	
IOSPITAL AND HOSPITAL HEALTH CARE OMPLEX IDENTIFICATION DATA					PROVIDER CCN:	PERIOD FROM TO _	WORKSHEET S-2 PART I (CONT.)		
Certified Transplant Center Information						1 1	2	_	
125 Does this facility operate a Medicare-certified transplant center? Enter	"V" for yes or "N" for no. If yes enter certification date(s) (mm/dd/	(anna) below				1	2	125	
126 If this is a Medicare-certified kidney transplant program, enter the certi-								126	
127 If this is a Medicare-certified heart transplant program, enter the certified								127	
128 If this is a Medicare certified liver transplant program, enter the certification of the								128	
129 If this is a Medicare certified lung transplant program, enter the certification of the c	- 11							129	
130 If this is a Medicare certified pancreas transplant program, enter the certified								130	
131 If this is a Medicare certified intestinal transplant program, enter the cer	/ 11 /							131	
132 If this is a Medicare certified islet transplant program, enter the certifica								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	
	/ 11 /								
All Providers						1	2		
140 Are there any related organization or home office costs as defined in Cl If yes, and home office costs are claimed, enter in column 2 the home o		n 1.						140	
•						•	•	•	
f this facility is part of a chain organization, enter on lines 141 through 143 the n	ame and address of the home office and enter the home office contra		mber.		TC + + 1 N 1			141	
141 Name:	D ○ D	Contractor's Name: Contractor's Number:							
142 Street:	P. O. Box:	7: 0 1						142	
143 City:	State:	Zip Code:						143	
							1 2	_	
144 Are provider based physicians' costs included in Worksheet A?						1	2	144	
145 If costs for renal services are claimed on Wkst. A, line 74, are the costs	for invoting against and Party Will for you or "NII for up in a law	1						144	
If column 1 is no, does the dialysis facility include Medicare utilization								143	
146 Has the cost allocation methodology changed from the previously filed			20)			+	_	146	
If yes, enter the approval date (mm/dd/yyyy) in column 2.	cost report: Enter 1 for yes of 10 for no in column 1. (See CW)	3 r ub. 13-2, chapter 40, 940	(20)					140	
147 Was there a change in the statistical basis? Enter "Y" for yes or "N" for	r no							147	
148 Was there a change in the order of allocation? Enter "Y" for yes or "N"								148	
149 Was there a change in the order of anocation. Enter 1 for yes of 14								149	
was there a change to the simplified cost infaming method. Effect 1 Re	r yes or 14 torne.					1		147	
				Tit	le XVIII				
Does this facility contain a provider that qualifies for an exemption from the appli	cation of the lower of costs or charges?			Part A	Part B	Title V	Title XIX		
inter "Y" for yes or "N" for no for each component for Part A and Part B. (see	42 CFR 413.13)			1	2	3	4		
155 Hospital								155	
156 Subprovider - IPF								156	
157 Subprovider - IRF								157	
158 Subprovider - Other								158	
159 SNF								159	
160 HHA								160	
161 CMHC								161	
Multicampus	. 1.00 * CDC * O D * HX/H C HX/H C			_				165	
165 Is this hospital part of a multicampus hospital that has one or more cam		ETE/Communication and the conference of the	it)					165 166	
166 If line 165 is yes, for each campus enter the name in column 0, county i		FIE/Campus in column 5. (Ctata	Zin Cod:	CDCA	ETE/Cam	100	
	Name 0		County	State 2	Zip Code	CBSA 4	FTE/Campus 5	-	
	U		1		3	4	J	\dashv	
			<u> </u>	1			<u> </u>		
Iealth Information Technology (HIT) incentive in the American Recovery and R	einvestment Act					1	2		
167 Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes						1	-	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)

170 Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yyyy)

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

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)
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)

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.

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168.01 169

170

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

15

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

Bed Complement

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General	Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.	•		
COMPL	ETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)			
Capital I	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?			23
	If yes, see instructions.			
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.			24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			27
Interest l	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			29
	account? If yes, see instructions.			
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
Purchase	d Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services?			32
	If yes, see instructions.			
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?			33
	If no, see instructions.			
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			35
	reporting period? If yes, see instructions.			
		Y/N	Date	
	ffice 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?			38
	If yes, enter in column 2 the fiscal year end of the home office.			
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 Rei	oort Preparer Contact Information			
41	First name: Last name: Title:			41
42	Employer:			42
	Phone number: F-mail Address:			43

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

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

PART I	STATISTICAL DATA																
					Inpatient Days / Outpatient Visits / Trips Full Time Equivalents								Discharges				
		Worksheet															
		A							Total	Total	Employees					Total	
		Line	No. of	Bed Days	CAH/REH		Title	Title	All	Interns &	On	Nonpaid		Title	Title	All	
	Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents	Payroll	Workers	Title V	XVIII	XIX	Patients	
		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																1
	Bed, Observation Bed and Hospice days) (see instructions for																
	col. 2 for the portion of LDP room available beds)																
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																7
	observation beds) (see instructions)																
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
15.10	REH hours and visits																15.10
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
	Hospice (non-distinct part)																24.10
	CMHC																25
	RHC/FQHC (specify)																26
27	Total (sum of lines 14-26)																27
28	Observation Bed Days																28
29	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days - IRF																31
32	Labor & delivery (see instructions)																32
32.01	Total ancillary labor & delivery room																32.01
	outpatient days (see instructions)																
33	LTCH non-covered days																33
33.01	LTCH site neutral days and discharges																33.01
34	Temporary Expansion COVID-19 PHE Acute Care																34
				-													

	. ,	CMS-2	.332-10					04-23
HOSPIT	AL WAGE INDEX INFORMATION				PROVIDER CCN:		WORKSHEET	ſ S-3
						FROM	PART II	
						TO		
Part II -	Wage Data				_			
				Reclassification	Adjusted	Paid Hours	Average	i
		Wkst. A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(col. 2 ±	to Salaries	(col. 4 ÷	i
		Number	Reported	Wkst. A-6)	col. 3)	in column 4	col. 5)	i
		1	2	3	4	5	6	
	SALARIES							.
1	Total salaries (see instructions)							1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician and Non Physician-Part B							5
6	Non-physician-Part B for hospital-based RHC and FQHC services							6
7	Interns & residents (in an approved program)							7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF							9
10	Excluded area salaries (see instructions)							10
	OTHER WAGES AND RELATED COSTS							
11	Contract labor: Direct Patient Care							11
12	Contract labor: Top level management and other management and							12
	administrative services							<u> </u>
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
24	Wage-related costs (RHC/FQHC)							
25	Interns & residents (in an approved program)			1				25 25.50
25.50								25.50
25.51 25.52	Related organization wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)							25.51
				1	-			
25.53	Home office: Physicians Part A - Teaching - wage-related (core)			I	I			25.53

11-10		FUKI	VI CIVIS-23	32-10			4090 (1	com.)
HOSPIT	AL WAGE INDEX INFORMATION				PROVIDER CCN:		WORKSHEET	S-3
						FROM	PART II & III	
						TO	_	
Part II -	Wage Data							
		Worksheet		Reclassification	Adjusted	Paid Hours	Average	
		A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(column 2 ±	to Salaries	(column 4 ÷	
		Number	Reported	Worksheet A-6)	column 3)	in column 4	column 5)	
		1	2	3	4	5	6	
	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)						1	4
5	Subtotal wage-related costs (see instructions)						1	5
6	Total (sum of lines 3 through 5)						1	6
7	Total overhead cost (see instructions)							7

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1 401k Er 2 Tax Shk 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrig 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker			FROMTO_	Amount Reported	1 2 3 4
RETIRI	EMENT COST Imployer Contributions Eltered Annuity (TSA) Employer Contribution Elified Defined Benefit Plan Cost (see instructions) Id Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees Icocounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees TH AND INSURANCE COST				3
RETIRI 1 401k E 2 Tax She 3 Nonqua 4 Qualifie PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health I 8.01 Health I 8.02 Health I 8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	EMENT COST Imployer Contributions Eltered Annuity (TSA) Employer Contribution Elified Defined Benefit Plan Cost (see instructions) Id Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees In And Insurance Management Fees-Pension Plan Elemanaged Care Program Administration Fees THAND INSURANCE COST				3
RETIRI 1 401k E 2 Tax She 3 Nonqua 4 Qualifie PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health I 8.01 Health I 8.02 Health I 8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	EMENT COST Imployer Contributions Eltered Annuity (TSA) Employer Contribution Elified Defined Benefit Plan Cost (see instructions) Id Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees In And Insurance Management Fees-Pension Plan Elemanaged Care Program Administration Fees THAND INSURANCE COST				3
1 401k Er 2 Tax Shh 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	nployer Contributions Eltered Annuity (TSA) Employer Contribution Lified Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): EA Plan Administration fees Cocounting/Management Fees-Pension Plan Ed Managed Care Program Administration Fees EH AND INSURANCE COST				3
1 401k Er 2 Tax Shh 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	nployer Contributions Eltered Annuity (TSA) Employer Contribution Lified Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): EA Plan Administration fees Cocounting/Management Fees-Pension Plan Ed Managed Care Program Administration Fees EH AND INSURANCE COST				3
1 401k Er 2 Tax Shh 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	nployer Contributions Eltered Annuity (TSA) Employer Contribution Lified Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): EA Plan Administration fees Cocounting/Management Fees-Pension Plan Ed Managed Care Program Administration Fees EH AND INSURANCE COST				3
1 401k Er 2 Tax Sh6 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	nployer Contributions Eltered Annuity (TSA) Employer Contribution Lified Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): EA Plan Administration fees Cocounting/Management Fees-Pension Plan Ed Managed Care Program Administration Fees EH AND INSURANCE COST				3
1 401k Er 2 Tax Sh6 3 Nonqua 4 Qualifice PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	nployer Contributions Eltered Annuity (TSA) Employer Contribution Lified Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) Ed Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): EA Plan Administration fees Cocounting/Management Fees-Pension Plan Ed Managed Care Program Administration Fees EH AND INSURANCE COST				3
2 Tax She 3 Nonqua 4 Qualific PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	Iltered Annuity (TSA) Employer Contribution lified Defined Benefit Plan Cost (see instructions) d Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees .ccounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees H AND INSURANCE COST				3
3 Nonqua 4 Qualifie PLAN / 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	lified Defined Benefit Plan Cost (see instructions) Id Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees coounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees H AND INSURANCE COST				3
4 Qualifie PLAN / 5 401k/Ts 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	d Defined Benefit Plan Cost (see instructions) ADMINISTRATIVE COSTS (Paid to External Organization): 5A Plan Administration fees ccounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees TH AND INSURANCE COST				_
PLAN A 5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	ADMINISTRATIVE COSTS (Paid to External Organization): SA Plan Administration fees ccounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees 'H AND INSURANCE COST				4
5 401k/TS 6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	SA Plan Administration fees ccounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees 'H AND INSURANCE COST				
6 Legal/A 7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	ccounting/Management Fees-Pension Plan ee Managed Care Program Administration Fees 'H AND INSURANCE COST				
7 Employ HEALT 8 Health 1 8.01 Health 1 8.02 Health 1 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	ee Managed Care Program Administration Fees H AND INSURANCE COST				5
HEALT 8 Health 8.01 Health 8.02 Health 8.03 Health 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabilit 14 Long-T 15 Worker	H AND INSURANCE COST				6
8 Health I 8.01 Health I 8.02 Health I 8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker					7
8.01 Health I 8.02 Health I 8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker					8
8.02 Health I 8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	Insurance (Self Funded without a Third Party Administrator)				8.01
8.03 Health I 9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-Ti 15 Worker	Insurance (Self Funded without a Third Party Administrator)				8.02
9 Prescrip 10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-Ti 15 Worker	insurance (Purchased)				8.03
10 Dental, 11 Life Ins 12 Accider 13 Disabili 14 Long-To 15 Worker	tion Drug Plan				9
11 Life Ins 12 Accider 13 Disabili 14 Long-T 15 Worker	Hearing and Vision Plan			- 	10
12 Accider 13 Disabili 14 Long-To 15 Worker	urance (If employee is owner or beneficiary)				11
14 Long-To 15 Worker	at Insurance (If employee is owner or beneficiary)				12
15 Worker	ty Insurance (If employee is owner or beneficiary)				13
	erm Care Insurance (If employee is owner or beneficiary)				14
16 Retirem	s' Compensation Insurance				15
10 Itemen	ent Health Care Cost (Only current year, not the extraordinary accrual required	by FASB 106 Noncumulative portion	on)		16
TAXES					
	mployers Portion Only				17
	re Taxes - Employers Portion Only				18
	oyment Insurance				19
	Federal Unemployment Taxes				20
OTHER					
	ve Deferred Compensation (Other Than Retirement Cost Reported on lines 1 to	hrough 4 above)(see instructions)			21
	G : 1.411				22
	re Cost and Allowances				23
24 Total W	re Cost and Allowances Reimbursement (age Related cost (Sum of lines 1 through 23)				24

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

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	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
	Separately Certified ASC			12
	Hospital-Based Hospice			13
	Hospital-Based Health Clinic RHC			14
	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

4090 ((Cont.)	FORM CMS-2552-1	0						10-12
	TAL-BASED HOME HEALTH AGENCY		PROVIDE	R CCN:	PERIOD:		WORKSHI	EET S-4	
STATIS	STICAL DATA				FROM				
			HHA CCN	:	TO				
	HOME WELL THE ACTIVITY OF LITTERS AND DATE.								
	HOME HEALTH AGENCY STATISTICAL DATA				County	:			
				Title V	Title XVIII	Title XIX	Other	Total	
	Description			1	2	3	4	5	1
1	Home Health Aide Hours								1
2	Unduplicated Census Count (see instructions)								2
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					Num	nber of Empl		1
	Enter the number of hours in						Time Equiv		
	your normal work week					Staff	Contract	Total	1
	your norman work week					1	2	3	i
3	Administrator and Assistant Administrator(s)					_	_		3
	Director(s) and Assistant Director(s)								4
5									5
	Direct Nursing Service								6
7	Nursing Supervisor								7
- 8	<u> </u>								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								15	
16								16	
17									17
	Other (specify)								18
	Suiter (speed))							I	
	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 perio	d (line 20 contains the first code).							20
	PPS ACTIVITY			Enll I	pisodes			Total	1
				Without	With	LUPA	PEP only	(columns 1	
				Outliers	Outliers	Episodes	Episodes	through 4)	
				1	2	3	4	5 5	1
21	Skilled Nursing Visits			1	1 4	,	-	ر	21
22	Skilled Nursing Visit Charges								22
23	Physical Therapy Visits								23
24	Physical Therapy Visits Physical Therapy Visit Charges								23
25	Occupational Therapy Visits				1				25
26	Occupational Therapy Visits Occupational Therapy Visit Charges								26
27									27
28	Speech Pathology Visits Speech Pathology Visit Charges				1			 	
29	Speech Pathology Visit Charges				 			 	28 29
30	Medical Social Service Visits				1				30
	Medical Social Service Visit Charges				1				31
31	Home Health Aide Visits				 			 	
32	Home Health Aide Visit Charges				 			 	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)				1				33
34	Other Charges Total Charges (sum of lines 22, 24, 26, 28, 20, 22, and 24)				1			 	34
	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)							 	35 36
36	Total Number of Episodes (standard/non-outlier)							 	36
38	Total Number of Outlier Episodes				-				38
38	Total Non-Routine Medical Supply Charges				1			I	38

	TAL RENAL DIALYSIS DEPA	RTMENT			PROVIDER CCN:	PERIOD:	WORKSHEET S-5	
STATIS	TICAL DATA					FROM		
	RENAL DIALYSIS STATIST	TCS				ТО		
	ALL VILLE BILLET SIGN STITLES		atient	Tra	ining	Но	ome	
				Hemo-	CAPD	Hemo-	CAPD	
	DEGGDYDTION	Regular	High Flux	dialysis	CCPD	dialysis	CCPD	
	DESCRIPTION Number of patients in	1	2	3	4	5	6	1
1	program at end of cost							1
	reporting period							
2	Number of times per							2
	week patient receives							
	dialysis							
3	Average patient dialysis							3
	time including setup							
4	CAPD exchanges per day							4
5	Number of days in year							5
6	dialysis furnished Number of stations							6
7	Treatment capacity per							7
,	day per station							· '
- 8	Utilization (see instructions)							8
9	Average times							9
	dialyzers re-used							
10	Percentage of patients							10
	re-using dialyzers							
								1
10.01	ESRD PPS	1 1 1 0 22	C 4:	· 10		1	2	10.01
10.01	Is the dialysis facility approved		y for this cost reporting	period?				10.01
10.02	Enter "Y" for yes or "N" for no Did your facility elect 100% P.		0112 Enter "V" for vec	or "N" for no				10.02
10.02	(See instructions for "new" pro		off: Effet 1 for yes	of in for no.				10.02
10.03	If you responded "N" to line 10		he year of transition for	periods prior to January	l and			10.03
	enter in column 2 the year of to							
		•		<i>'</i>			•	
	TRANSPLANT INFORMATI	ON						
11	Number of patients on transpla							11
12	Number of patients transplants	ed during the cost reporti	ng period					12
	EDOCTDI							
13	EPOETIN Net costs of Epoetin furnished	to all maintanana dialy	nia matianta bretha muari	don			I	13
14	Epoetin amount from Worksho			uei				13
15	Number of EPO units furnishe							15
16	Number of EPO units furnishe							16
	•		· 1					•
	ARANESP							
17	Net costs of ARANESP furnis			ovider				17
18	ARANESP amount from Work							18
19	Number of ARANESP units fi							19
20	Number of ARANESP units for	urnished relating to the h	iome dialysis departmen	t				20
	PHYSICIAN PAYMENT ME	THOD (Enter "V" for an	nlicable method(c))					
21		INITIAL METHOD	phenoic memou(s))					21
				Net Cost of	Net Cost of	Number of ESA	Number of ESA	
			ESA	ESAs for	ESAs for	Units - Renal	Units - Home	Ī
			Description	Renal Patients	Home Patients	Dialysis Dept.	Dialysis Dept.]
	Erythropoiesis-Stimulating Age		1	2	3	4	5	ļ
22	Enter in column 1 the ESA des	*						22
	Enter in column 2 the net costs	s of ESAs furnished						
	to all renal dialysis patients. Enter in column 3 the net cost	of ECA o framished						
	to all home dialysis program p							
	Enter in column 4 the number							
	furnished to patients in the ren							
	department.							
	Enter in column 5 the number							
	to patients in the home dialysis	s program.						
	(see instructions)							
						CCN	Treatments	ı
	LOW VOLUME					1	2	1
23	If line 10.01 is yes, enter in co	lumn 1 the CCN for each	h renal dialysis facility li	sted on Worksheet S-2. F	Part I, line 18, and	· ·		23
	its subscripts. Enter in column				* *			1

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HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AN	ID	PROVIDER CCN:	PERIOD:	WORKSHEET S-6		
OTHER OUTPATIENT REHABILITATION			FROM			
PROVIDER STATISTICAL DATA		COMPONENT CCN:	TO			
COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)						
Check [] CMHC [] OOT						
applicable [] CORF [] OSP						
box: [] OPT						
inter the number of hours in your normal workweek						

		s	taff	Contract	Total (col. 1 + col. 2)	
			1	2	3	1
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

	1 014.1 01.15 2002 1	•		.0,0(
PROSPI	ECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7	
STATIS	TICAL DATA		FROM		
			TO		
			Y/N	Date	
			1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Med	licare utilization?			1
	Enter "Y" for yes and do not complete the rest of this worksheet.				
2	2 Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or				2
	"N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				

	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	i
3	RUX		3	'	3
4	RUL				4
5	RVX				3 4 5 6 7 8
6	RVL				- 6
7	RHX				7
- 8	RHL				8
9	RMX				0
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				12
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				10
18	RHC				17 18
19	RHB				19
20	RHA				20
	RHA DMC				20
21 22	RMC RMB				20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35
					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
42	LC1				42
43	LB2				43 44 45
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47 48
48	CD1				48
49	CC2				49
50	CC1				50 51
51	CB2				51
52	CB1				52
53	CA2				53 54
54	CAI				54

	TIVE PAYMENT FOR SNF CAL 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 SERV	ICES				
			CBSA at Beginning of Cost Reporting	CBSA on/after October 1 of the Cost Reporting	

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

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

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

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

cost reporting period.

Rev. 22

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)

Total

Visits

5

15

XVIII

Y/N

1

XIX

4090 ((Cont.)		FORM C	MS-2552-10				02-24
	CAL-BASED HOSPICE IDENTIFICATION	ON DATA			PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-9 PARTS I THROUG	H IV
					HOSPICE CCN:	то	_	
					<u> </u>	.1		
PART I	- ENROLLMENT DAYS FOR COST RE	PORTING PERIODS	BEGINNING BEFO					
					nduplicated Days			
				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
		1	2	3	4	5	6	
1	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 REPORT	ING PERIODS BEGIN	NING BEFORE O			1		
				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
		1	2	3	4	5	6	
6	1 0							6
	hospice care							_
7	Total number of unduplicated contin-							7
	uous care hours billable to Medicare							
8	Average length of stay (line 5/line 6)							8
9	Unduplicated census count							9
PART II	I - ENROLLMENT DAYS FOR COST R	EPORTING PERIODS	BEGINNING ON	OR AFTER OCTOBE		' . 15		
					Undupi	icated Days	T . 1	
							Total	
				T': 1 3/3/1111	Trid NUN	0.4	(sum of	
				Title XVIII	Title XIX	Other	cols. 1 through 3)	
10	и : с : и с			1	2	3	4	10
10								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	V - CONTRACTED STATISTICAL DATA	A FOR COST REPOR	TING PERIODS BE	GINNING ON OR AF	TER OCTOBER 1, 20	15	Total	ı
							(sum of	
				Title XVIII	Title XIX	Other	cols 1 through 3)	I

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

15 Hospice Inpatient Respite Care16 Hospice General Inpatient Care

12-22 FORM 0	CMS-2552-10		4090	(Cont.)
HOSPITAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10	
CARE DATA		FROM	PART I	
	-	TO		
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge 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 Medi-	caid?			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 Hookid Lawrence Processor (CHID) (and instruction for each line)				
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 cnarges 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 (se	ee 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 progra	nms (sum of lines 8, 12, and 16)			19
The second of the second second second second second				
Uncompensated care cost (see instructions for each line)	Uninsured	Insured	Total	I
	patients	patients	(col. 1 + col. 2)	
	1	2	3	1
20 Charity care charges and uninsured discounts (see instructions)	<u> </u>			20
21 Cost of patients approved for charity care and uninsured discounts (see instructions)	İ			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 immediad on nationts saysand			24
	or-stay minit imposed on patients covered			24
by Medicaid or other indigent care program? 25 If line 24 is yes, enter the charges for patient days beyond the indigent care program's	1			25
	length-of-stay limit (see instructions)			25 25.01
25.01 Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)				
				26
				27 01
27.01 Medicare allowable bad debts (see instructions)				27.01
28 Non-Medicare bad debt amount (see instructions)	4:			28
29 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instruc	cuons)			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

4090 ((Cont.) FORM CMS-25	32-10			12-22
HOSPIT	FAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10,	
CARE I	DATA		FROM	PART II	
			ТО	_	
PART I	I - HOSPITAL DATA	•		<u> </u>	
Uncomp	pensated and Indigent Care Cost-to-Charge Ratio				
1	Cost to charge ratio (see instructions)				1
				<u> </u>	
Medicai	d (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	8				6
7	Medicaid cost (line 1 times line 6)				7
8	Difference between net revenue and costs for Medicaid program (see instructions)				8
	n's Health Insurance Program (CHIP) (see instructions for each line)				
9					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
0.1					
	ate or local government indigent care program (see instructions for each line)				12
14	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9) Charges for patients covered under state or local indigent care program (not included in lines 6 or	- 10)			13
15		r 10)			15
16	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructio	ma)			16
10	Difference between het revenue and costs for state of local indigent care program (see instruction	iis)			10
Grante	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	see instructions for each fine)			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	Tlines 8 12 and 16)			19
- 17	Total differenced cost for Fredicard, CTITE, and state and focal margent care programs (sum of	inics 0, 12, and 10)			17
Uncomr	pensated care cost (see instructions for each line)				
		Uninsured	Insured	Total	
		Patients	Patients	(col. 1 + col. 2)	
		1	2	3	1
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			24
	by Medicaid or other indigent care program?				
25	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-s	tay 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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HOSPI	TAL-BASED FQHC IDENT	TIFICATION DATA					PROVIDER CCN:	PERIOD:	WORKSHEET S-11	
								FROM:	PART I	
							COMPONENT CCN:	TO:		
DADEL	HOGDITAL DAGED FOLK	C IDENTIFICATION DATA								
PARTI	- HOSPITAL-BASED FQHO	C IDENTIFICATION DATA				T	Dete	V/I	D-tf	
						Type of control	Date		Date of	
		1				(see instructions)	Decertified	Decertification	CHOW	
	C'. M	1				2	3	4	5	
	Site Name:		DO D							1
	Street:	I a	P.O. Box:	9		N C 1 WYTH C 1				2
	City:	State:	ZIP Code:	County:		R" for rural or "U" for urb	an:			3
4	Is this hospital-based FQHO enter the entity's information		es or controls multiple FQ	HCs? Enter "Y" for yes or "N" for	r no. If yes,					4
5	Name of Entity:					I.				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	
Consoli	dated Cost Report					1	2	3	4	
- 8	Is this hospital-based FQHO	C filing a consolidated cost repor	t per CMS Pub. 100-04, cl	napter 9, §30.8? Enter "Y" for yes	or "N" for no in column 1.			1		8
	If column 1 is yes, complete	e columns 2 through 4, and line 9	beginning with line 9.01.	If column 1 is no, leave line 9 bla	ank. (see instructions)					
						CCN	CBSA	Date Requested	Date Approved	
		1				2	3	4	5	
9	List of Consolidated Provid	lers:								9
9.01	Site Name:									9.01
Hospita	l-Based FQHC Operations						1	2	3	
10	What type of organization is	s this hospital-based FQHC? If	you operate as more than	one sub-type of an organization, en	nter only the applicable alpha					10
	characters in column 2. (se	ee instructions)								
11	Did this hospital-based FQI	HC receive a grant under §330 of	the PHS Act during this	cost reporting period? If this is a co	onsolidated cost report, did the hospital-base	d FQHC reported				11
	on line 1, column 1, receive	e a grant under §330 of the PHS	Act during this cost report	ng period? Enter "Y" for yes or "N	N" for no. (complete line 12)					
12	If the response to line 11 is	yes, indicate in column 1, the typ	e of HRSA grant that was	awarded (see instructions). Enter	the date of the grant award in					12
	column 2, and enter the gra-	nt award number in column 3. If	you received more than o	ne grant subscript this line accordi	ngly.					
Medical	Malpractice									
13	Did this hospital-based FQI	HC submit an initial deeming or a	annual redeeming applicat	ion for medical malpractice covera	ge under the FTCA with HRSA? Enter "Y"	for				13
		1. If column 1 is yes, enter the	effective date of coverage	in column 2.						
	and Residents									
14				t C of Title VII of the PHS Act fro						14
	yes or "N" for no in column	1. If yes, enter in column 2, the	number of FTE residents	that your hospital-based FQHC tra	ined and received funding through your					
	THC grant in this cost repor	rting period and in column 3, ent	er the total number of visi	ts performed by residents funded b	y the THC grant in this cost reporting					
	neriod (see instructions)									

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02-24	ļ.			FORM CM	AS-2552-10				4090	(Cont.)
HOSPI	TAL-BASED FQHC IDENTIFICATIO	ON DATA					PROVIDER CCN: COMPONENT CCN: SUBCOMPONENT CCN	PERIOD: FROM TO	WORKSHEET S-11 PART II	
PART	II - HOSPITAL-BASED FQHC CONSC	LIDATED COST REPORT P.	ARTICIPANT IDENT	IFICATION DATA					•	
					Date Certified	Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW	
		1			2	3	4	5	6	
1	Site Name:									1
	Street:	P.O. Box:								2
3	City:	State:	ZIP Code:	County:		Designation - Enter "R" fo	or rural or "U" for urban:			3
Hoenita	al-Based FQHC Operations						1	2	3	
1	What type of organization is this hospi	ital-based FOHC? If you onera	te as more than one sul	n-type of an organization, enter or	ly the applicable		1	2	3	4
7	alpha characters in column 2. (see ins		te as more than one sa	type of an organization, enter of	ny the applicable					
5	Did this hospital-based FQHC receive	,	Act during this cost re	porting period? Enter "Y" for yes	or "N" for no. (complete	line 6)				5
	If the response to line 5 is yes, indicate					.,				6
	column 2 and enter the grant award nu				C					
		•	· ·				•		•	
Medica	l Malpractice						-	-		
7	Did this hospital-based FQHC submit		0 11		nder the FTCA with HRS	A?				7
	Enter "Y" for yes or "N" for no in colu	ımn 1. If column 1 is yes, ente	r the effective date of c	overage in column 2.						
Interne	and Residents									
	Did this hospital-based FQHC receive	a THC development grant auth	orized under Part C of	Title VII of the PHS Act from H	RSA?					8
	Enter "Y" for yes or "N" for no in colu					oh				
	views TLC agent in this cost reporting	• /		, ,			1			1

in this cost reporting period. (see instructions)

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1050 (Cont.)		1 Oldin Ci	110 2002 10				02 2 .
HOSPITAL-BASED FQHC IDENTIFICATION DA	ГА			PROVIDER CCN: COMPONENT CCN	PERIOD: FROM TO	WORKSHEET S- PART III	11
PART III - HOSPITAL-BASED FQHC STATISTICA	L DATA						
	COMPONENT CCN 0	Title V	Title XVIII 2	Title XIX 3	Other 4	Total All Patients 5	
1 Medical Visits							1
2 Total Medical Visits							2
3 Mental Health Visits							3
4 Total Mental Health Visits							4
5 IOP Visits	1						5
6 Total IOP Visits							6
7 Total FQHC Visits (sum of lines 2, 4, and 6)							7

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RECLAS	SSIFICATI	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD:	WORKSHEET A	
								FROM		
			1	1	1	1		TO		
							RECLASSIFIED		NET EXPENSES	
	COS	T CENTER DESCRIPTIONS	GAT A DITTO	OTTLED	TOTAL	RECLASSIFI-	TRIAL BALANCE	L D W JOTT CENTED	FOR ALLOCATION	
		(omit cents)	SALARIES	OTHER 2	(col. 1 + col. 2)	CATIONS 4	(col. 3 ± col. 4)	ADJUSTMENTS 6	(col. 5 ± col. 6)	
		GENERAL SERVICE COST CENTERS	1	2	3	4	3	6	/	
	00100	Capital Related Costs-Buildings and Fixtures								
1	00200	Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment								2
2	00200	Other Capital Related Costs							-0-	3
3		Employee Benefits Department							-0-	4
4		Administrative and General								5
3										
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	01600	Medical Records & Medical Records Library								16
17	01700	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	02200	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	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		Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46		Other Long Term Care							i i	46

RECLAS	SSIFICATI	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD:	WORKSHEET A	
								FROM		
								ТО		
							RECLASSIFIED		NET EXPENSES	ı
	COS	T CENTER DESCRIPTIONS			TOTAL	RECLASSIFI-	TRIAL BALANCE		FOR ALLOCATION	ı
		(omit cents)	SALARIES	OTHER	(col. 1 + col. 2)	CATIONS	$(col. 3 \pm col. 4)$	ADJUSTMENTS	$(col. 5 \pm col. 6)$	ı
			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	07300	Other Ancillary (specify)								76
77	07700	Allogeneic HSCT Acquisition								77
78	07700	CAR T-Cell Immunotherapy								78
/8	0/800	OUTPATIENT SERVICE COST CENTERS								/8
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)			 	+			+	89
90	09000	Clinic			 	+			-	90
	09000					-				90
91 92	09100	Emergency								91
	09200	Observation Beds								92
93.99	09399	Other Outpatient Service (specify)								93.99
93.99	09399	Partial Hospitalization Program								93.99

RECLAS	SSIFICAT	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD:	WORKSHEET A	
								FROM TO		
			<u> </u>	T	1	I	RECLASSIFIED	10	NET EXPENSES	
	COS	ST CENTER DESCRIPTIONS			TOTAL	RECLASSIFI-	TRIAL BALANCE		FOR ALLOCATION	1
	COL	(omit cents)	SALARIES	OTHER	(col. 1 + col. 2)	CATIONS	(col. 3 ± col. 4)	ADJUSTMENTS	(col. $5 \pm \text{col. } 6$)	1
		(onit cens)	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		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		Physicians' Private Offices								192
193	19300	Nonpaid Workers							, and the second	193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118 through 199)				- 0 -				200

RECLAS	SIFICATIONS						PROVIDER	CCN:	PERIOD:	WORKSH	EET A-6	
									FROM			
									ТО			
					EASES				EASES			Ì
		CODE		WKST. A				WKST. A			WKST. A-7	1
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	CENTER	LINE#	SALARY	OTHER	REF.	1
		1	2	3	4	5	6	7	8	9	10	
1												1
2												2
3												3 4
4												4
5												5
6												6
7												7 8 9
8												8
9												9
10												10
11												11
12												12
13												13 14
14												14
15												15
16												16 17
17												17
18												18 19
19												19
20												20
21												21
22												22
23												23 24
24												24
25												25
26												26
27												27
28												26 27 28 29
29												29
30											_	30 31
31											_	31
32											_	32 33
33											_	33
34				ļ								34

500 Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)

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

RECONCILIATION O	F CAPITAL COSTS CENTERS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-7, PARTS I, II & III	
PARTI - ANALYSIS	OF CHANGES IN CAPITAL ASSET BALANCES								
THETT HETETOIS	OF CHEROLES IN CHAINE ASSET BREAKCES			Acquisitions		Disposals		Fully	
		Beginning		1		and	Ending	Depreciated	
Descrip	tion	Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
•		1	2	3	4	5	6	7	
1 Land									1
2 Land Improve	ements								2
3 Buildings and	1 Fixtures								3
4 Building Imp	rovements								4
5 Fixed Equipment	nent								5
6 Movable Equ	ipment								6
7 HIT-designat	red Assets								7
8 Subtotal (sun	n of lines 1 through 7)								8
9 Reconciling I	Items								9
10 Total (line 7 i	minus line 9)								10
				•		-	-		
PART II - RECONCIL	IATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LI	INES 1 AND 2							
					SUMMARY OF CAPIT	AL			
							Other Capital-	Total (1)	
					Insurance	Taxes	Related Costs	(sum of	
Descrip	tion	Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1 Capital Relat	ed Costs-Buildings and Fixtures								1
	ed Costs-Movable Equipment								2
3 Total (sum of									3
(1) The amount in	n columns 9 through 14 must equal the amount on Worksheet A, columns	nn 2, lines 1 and 2. Enter in each co	olumn the appropriate a	mounts including any d	irectly assigned cost that n	nav have been included i	in Worksheet A.	•	

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

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

				SUMMARY OF CAPIT	AL			
						Other Capital-	Total (2)	1
				Insurance	Taxes	Related Costs	(sum of	
Description	Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*	9	10	11	12	13	14	15	
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.)

⁽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.

ADJUS	TMENTS TO EXPENSES		PROVIDER O	CCN:	PERIOD:	WORKSHEET	A-8	
					FROM	-		
					TO			
		1	1	_	EXPENSE CLASSIFIC	ATION ON	1	1
	DESCRIPTION (1)				WORKSHEET A TO/FR		Wkst.	
	DESCRIPTION (1)	BASIS /			THE AMOUNT IS TO B		A-7	
		CODE (2)	AMOUNT		COST CENTER		Ref.	
		1	2		3	4	5	
1	Investment income - buildings and fixtures (chapter 2)	1			ngs and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)				ole Equipment	2		2
3	Investment income - other (chapter 2)					_		3
4	Trade, quantity, and time discounts (chapter 8)						1	
5	Refunds and rebates of expenses (chapter 8)							5
6	Rental of provider space by suppliers (chapter 8)							(
7	Telephone services (pay stations excluded) (chapter 21)							
8	Television and radio service (chapter 21)							8
9	Parking lot (chapter 21)							ç
10	Provider-based physician adjustment	Worksheet A-8-2						10
11	Sale of scrap, waste, etc. (chapter 23)							11
12	Related organization transactions (chapter 10)	Worksheet A-8-1						12
13	Laundry and linen service							13
14	Cafeteria-employees and guests							14
15	Rental of quarters to employee and others							15
16	Sale of medical and surgical							16
	supplies to other than patients							
17	Sale of drugs to other than patients							17
18	Sale of medical records and abstracts							18
19	Nursing and allied health education (tuition,							19
	fees, books, etc.)							
20	Vending machines							20
21	Income from imposition of interest,							21
	finance or penalty charges (chapter 21)							
22	Interest expense on Medicare overpayments and							22
	borrowings to repay Medicare overpayments							
23	Adjustment for respiratory therapy							23
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respir	atory Therapy	65		
24	Adjustment for physical therapy costs							24
	in excess of limitation (chapter 14)	Worksheet A-8-3			al Therapy	66		
25	Utilization review - physicians' compensation (chapter 21)				ation Review - SNF	114		25
26	Depreciation - buildings and fixtures				ngs and Fixtures	1		26
27	Depreciation - movable equipment				ole Equipment	2		27
28	Non-physician Anesthetist			Nonph	nysician Anesthetist	19		28
29	Physicians' assistant							29
30	Adjustment for occupational therapy costs	W1-1	I	0	-4:1 Th	(2		30
20.00	in excess of limitation (chapter 14)	Worksheet A-8-3			ational Therapy	67 30	1	20.00
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	I	Smac -1	h Dotholoov	68		31
22	CAH HIT adjustment for depreciation	Worksneet A-8-3		Speeci	h Pathology	08		22
32							 	32
33	Other adjustments (specify) (3)							33
50	TOTAL (sum of lines 1 through 49)		I					50
	(Transfer to Worksheet A, column 6, line 200)							

 $^{^{\}left(1\right)}$ Description - all chapter references in this column pertain to CMS Pub. 15-1

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

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⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

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

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

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

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

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

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

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

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

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

 $^{^{\}left(1\right)}$ 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

PROVID		D PHYSICIANS ADJUSTMENTS					PROVIDER CCN:	PERIOD: FROMTO	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	
2										2
3										1 3
4										
5										4
6										(
7										7
8										9
10										10
11										11
200	TOTAL									200
	Wkst. A Line #	Cost Center/ Physician Identifier 11	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 17	Adjustment	
1										1
2										3
3 4	 							1		4
5										5
6										6
7										7
8										8
9			_							9
10										10
11										11
200	TOTAL			ĺ	ĺ	Ī		I	I	200

4090	90 (Cont.) FORM CMS-2552-10								
	ONABLE COST DETERMINATION FOR THERAPY SERVICES IISHED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8-	3,		
Check a	applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology								
PART I	I - GENERAL INFORMATION								
1	1 Total number of weeks worked (excluding aides) (see instructions)						1		
2	2 Line 1 multiplied by 15 hours per week						2		
3	3 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3		
4	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	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						6		
	supervisor and/or therapist was not present during the visit(s)) (see instructions)								
7	7 Standard travel expense rate								
- 8	8 Optional travel expense rate per mile						8		
		Supervisors	Therapists	Assistants	Aides	Trainees			
		1	2	3	4	5			
	9 Total hours worked						9		
	0 AHSEA (see instructions)						10		
11	Standard travel allowance (columns 1 and 2, one-half of column 2,						11		
	line 10; column 3, one-half of column 3, line 10)								
	Number of travel hours (see instructions)						12		
13	Number of miles driven (see instructions)						13		
DADTI	H. GALARY FOLINAL FRON COMPUTATION								
	II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, line 10)						14		
	5 Therapists (column 2, line 9 times column 2, line 10)						15		
	6 Assistants (column 3, line 9 times column 3, line10)						16		
	7 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17		
	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy of lines 14-16 for all others) Aides (column 4, line 9 times column 4, line 10)						18		
	9 Trainees (column 4, line 9 times column 9, line 10)						19		
	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20		
	1 total anowance amount (sum of times 17-19 for respiratory therapy or times 17 and 18 for all others)						20		

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)

the amount from line 20. Otherwise complete lines 21 through 23.

22 Weighted allowance excluding aides and trainees (line 2 times line 21)

23 Total salary equivalency (see instructions)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER CCN	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
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)			
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDE	ED CITE		
Standard Travel Expense	EKSITE		
36 Therapists (line 5 times column 2, line 11)			36
37 Therapists (time 6 times column 3, line 11) 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
55 Samuel durier expense (sine) united the dam of sine 55 and 6)			
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)		<u> </u>	45
46 Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)			46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8- PARTS V-VI	-3,
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						47
lines 48-55 and enter zero in each column of line 56)						
48 Overtime rate (see instructions)						48
49 Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT	T		_			
50 Percentage of overtime hours by category (divide the hours in each column on line 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
DESCRIPTION OF SUPPLIES AND SUP						
DETERMINATION OF OVERTIME ALLOWANCE 52 Adjusted hourly salary equivalency amount (see instructions)	1			1		52
52 Adjusted nourly safary equivalency amount (see instructions) 53 Overtime cost limitation (line 51 times line 52)						53
53 Overtime cost limitation (line 51 times line 52) 54 Maximum overtime cost (enter the lesser of line 49 or line 53)						54
54 Portion of overtime already included in hourly computation at the AHSEA (multiply			+			55
line 47 times line 52)						33
56 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5, the sum of columns 1, 3, and 4, for respiratory						56
therapy, and columns 1 through 3 for all others.)						30
aicrapy, and condition 1 through 3 for an outers.)	l	<u>I</u>	ı	ı		
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 A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST		PITAL ED COSTS						
COS	T CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	GENERAL SERVICE COST CENTERS	U	1	2	4	4A	3	0	/	-
	Capital Related Costs-Buildings and Fixtures									
	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department									4
										5
	Maintenance and Repairs									6
	Operation of Plant									7
8	*									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
	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	1 (1)/									42
43										43 44
	Skilled Nursing Facility Nursing Facility									44
										45
46	Other Long Term Care									46

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

COST ALL	OCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST	CAP RELATE							
COST	CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	4	4A	5	6	7	1
	THER REIMBURSABLE COST CENTERS									4
	Iome Program Dialysis									94
	Ambulance Services									95
	Ourable Medical Equipment-Rented									96
	Ourable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	ntern-Resident Service (not appvd. tchng. prgm.)									100
	Iome Health Agency									101
	Opioid Treatment Program									102
S	PECIAL PURPOSE COST CENTERS									
105 K	Lidney Acquisition									105
106 H	Ieart Acquisition									106
107 L	iver Acquisition									107
108 L	ung Acquisition									108
109 P	ancreas Acquisition									109
110 In	ntestinal Acquisition									110
111 Is	slet Acquisition									111
	Other Organ Acquisition (specify)									112
115 A	Ambulatory Surgical Center (Distinct Part)									115
116 H										116
117 C	Other Special Purpose (specify)									117
118 S	UBTOTALS (sum of lines 1 through 117)									118
N	ONREIMBURSABLE COST CENTERS									
190 C	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
192 P	'hysicians' Private Offices									192
	Jonpaid Workers									193
	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
	legative Cost Centers									201
	OTAL (sum lines 118 through 201)									202

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

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

COST ALLOCATION - GENERAL SERVICE COSTS							_	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
OTHER REMOVING A RUE GOOT CENTERS	8	9	10	11	12	13	14	15	16	17	
OTHER REIMBURSABLE COST CENTERS 94 Home Program Dialysis											94
94 Home Program Dialysis 95 Ambulance Services											95
											96
96 Durable Medical Equipment-Rented											
97 Durable Medical Equipment-Sold											97 98
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											
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				<u> </u>							116
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1 through 117)											118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen											190
191 Research											191
192 Physicians' Private Offices											192
193 Nonpaid Workers											193
194 Other Nonreimbursable (specify)											194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118 through 201)											202

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

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

COST A	LLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD:	WORKSHEET B,	
									FROM	PART I	
			1	ı	T	T			TO		
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
	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers										193
	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		TTAL D COSTS						
cos	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
-	GENERAL SERVICE COST CENTERS	U	1	2	ZA.	4	3	0	/	_
1	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department						1			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
	Maintenance of Personnel									12
	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
										18
	1 2									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									36
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider (specify)									42
43										43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		TTAL D COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	2A	4	5	6	7	+-
	Operating Room									50
	Recovery Room					†		+	+	51
	Labor Room and Delivery Room									52
	Anesthesiology									52 53
	Radiology-Diagnostic									54
										55
56	Radioisotope									55 56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part) Other Ancillary (specify)									75 76
						+		+	+	77
70	Allogeneic HSCT Acquisition CAR T-Cell Immunotherapy					+		+	+	78
	OUTPATIENT SERVICE COST CENTERS									/8
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)				1	+		+		89
	Clinic	 				1		1		90
	Emergency							+		91
	Observation Beds									92
	Other Outpatient Service (specify)									93
	Partial Hospitalization Program									93.99

ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
	DIRECTLY ASSIGNED	CAP RELATE	ITAL D COSTS						
COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	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 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	8	,	10	11	12	13	17	13	10	17	_
1 Capital Related Costs-Buildings and Fixtures											_
Capital Related Costs-Movable Equipment	╡										
4 Employee Benefits Department	1										
5 Administrative and General	1										
6 Maintenance and Repairs	1										
7 Operation of Plant	1										
8 Laundry and Linen Service											
9 Housekeeping			1								
10 Dietary											1
11 Cafeteria											1
12 Maintenance of Personnel											
13 Nursing Administration											
14 Central Services and Supply								1			
15 Pharmacy											
16 Medical Records & Medical Records Library											
17 Social Service											1
18 Other General Service (specify)											
19 Nonphysician Anesthetists											
20 Nursing Program											2
21 Intern & Res. Service-Salary & Fringes (Approved)											2
22 Intern & Res. Other Program Costs (Approved)											2
23 Paramedical Education Program (specify)											2
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											1
31 Intensive Care Unit											3
32 Coronary Care Unit											17
33 Burn Intensive Care Unit											
34 Surgical Intensive Care Unit											
35 Other Special Care Unit (specify)											- 1
40 Subprovider IPF											4
41 Subprovider IRF											4
42 Subprovider (specify)											
43 Nursery											4
44 Skilled Nursing Facility											4
45 Nursing Facility											
46 Other Long Term Care											

ALLOCA	TION OF CAPITAL-RELATED COSTS				_			_	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST	EENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	9	10	11	12	13	14	13	10	17	
50	Operating Room											5
	Recovery Room											5
	Labor Room and Delivery Room											5
53	Anesthesiology											5
	Radiology-Diagnostic											5
	Radiology-Therapeutic											5
	Radioisotope											
57	Computed Tomography (CT) Scan											5
	Magnetic Resonance Imaging (MRI)											5
	Cardiac Catheterization											5
	Laboratory											(
61	PBP Clinical Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells											(
	Blood Storing, Processing, & Trans.											6
	Intravenous Therapy							-	-			6
	Respiratory Therapy											- (
	Physical Therapy											- (
	Occupational Therapy											- 6
	Speech Pathology											6
	Electrocardiology											6
	Electroencephalography											7
	Medical Supplies Charged to Patients											7
72	Implantable Devices Charged to Patients											7
	Drugs Charged to Patients											7
	Renal Dialysis											
	ASC (Non-Distinct Part)											í
	Other Ancillary (specify)											
	Allogeneic HSCT Acquisition											7
	CAR T-Cell Immunotherapy											7
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											8
	Federally Qualified Health Center (FQHC)											8
	Clinic							ļ				ý
	Emergency Observation Beds											9
	Other Outpatient Service (specify)											3
	Partial Hospitalization Program				 	 		 	 	+	+	93.9

ALLOCATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROMTO	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	
OTHER REPORTED AND EGGET GENETING	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
99 Outpatient Rehabilitation Provider (specify)											
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

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

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

ALLOCA	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART II	
									то		
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										4
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
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
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										113
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers										193
	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments								1		200
	Negative Cost Centers										201
	TOTAL (sum lines 118 through 201)										202

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B-1	
		CAPITAL RE	LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
909	TO CONTROL DISCONDING NO	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BENEFITS DEPARTMENT	process	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE FEET)	(DOLLAR VALUE)	(GROSS SALARIES) 4	RECONCIL- IATION 5A	(ACCUM. COST)	(SQUARE FEET) 6	(SQUARE FEET) 7	-
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
4	Employee Benefits Department								
5	Administrative and General								5
6	Maintenance and Repairs								6
7	Operation of Plant								7
8	Laundry and Linen Service								8
9	Housekeeping								ç
10	Dietary								10
11	Cafeteria								11
12	Maintenance of Personnel								12
	Nursing Administration								13
14	Central Services and Supply								14
									15
16	Medical Records & Medical Records Library								16
17	Social Service								17
	Other General Service (specify)								13
	Nonphysician Anesthetists								19
	Nursing Program								20
	Intern & Res. Service-Salary & Fringes (Approved)								2
	Intern & Res. Other Program Costs (Approved)								22
23	Paramedical Education Program (specify)								2.
	INPATIENT ROUTINE SERVICE COST CENTERS								
	Adults and Pediatrics (General Routine Care)								3
	Intensive Care Unit								3
	Coronary Care Unit								3
	Burn Intensive Care Unit								3:
	Surgical Intensive Care Unit								3-
	Other Special Care Unit (specify)								33
	Subprovider IPF								40
	Subprovider IRF								4
	Subprovider (specify)								42
	Nursery								43
	Skilled Nursing Facility								44
	Nursing Facility								4:
46	Other Long Term Care								46

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM		
							ТО		
			ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
	Operating Room								50
	Recovery Room								51
	Labor Room and Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
									60
	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
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
	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
	Emergency								91
	Observation Beds								92
93	Other Outpatient Service (specify)								93
	Partial Hospitalization Program								93.99
	· · · · · ·					-			

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

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

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

COST A	LLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
										FROM		
										TO		
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
		& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
COST	CENTER DESCRIPTIONS	(POUNDS OF	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	
		LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	REQUIS.)	REQUIS.)	SPENT)	SPENT)	
		8	9	10	11	12	13	14	15	16	17	1
	OTHER REIMBURSABLE COST CENTERS											
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
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
	Heart Acquisition											106
	Liver Acquisition											107
	Lung Acquisition											108
	Pancreas Acquisition											109
	Intestinal Acquisition											110
	Islet Acquisition					1						111
	Other Organ Acquisition (specify)					1						112
115	Ambulatory Surgical Center (Distinct Part)					1						115
	Hospice					1						116
	Other Special Purpose (specify)	+			•	•		•	.			117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											110
	Gift, Flower, Coffee Shop, & Canteen											190
	Research				 	 		 				190
	Physicians' Private Offices				 	 		 				191
	Nonpaid Workers				 	 		 				192
	Other Nonreimbursable (specify)											193
	Cross foot adjustments											200
	Negative cost centers											200
202	Cost to be allocated (per Worksheet B, Part I)											201
	Unit cost multiplier (Worksheet B, Part I)				 	 		 				202
	Cost to be allocated (per Worksheet B, Part II)	+			 	 		 			1	203
	Unit cost multiplier (Worksheet B, Part II)	+			 	 		 			1	204
	NAHE adjustment amount to be allocated (per Wkst. B-	21										203
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	4/										206
207	NAME unit cost multiplier (WKSt. D, Parts III and IV)											207

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									ТО		
			NON-			RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
		(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	GENERAL SERVICE COST CENTERS										
	Capital Related Costs-Buildings and Fixtures										1
	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
	Maintenance and Repairs										6
	Operation of Plant										7
8	Laundry and Linen Service										8
	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			1							19
	Nursing Program				1						20
	Intern & Res. Service-Salary & Fringes (Approved)					1					21
22	Intern & Res. Other Program Costs (Approved)						1				22
	Paramedical Education Program (specify)							1			23
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)										30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
	Subprovider (specify)										42
	Nursery										43
	Skilled Nursing Facility	ĺ									44
	Nursing Facility	ĺ									45
	Other Long Term Care										46

COST ALLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	
								TO TO		
										_
		NON-			RESIDENTS	PARA-		INTERN &		
	OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
	GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
	(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
ANCILLARY SERVICE COST CENTERS										
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										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)					1	İ				89
90 Clinic		1								90
91 Emergency		†								91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93
93.99 Partial Hospitalization Program		1								93.99
75.77 I artial Hospitalization i Togram										93.9

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									ТО		
			NON-			RESIDENTS	PARA-		INTERN &		
		OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
		GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST	CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
		(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
	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
	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
	Unit cost multiplier (Worksheet B, Part I)										203
	Cost to be allocated (per Worksheet B, Part II)										204
	Unit cost multiplier (Worksheet B, Part II)										205
	NAHE adjustment amount to be allocated (per Wkst. B-2)										206
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										207

POST S	TEPDOWN ADJUSTMENTS	PROVIDER CCN:	PER FRO	IOD:		WORKSHEET B-2	
			TO				
				VORK	SHEET		
	DESCRIPTION				LINE NO.	AMOUNT	
	1			2	3	4	
1	Adjustment for EPO costs in Renal Dialysis cost center			1	74		1
2				1	94		2 3 4 5 6
3				1	74		3
				1	94		4
	Adjustment for ESA costs in Renal Dialysis cost center (see instructions)		_	1	74 94		5
	Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)		-	1	94		7
7			-				8
9			-				9
10							10
11							11
12							12
13			1				13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21			-				21
22			-				22
23 24			-				23 24
25			-				25
26			+				26
27							27
28							28
29							29 30
30							30
31							31
32							32
33							33
34							34 35
35							35
36 37			-				36 37
38			-				38
39			-				39
40			+		 		40
41			1		i e		41
42			1				42
43			1				42 43
44							44
45							45
46							46
47							47
48			₩				48
49			-				49
50 51			-				50 51
52			+		-		52
53			+				53
54			1				54
55			1				55
			1				56
56			_				57
56 57							31
							58

COMPU	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO _		WORKSHEET O	<u> </u>
COST	CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I,, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Dis- allowance 4	Total Costs 5	Inpatient 6	Charges Outpatient 7	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio	_
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)												30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
	Other Special Care (specify)	1											35
	Subprovider IPF	1											40
	Subprovider IRF												41
42	Subprovider (Specify)												42
	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
	Labor Room and Delivery Room												52
53	Anesthesiology												53
54	Radiology-Diagnostic												54
55	Radiology-Therapeutic												55
56	Radioisotope												56
	Computed Tomography (CT) Scan												57
	Magnetic Resonance Imaging (MRI)												58
	Cardiac Catheterization	1											59
60	Laboratory	1											60
61	PBP Clinical Laboratory Services-Prgm. Only							1					61
	Whole Blood & Packed Red Blood Cells	1											62
	Blood Storing, Processing, & Trans.	1											63
	Intravenous Therapy	1											64
	Respiratory Therapy												65
	Physical Therapy												66
	Occupational Therapy												67
	Speech Pathology	1											68

COMPUTATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I	С
	т т		ı	G .		1	CI		10			
	T + 1.0 +	TI.		Costs			Charges	T . 1	_	TEED 4	ppc	
GOOT GEVITED DEGCDIPTIONS	Total Cost	Therapy	T . 1	RCE	m . 1			Total		TEFRA	PPS	
COST CENTER DESCRIPTIONS	(from Wkst. B,	Limit	Total	Dis-	Total			(column 6	Cost or	Inpatient	Inpatient	
	Part I., col. 26)	Adj.	Costs	allowance	Costs	Inpatient	Outpatient	+ column 7)	Other Ratio	Ratio	Ratio	
	1	2	3	4	5	6	7	8	9	10	11	
69 Electrocardiology												69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients												7:
72 Implantable Devices Charged to Patients												72
73 Drugs Charged to Patients												73
74 Renal Dialysis												74
75 ASC (Non-Distinct Part)												7:
76 Other Ancillary (specify)												70
77 Allogeneic HSCT Acquisition												7'
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												9
92 Observation Beds (see instructions)												92
93 Other Outpatient Service (specify)						1						9:
93.99 Partial Hospitalization Program				1		†						93.9
OTHER REIMBURSABLE COST CENTERS												75.57
94 Home Program Dialysis												9.
95 Ambulance Services												9:
96 Durable Medical Equipment-Rented												90
97 Durable Medical Equipment-Sold												9'
98 Other Reimbursable (specify)				-		+			1			9
99 Outpatient Rehabilitation Provider (specify)						+						99
100 Intern-Resident Service (not appvd. tchng. prgm.)						1						10
100 Intern-Resident Service (not appvd. icnng. prgm.)												
101 Home Health Agency												10
102 Opioid Treatment Program												10:
SPECIAL PURPOSE COST CENTERS												- 10
105 Kidney Acquisition												10:
106 Heart Acquisition												100
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition						ļ						109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112
115 Ambulatory Surgical Center (Distinct Part)						1						11:
116 Hospice												11
117 Other Special Purpose (specify)												11
200 Subtotal (see instructions)												20
201 Less Observation Beds												20
202 Total (see instructions)												20

					(
CALCULATION OF OUTPATE	ENT SERVICE COST	T TO	PROVIDER CCN:	PERIOD:	WORKSHEET C,
CHARGE RATIOS NET OF RE	DUCTIONS FOR MI	EDICAID ONLY		FROM	PART II
				ТО	
Check applicable box:	[] Title V	[] Title XIX			

(Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
	ANCILLARY SERVICE COST CENTERS	1	Z	3	4	3	0	/		-
50	Operating Room									50
	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Prgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78

1070 (Cont.)			1 Oldvi Civis 233	2 10				12 2.
CALCULATION OF OUTPATI	IENT SERVICE COST	ГО			PROVIDER CCN:	PERIOD:	WORKSHEET C.	
CHARGE RATIOS NET OF RE	EDUCTIONS FOR MED	ICAID ONLY				FROM	PART II (CONT.)	
						ТО		
Check applicable box:	[] Title V	[] Title XIX						

	.	Total Cost	Capital Cost (Wkst B,	Operating Cost Net of		Operating Cost	Cost Net of Capital and	Total Charges	Outpatient Cost	$\overline{\mathbf{I}}$
	Cost Center Descriptions	(Wkst. B,	Part II,	Capital Cost	Capital	Reduction	Operating Cost	(Worksheet C,	to Charge Ratio	
		Part I, col. 26)	col. 26)	(col. 1 - col. 2)	Reduction	Amount	Reduction	Part I, column 8)	(col. 6 ÷ col. 7)	
		1	2	3	4	5	6	7	8	
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds (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
	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
	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
	Other Special Purpose (specify)									117
	Subtotal (sum of lines 50 through 199)									200
201	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

	FIONMENT OF INPATIENT ROUT TE CAPITAL COSTS		PROVIDER CCN:		PERIOD: FROM		WORKSHEET D, PART I			
Check [] Title V [] Hospital applicable [] Title XVIII, Part A [] PARHM Demonstration boxes: [] Title XIX			monstration	[] PPS [] TEFRA						
	• • • • • • • • • • • • • • • • • • • •		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS		1	2	3	4	5	6	7	
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

1070	(Cont.)	1 (JICINI CIVID 2332	10			01 23	
APPOR	TIONMENT OF INPATIENT ANCILLARY		PROVIDER CCN:	PERIOD:	WORKSHEET D			
SERVIC	E CAPITAL COSTS			FROM PART II				
				COMPONENT CCN:	то			
Check	[] Title V [] Hospita			[] PPS				
applicab		nonstration	[] TEFRA					
boxes:	[] Title XIX [] IRF	Capital	T				т —	
		Related Cost	Total Charges	Ratio of Cost	Inpatient			
		(from Wkst. B	(from Wkst. C,	to Charges	Program	Capital Costs		
		Part II, col. 26)	Pt .I, col. 8)	(col .1 ÷ col. 2)	Charges	(col. 3 x col. 4)		
(A)	Cost Center Description	1	2	3	4	5	+	
()	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	
	Physical Therapy						66	
67	Occupational Therapy						67	
68	Speech Pathology						68	
69	Electrocardiology						69	
	Electroencephalography						70	
71	Medical Supplies Charged to Patients						71	
72	Implantable Devices Charged to Patients						72	
73 74	Drugs Charged to Patients Renal Dialysis						73 74	
75	ASC (Non-Distinct Part)						75	
76	Other Ancillary (specify)						76	
77	Allogeneic HSCT Acquisition						77	
	CAR T-Cell Immunotherapy						78	
	OUTPATIENT SERVICE COST CENTERS						76	
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 100)		· · · · · · · · · · · · · · · · · · ·			1	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 applicab boxes:	ole	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] PARHM Der	monstration		[] 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 I	Description ROUTINE SERVICE COST CENTERS	1A	1	2A	2	3	4	5	6	7	8	9	
30	Adults & Ped	diatrics												30
31	Intensive Car	re Unit												31
32	Coronary Ca	re Unit												32
33	Burn Intensi	ve Care Unit												33
34	Surgical Inte	ensive Care Unit												34
35	Other Specia	al Care Unit (specify)												35
40	Subprovider	IPF												40
41	Subprovider	IRF												41
42	Subprovider	(Other)												42
43	Nursery													43
44	Skilled Nurs	ing Facility												44
45	Nursing Faci	ility												45
200	Total (sum o	f lines 30 through 199)												200

⁽A) Worksheet A line numbers

	IONMENT OF INPATIENT/OUTF E OTHER PASS-THROUGH COST							PROVIDER CCN:	PERIOD:	WORKSHEET D, PART IV	
SERVICE	E OTHER PASS-THROUGH COS	18							FROM	PARTIV	
								COMPONENT CCN:	10		
Check applicable boxes:	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed S	NF	[] PARHM Demon		[] 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		l	2A	2	3A	3	4	5	6	
-	ANCILLARY SERVICE COST CE	NTERS									
	Operating Room										50
	Recovery Room										51
52	Labor room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)								 	58
	Cardiac Catheterization	,								 	59
	Laboratory									 	60
	PBP Clinical Laboratory ServPrgn	- Only									61
	Whole Blood & Packed Red Blood										62
	Blood Storing, Processing, & Trans	fusing								<u> </u>	63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged To Paties	nts									71
72	Implantable Devices Charged to Pat	ients									72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)									1	75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy									 	78
	OUTPATIENT SERVICE COST C	ENTERS									,,0
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (I	EOLIC)	+							 	89
	Clinic	rQIIC)	+							 	90
			1							 	
	Emergency										91
	Observation Beds									_	92
	Other Outpatient Service (specify)		ļ								93
93.99	Partial Hospitalization Program				1		ĺ	1	1	1	93.99

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

⁽A) Worksheet A line numbers

	ONMENT OF INPATIENT/OUTP. OTHER PASS THROUGH COST							PROVIDER CCN:	PERIOD: FROM	WORKSHEET D, PART IV (Cont.)	
								COMPONENT CCN:	то	-	
Check applicable boxes:	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed SI	NF	[] PARHM Demons		[] PPS [] TEFRA [] Other				
				Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description			7	8	9	10	11	12	13	
	NCILLARY SERVICE COST CE	NTERS									
	perating Room										50
	ecovery Room										51
	Pelivery Room and Labor Room										52
	nesthesiology										53
	adiology-Diagnostic										54
	adiology-Therapeutic										55
	adioisotope										56
	omputed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI))									58
	ardiac Catheterization										59
	aboratory	2.1									60
	BP Clinical Laboratory ServPrgm										61
	Vhole Blood & Packed Red Blood										62
	lood Storing, Processing, & Transf ntravenous Therapy	using									63 64
	espiratory Therapy										65
	hysical Therapy										66
	occupational Therapy				-			+		+	67
	peech Pathology										68
	lectrocardiology										69
	lectroencephalography										70
	fedical Supplies Charged To Patien	ite									71
	nplantable Devices Charged to Pati										72
	rugs Charged to Patients										73
	enal Dialysis										74
	SC (Non-Distinct Part)										75
	other Ancillary (specify)										76
	Illogeneic HSCT Acquisition										77
	AR T-Cell Acquisition										78
	UTPATIENT SERVICE COST CE	ENTERS									
88 R	ural Health Clinic (RHC)										88
89 F	ederally Qualified Health Center (F	QHC)									89
90 C	linic										90
91 E	mergency										91
92 O	bservation Beds										92
93 O	ther Outpatient Service (specify)										93
02.00 D	- sti-1 II - suit-1i-sti-su Document										02.00

	NMENT OF INPATIENT/OUTP THER PASS THROUGH COST							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	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 S	NF	[] PARHM Demons		[] 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	
OT	HER REIMBURSABLE COST	CENTERS									
	me Program Dialysis										94
95 An	bulance Services										95
	rable Medical Equipment-Rented	l									96
97 Du	rable Medical Equipment-Sold										97
98 Otl	ner Reimbursable (specify)	_									98
200 To	al (sum of lines 50 through 199)	_							·		200

⁽A) Worksheet A line numbers

4090 (C	Cont.)			FO	RM CMS-255	52-10					07-23
APPORT	ONMENT OF MEDICAL AND OT	HER				PROVIDER CCN		PERIOD		WORKSHEET D	,
HEALTH	SERVICES COSTS					COMPONENT CO	CN:	FROM _ TO		PART V	
Check applicable boxes:	[] Title V - O/P [] Title XVIII, Part B [] Title XIX - O/P	[] Hospital [] IPF [] IRF	I	[] Subprovides [] SNF [] NF	r (Other)	[] Swing-Bed SN [] Swing-Bed NI [] ICF/IID			RHM Demonstration		
PART V -	APPORTIONMENT OF MEDICAL	AND OTHER	HEALTH SERVI	CES 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.)		vices ee	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	5	6	7	
	ANCILLARY SERVICE COST CEN	TERS									50
	Operating Room Recovery Room										50 51
	Labor & Delivery Room										52
_	Anesthesiology										53
54	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan Magnetic Resonance Imaging (MRI)										57 58
	Cardiac Catheterization										59
_	Laboratory										60
	PBP Clinical Laboratory ServPrgm.	Only									61
62	Whole Blood & Packed Red Blood C	ells									62
	Blood Storing, Processing, & Transfu	sing									63
	Intravenous Therapy										64
	Respiratory Therapy Physical Therapy										65 66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged To Patients										71
	Implantable Devices Charged to Patie	nts									72
	Drugs Charged to Patients Renal Dialysis										73 74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
77	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	DUTPATIENT SERVICE COST CEN	NTERS									00
	Rural Health Clinic (RHC) Federally Qualified Health Center (FQ	OHC)									88 89
	Clinic	(IIC)									90
91	Emergency										91
92	Observation Bed										92
	Other Outpatient Service (specify)										93
	Partial Hospitalization Program	ENTERG									93.99
	OTHER REIMBURSABLE COST CI Home Program Dialysis	ENTERS									94
_	Ambulance				 						95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable Cost Center										98
	Subtotal (see instructions)										200
	Less PBP Clinic Lab. Services-Progra	ım			I						201
	Only Charges Net Charges (line 200 - line 201)										202
202	rece Charges (line 200 - line 201)				I						202

07-23			FURINI CIVIS-2332	2-10		4090 (Cont.)
COMPU	TATION OF INPATIENT			PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERA'	TING COST				FROM	PART I	
				COMPONENT CCN:	TO		
Check	Title V - I/P	[] Hospital	[] NF		[] PPS	•	
applicab		[] IPF	[] ICF/IID		[] TEFRA		
boxes:	Title XIX - I/P	[] IRF	PARHM Demonstration		[] Other		
00.100.	[]	[] Subprovider (other)	[] Trading Demonstration		[] Galler		
		[] SNF					
PART I	- ALL PROVIDER COMPONENTS	[] 5141					
1711(1 1	INPATIENT DAYS						
1	Inpatient days (including private room	days and swing-hed days exclud	ing newborn)				1
2	Inpatient days (including private room of		,				2
3	Private room days (excluding swing-be		• /	not complete this line			3
4	Semi-private room days (excluding swing se			s not complete uns mic.			4
5	Total swing-bed SNF type inpatient day	•	·	enorting period			5
6	Total swing-bed SNF type inpatient day		·				6
Ü	calendar year, enter 0 on this line)	ys (merading private room days) t	and Beechider 31 of the cost repo	ring period (ii			
7	Total swing-bed NF type inpatient days	s (including private room days) th	rough December 31 of the cost ret	porting period			7
- 8	Total swing-bed NF type inpatient days						8
Ü	calendar year, enter 0 on this line)	(merading private room days) ar	ter Beccineer 31 of the cost report	ting period (ii			
9	Total inpatient days including private ro	oom days applicable to the Progra	am (excluding swing-hed and new	horn days) (see instructions)			9
10	Swing-bed SNF type inpatient days app						10
10	cost reporting period (see instructions)	•	mig private room days) unough Do	ecember 31 of the			10
11	Swing-bed SNF type inpatient days app		ding private room days) after Deco	ember 31 of the			11
- 11	cost reporting period (if calendar year,	•	mig private room days) arter Beec	ember 51 of the			- 11
12	Swing-bed NF type inpatient days appli		cluding private room days) through	December 31 of			12
12	the cost reporting period.	teacte to titles v or 71171 only (inc	rading private room days) amough	1 Beccinioci 31 01			12
13	Swing-bed NF type inpatient days appli	icable to titles V or YIV only (inc	cluding private room days) after D	ecember 31 of the			13
13	cost reporting period (if calendar year,		rading private room days) area by	ecember 31 of the			13
14	Medically necessary private room days		ding swing-hed days)				14
15	Total nursery days (title V or XIX only)		ding swing bed days)				15
16	Nursery days (title V or XIX only)	,					16
10	SWING BED ADJUSTMENT					<u>.</u>	10
17	Medicare rate for swing-bed SNF servi	ces applicable to services through	h December 31 of the cost reporting	og period			17
18	Medicare rate for swing-bed SNF servi						18
19	Medicaid rate for swing-bed NF service	11	1 01				19
20	Medicaid rate for swing-bed NF service	11					20
21	Total general inpatient routine service of	* *					21
22	Swing-bed cost applicable to SNF type		of the cost reporting period (line 5	x line 17)			22
23	Swing-bed cost applicable to SNF type						23
24	Swing-bed cost applicable to NF type s						24
25	Swing-bed cost applicable to NF type s			<u> </u>			25
26	Total swing-bed cost (see instructions)			•			26
27	General inpatient routine service cost n	et of swing-bed cost (line 21 min	ius line 26)				27
	PRIVATE ROOM DIFFERENTIAL A						
28	General inpatient routine service charge		ervation bed charges)				28
29	Private room charges (excluding swing		· · · · · · · · · · · · · · · · · · ·				29
30	Semi-private room charges (excluding	swing-bed charges)					30
31	General inpatient routine service cost/c	<u> </u>					31
32	Average private room per diem charge	(line 29 ÷ line 3)					32
33	Average semi-private room per diem ch	7					33
34	Average per diem private room charge	differential (line 32 minus line 33	3) (see instructions)				34
35	Average per diem private room cost dif						35
36	Private room cost differential adjustmen						36
37	Canaral innatiant routing carving cost n		room cost differential (line 27 min	us line 26)		i	37

COMPUTATION OPERATING COS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-1, PART II	
0121011110 000	•				COMPONENT CCN			
Check	[] Title V - I/P	[] Hospital	[] PARH!	M Demonstration	[] PPS	1		
applicable	Title XVIII, Part A	[] IPF	[] Tritein	vi Demonstration	[] TEH			
boxes:	Title XIX - I/P	[] IRF			[] Oth			
		[] Subprovider (oth	er)					
PART II - HOSPIT	AL AND SUBPROVIDERS ONLY		,					
	M INPATIENT OPERATING COST B	EFORE						
PASS-TH	ROUGH COST ADJUSTMENTS						1	
38 Adjusted	general inpatient routine service cost per	diem (see instructions)						38
39 Program g	general inpatient routine service cost (lin	e 9 x line 38)						39
40 Medically	necessary private room cost applicable	to the Program (line 14)	x line 35)					40
41 Total Prog	gram general inpatient routine service co	ost (line 39 + line 40)						41
					Average			
			Total	Total	Per Diem	Program	Program Cost	
			Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2)	Days	(col. 3 x col. 4)	
			1	2	3	4	5	
	itle V & XIX only)							42
	Care Type Inpatient							
Hospital U								$\overline{}$
43 Intensive								43
44 Coronary								44
	nsive Care Unit							45
	ntensive Care Unit							46
47 Other Spe	cial Care Unit (specify)							47
							1	
	npatient ancillary service cost (Workshe							48
	npatient cellular therapy acquisition cos							48.01
49 Total Pro	gram inpatient costs (sum of lines 41 thr	ough 48.01) (see instruc	ctions)					49
DAGG TIT	DOLIGH GOST ADMISTATIVES							
	ROUGH COST ADJUSTMENTS Igh costs applicable to Program inpatien	t navitina samilaas (fuam 1	Wantahaat D. aum of Dan	to Lond III)			1	50
	igh costs applicable to Program inpatien							51
	gram excludable cost (sum of lines 50 ar		i worksheet D, suili of 1 a	its ii aliu iv)				52
	gram inpatient operating cost excluding	,	cian anesthetist, and med	ical education costs (li	ne 49 minus line 52)			53
	5		,	(, , _,			
TARGET	AMOUNT AND LIMIT COMPUTATI	ON						
54 Program o								54
	ount per discharge							55
	t adjustment amount per discharge							55.01
	nt amount per discharge (contractor use	only)						55.02
56 Target am	ount (line 54 x sum of lines 55, 55.01, a	and 55.02)						56
57 Difference	e between adjusted inpatient operating c	ost and target amount (li	ne 56 minus line 53)					57
58 Bonus pay	yment (see instructions)							58
	osts (lesser of line 53 ÷ line 54, or line				by the market basket)			59
	costs (lesser of line 53 ÷ line 54, or line							60
	us improvement bonus payment (if line 5							61
	which operating costs (line 53) are less	than expected costs (lin	es 54 x 60), or 1 % of the	target amount (line 56)	, otherwise enter zero. (see instructions)		<u> </u>
	ment (see instructions)							62
63 Allowable	Inpatient cost plus incentive payment	(see instructions)						63
	M INPATIENT ROUTINE SWING BE							
	swing-bed SNF inpatient routine costs t	hrough December 31 of	the cost reporting period	(see instructions)				64
(title XVI	¥7							
	swing-bed SNF inpatient routine costs a	after December 31 of the	cost reporting period (se	e instructions)				65
(title XVI								<u> </u>
	licare swing-bed SNF inpatient routine							66
	XIX swing-bed NF inpatient routine co							67
	XIX swing-bed NF inpatient routine co			(line 13 x line 20)			-	68
69 Total title	V or XIX swing-bed NF inpatient routi	ne costs (line 6/ + line 6	0)				1	69

01-22		FORM CMS-255	2-10		4090 (Cont.)
COMPU	JTATION OF INPATIENT		PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERA	TING COST		GOV MONENE GOV	FROM	PARTS III & IV	
			COMPONENT CCN:	ТО		
Check applicab boxes:	[] Title XIX - I/P [] IRF	[] SN [] NF [] ICH		[] PPS [] TEFRA [] Other		
PART II	II - SNF, NF, AND ICF/IID ONLY	ier (Other)	<u>L</u>			
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	e 14 x line 35)				73
74	Total Program general inpatient routine service costs (line 72 + lin	ne 73)				74
75	Capital-related cost allocated to inpatient routine service costs (fro	om Worksheet B, Part II, colu	amn 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	r records)				79
80	Total Program routine service costs for comparison to the cost lim	nitation (line 78 minus line 79	9)			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 8	85)				86
PART I	V - COMPUTATION OF OBSERVATION BED PASS-THROUG	SH COST				ı
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				
		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)	
		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	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,
	SERVICES RENDERED BY		FROM	PARTS I-III
	INTERNS AND RESIDENTS		TO	

Con Centers Accepted Time Application		- NOT IN APPROVED TEACHING PROGRAM	Percent of	Expense	Total Inpatient Days	
1 Total cost of services rendeced 100,000 2 3 100,000 2 3 100,000 2 3 100,000 3 100,00		Cost Centers		-		
1 Total cort of services rendered		Cost Centers	Assigned Time			
Hospital Inputier Resilies Services	1	Total cost of services rendered	100.00		J	
2						
1	2	1 1				:
5 Burn Intensive Care Unit	3					
6 Surgical Intensive Care Unit 7 Older Special Care (specify)	4					
6 Surgical Intensive Care Unit 7 Older Special Care Open(9) 8 Numery 9 Subtead (sem of lines 2 through 8) 10 IPF - Inputitient routine service 11 Subprovider (Other) - Inputitient outine service 12 Subprovider (Other) - Inputitient outine service 13 Subprovider (Other) - Inputitient outine service 14 Numery Earlisy 15 Other Long Facility 16 Numery Earlisy 17 Outpetient Resultine Providers 18 Hone Health Agency 18 Outpetient Resultine Providers 19 Outpetient Resultine Providers 19 Outpetient Resultine Providers 19 Outpetient Resultine Providers 19 Outpetient Resultine Providers 19 Outpetient Resultine Services 19 Outpetient Resultine Services 10 Outpetient Resultine Services 10 Outpetient Resultine Services 10 Outpetient Resultine Services 10 Outpetient Resultine Service (specify) 10 Outpetient Resultine Service (specify) 11 Outpetient Resultine Service (specify) 12 Substant Gunn of lines 9 through 26) 13 Outpetient Resultine Service (specify) 14 Energency 15 Observation beda 16 Outpetient Resultine Service (specify) 16 Outpetient Resultine Service (specify) 17 Substant Gunn of lines 20 and 27 Introduction Service (specify) 18 Outpetient Resultine Service (specify) 19 Substant Gunn of lines 20 and 27 Introduction Service (specify) 20 Adults & Pediatrisis (specient countries care) 21 Resulting Control of lines 20 and 27 Introduction Service (specify) 22 Substant Gunn of lines 20 and 27 Introduction Service (specify) 23 Substant Gunn of lines 20 and 27 Introduction Service (specify) 24 Entropy of the Service (specify) 25 Outpetient Service (specify) 26 Outpetient Service (specify) 27 Substant Gunn of lines 20 and 20 Introduction Service (specify) 28 Substant Gunn of lines 20 and 20 Introduction Service (specify) 29 Adults & Pediatrisis (special Care Openity Introduction Service (specify) 30 Substant Gunn of lines 20 and 20 Introduction Service (specify) 31 Substant Gunn of lines 20 and 20 Introduction Service (specify) 32 Substant Gunn of lines 20 and 20 Introduction Service (specify) 33 Substant Gunn of lines 20	5	Burn Intensive Care Unit				
8 Nurcery Subroal (sam of lines 2 through 8) Subroal (sam of lines 2 through 20) Subroal (sam of lines 2 th	6					
8 Nurcery Subroal (sam of lines 2 through 8) Subroal (sam of lines 2 through 20) Subroal (sam of lines 2 th	7	Other Special Care (specify)				,
10 IP - Inputient routine service	8					
11 IR - Inguisitent routine service	9	Subtotal (sum of lines 2 through 8)				
12 Subprovider (Other) - Impatient routine service	10	IPF - Inpatient routine service				10
13 Skilled Nursing Facility	11	IRF - Inpatient routine service				1
14 Nursing Facility	12	Subprovider (Other) - Inpatient routine service				13
15 Home Flath Agency	13	Skilled Nursing Facility				1.
16 Home Health Agency	14	Nursing Facility				14
17 Outpatient Rehabilitation Providers	15					1:
18 Ambulatory Surgical Center	16					10
18 Ambulatory Surgical Center	17	Outpatient Rehabilitation Providers				1'
Subtotal (sum of lines 9 through 19)	18					1
Hospital Outpatient Services:	19	Hospice				19
Hospital Outpatient Services: Crim Wist. C, Pt. 1, col. 8, lines 88 Col. 1, col. 8, lines 89 Col. 1, col. 8, lines 89 Col. 1, col. 8, lines 93 Col. 1, col. 8, lines 93 Col. 1, col. 8, lines 93 Col. 1, col. 8, lines 94 Col. 1, col. 9, line 94 Col. 9, line 94 Col. 9, line 94 Col. 9, line 10 Co	20	Subtotal (sum of lines 9 through 19)				20
Hospital Outpatient Services:						
Hospital Outpatient Services:					(from Wkst. C, Pt. I,	
Rural Health Clinic (RHC)					col. 8, lines 88	
Federally Qualified Health Center (FQHC)		Hospital Outpatient Services:			through 93)	
Clinic Emergency	21	Rural Health Clinic (RHC)				2
25	22	Federally Qualified Health Center (FQHC)				2.
25 Observation beds	23	Clinic				2:
26		Emergency				24
27 Substal (sum of lines 20 and 27) 100.00						2:
28 Total (sum of lines 20 and 27) 100.00						2
ART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wsts. B, Pt. 1 cols. 21 and 22 Amount (col. 1 plus col. 2)		Subtotal (sum of lines 21 through 26)				
Expenses Allocated to cost centers on Wisst. B, Pt. 1 cols. 21 and 22 Amount (col. 1 plus col. 2)						2
Net Cost Net Cost College Net Cost College C		Total (sum of lines 20 and 27)				2
Net Cost Cool. 2 and 22		Total (sum of lines 20 and 27)	TNE COSTS ONLY)			
No. No.		Total (sum of lines 20 and 27)	INE COSTS ONLY) Expenses Allocated			
Hospital Inpatient Routine Services: 1 2 3 3 3 3 3 3 4 3 3 5 4 3 4 3 4 3 4 3 4 3 4 4		Total (sum of lines 20 and 27)	Expenses Allocated to cost centers	G : D1	Neg	
29 Adults & Pediatrics (general routine care)		Total (sum of lines 20 and 27)	Expenses Allocated to cost centers on Wkst. B, Pt. I			
30 Swing Bed - SNF		Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
31 Swing Bed - NF	ART I	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services:	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	29
32	29	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care)	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2:
33 Coronary care unit	29 30	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2:
34 Burn Intensive Care Unit	29 30 31	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	29
35 Surgical Intensive Care Unit 36 Other Special Care (specify)	29 30 31 32	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3.
36 Other Special Care (specify)	29 30 31 32 33	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3
37 Subtotal (sum of lines 29, and 32 through 36) 38 IPF - Inpatient routine service 9 1RF - Inpa	29 30 31 32 33 34	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3
38 IPF - Inpatient routine service	29 30 31 32 33 34 35	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3
39 IRF - Inpatient routine service	29 30 31 32 33 34 35 36	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify)	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3 3
Subprovider (Other)- Inpatient routine service	29 30 31 32 33 34 35 36 37	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36)	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3 3 3 3 3
ART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) ART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Not In Approved Teaching Program (from Part I) Amount	29 30 31 32 33 34 35 36 37 38	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3 3 3 3 3 3 3
Total (sum of lines 37 through 41) RRT III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED) Not In Approved Teaching Program (from Part I) Amount	29 30 31 32 33 34 35 36 37 38 39	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
Not In Approved Teaching Program (from Part I) Amount	29 30 31 32 33 34 35 36 37 38 39 40	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service Subprovider (Other)- Inpatient routine service	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 3 3 3 3 3 3 3 3 3 3 4
Not In Approved Teaching Program (from Part I) Amount	29 30 31 32 33 34 35 36 37 38 39 40	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility	Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	2 2 3 3 3 3 3 3 3 3 3 3 3 3 4 4 4 4 4 4
Hospital Col. 9, line 27 Total Hospital (sum of lines 43 and 44) Fig. 1 Fig. 1 Fig. 2 Fi	29 30 31 32 33 34 35 36 37 38 39 40 41 42	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount	(col. 1 plus col. 2)	2: 3: 3: 3: 3: 3: 3: 3: 3: 4: 4:
Hospital 1 2	29 30 31 32 33 34 35 36 37 38 39 40 41 42	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2	(col. 1 plus col. 2) 3	2:
43 Inpatient	29 30 31 32 33 34 35 36 37 38 39 40 41 42	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2 Not In Approve	(col. 1 plus col. 2) 3 d Teaching Program	2: 3: 3: 3: 3: 3: 3: 3: 3: 4: 4:
44 Outpatient col. 9, line 27 45 Total Hospital (sum of lines 43 and 44) col. 9, line 10 46 IPF - Inpatient routine service col. 9, line 10 47 IRF - Inpatient routine service col. 9, line 11 48 Subprovider (Other)- Inpatient routine service col. 9, line 12	29 30 31 32 33 34 35 36 37 38 39 40 41 42	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - SNF Intensive care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND III)	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2 Not In Approve	d Teaching Program Amount	2 2 3 3 3 3 3 3 3 3 3 3 3 3 4 4 4 4 4 4
45 Total Hospital (sum of lines 43 and 44) 46 IPF - Inpatient routine service 47 IRF - Inpatient routine service 48 Subprovider (Other)- Inpatient routine service 48 Subprovider (Other)- Inpatient routine service	29 30 31 32 33 34 35 36 37 38 39 40 41 42 ART I	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Not In Approve (from Part I)	d Teaching Program Amount	2 3 3 3 3 3 3 3 3 3 3 3 4 4 4 4
46 IPF - Inpatient routine service col. 9, line 10 47 IRF - Inpatient routine service col. 9, line 11 48 Subprovider (Other)- Inpatient routine service col. 9, line 12	29 30 31 32 33 34 35 36 37 38 39 40 41 42 ART I	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I Hospital Inpatient	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9	d Teaching Program Amount	2 3 3 3 3 3 3 3 3 4 4 4 4
47 IRF - Inpatient routine service col. 9, line 11 48 Subprovider (Other)- Inpatient routine service col. 9, line 12	29 30 31 32 33 34 35 36 37 36 40 41 42 4ART I	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I Inpatient Hospital Inpatient Outpatient	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9	d Teaching Program Amount	2 3 3 3 3 3 3 3 3 3 4 4 4 4 4
48 Subprovider (Other)- Inpatient routine service col. 9, line 12	29 30 31 32 33 34 35 36 37 38 39 40 41 42 42 ART I	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT) Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27	d Teaching Program Amount	22 33 33 33 33 33 33 44 44 44 44 44
	29 30 31 32 33 34 35 36 37 38 39 40 41 41 42 4ART I	Total (sum of lines 20 and 27) I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND III) Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27 col. 9, line 10	d Teaching Program Amount	2 2 2 3 3 3 3 3 3 3 3 3 3 3 4 4 4 4 4 4
77 Samed reasing 1 desired	29 30 31 32 33 34 35 36 37 38 39 40 41 42 42 47	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 10 col. 9, line 11	d Teaching Program Amount	2 2 3 3 3 3 3 3 3 3 3 4 4 4 4 4 4 4 4 4
	299 300 311 32 333 344 355 366 377 388 399 400 411 42 4ART I	Total (sum of lines 20 and 27) - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUT Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service Subprovider (Other)- Inpatient routine service Subprovider (Other)- Inpatient routine service	INE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22 1	Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 10 col. 9, line 11 col. 9, line 12	d Teaching Program Amount	2: 3: 3: 3: 3: 3: 3: 3: 3: 4: 4:

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

一	Average Cost	TEACHING PROGRAM Heal	th Care Program Inpatient	Davs	Title V	Title XVIII	Title XIX
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)
┢	4	5	6	7	8	9	10
1	-	J	0	,	0	,	10
_							
2							
3							
4							
5							
6							
7							
8							
9							
0							
1							
2							
3							
4							
.5							
6							
7							
8							
9							
20							
	n / 60		es V and XIX Outpatient		Tit	les V and XIX Outpatient	and
	Ratio of Cost		Title XVIII Part B Charge		TC:-1	Title XVIII Part B Cost	m'd
	to Charges	Title	Title XVIII	Title	Title	Title XVIII	Title
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX
21							
2							
23							
_							
25							
26 27							
28							
	IN AN APPROVED ?	FACHING PROGRAM	I (TITLE XVIII, PART B	INPATIENT ROUTIN	F COSTS ONLY)		
<u> </u>	IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	L. Term to The on in	(11122111111111111111111111111111111111	Expenses	L COBID GIALI)		
	Total	Average Cost	Title XVIII	Applicable			
	Inpatient Days -	Per Day	Part B	to Title XVIII			
	All Patients	(col. 3 ÷ col. 4)	Inpatient Days	(col. 5 x col. 6)			
H	4	5	6	7			
29	•		·	,			
30							
1							
32							
33							
34		1					
5		1					
6							
7							
8							
9							
0							
1							
2							
· III -	- SUMMARY FOR TI	TLE XVIII (TO BE CO	MPLETED ONLY IF BC		RE USED)		
	In Approved To	eaching Program	Total Title	XVIII Costs			
L	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)			
F	3	4	5	6			
F							
	line 37						
13	line 37						
13 14	line 37		line 22				
13 14	line 37		line 22 line 22				
13 14 15 16							
43 44 45 46 47 48	line 38		line 22				

INPATII	ENT ANCILLARY SERVICE	PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST A	PPORTIONMENT		FROM		
		COMPONENT CCN:	то		
Check	[] Title V [] Hospital [] SNF [] ICF/IID		[] PPS		
applicabl			[] TEFRA		
boxes:		I Swing-Bed SNF	[] Other		
	[] Subprovider (Other) [] Swing-Bed NF				
		Detie of Cost	Y	Itit D	
	COST CENTER DESCRIPTION	Ratio of Cost	Inpatient	Inpatient Program Costs	ı
(A)	COST CENTER DESCRIPTION	to Charges	Program Charges 2	(col. 1 x col. 2)	ł
	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	
	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 PDR Clinical Laboratory Services Press Only				60
62	PBP Clinical Laboratory Services-Prgm. Only 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
	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
	Other Ancillary (specify)				76
77	Allogeneic HSCT Acquisition				77
	CAR T-Cell Immunotherapy				78
	OUTPATIENT SERVICE COST CENTERS	ı	T	т	
	Rural Health Clinic (RHC)				88
	Federally Qualified Health Center (FQHC)			1	89
	Clinic				90
91	Emergency Observation Reds (see instructions)			 	91 92
92	Observation Beds (see instructions) Other Outpatient Service (specify)		 	 	92
	Partial Hospitalization Program			 	93.99
	OTHER REIMBURSABLE COST CENTERS				13.33
	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Noted 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		OPO CCN:	PERIOD: FROM TO	WORKSHEET D-4, PART I	
Check [] HEART [] LIVER [] PANCRI applicable box: [] KIDNEY [] LUNG [] INTEST.		ISLET			
PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT F	ROUTINE AND ANCILI	LARY SERVICES)			
	Inpatient		Organ		
Computation of Inpatient	Routine Organ	Per Diem Costs	Acquisition	Cost	
Routine Service Costs	Charges	(from Wkst. D-1, Part II) Days	(col. 2 x col. 3)	
Applicable to Organ Acquisition	1	D 2	3	4	1
1 Adults and Pediatrics		38			1

Comp	utation of Inpatient	Routine Organ		Per Diem Costs	Acquisition	Cost	
Routine Service Costs		Charges	(from Wkst. D-1, Part II)		Days	(col. 2 x col. 3)	
Appli	cable to Organ Acquisition	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
				Ratio of Cost	Organ	Organ	
				to Charges	Acquisition	Acquisition	

			Ratio of Cost	Organ	Organ	
			to Charges	Acquisition	Acquisition	
Compu	utation of Ancillary		(from	Ancillary	Ancillary	
Service	e Costs Applicable		Wkst. C)	Charges	Costs	
to Orga	an Acquisition	C	1	2	3	
	Operating Room	50				8
9	Recovery Room	51				9
10	Labor Room & Delivery Room	52				10
11	Anesthesiology	53				11
12	Radiology-Diagnostic	54				12
13	Radiology-Therapeutic	55				13
14	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

4090 (Cont.)		FOI	KWI CWI S- 2332	JMIS-2552-10					
COMPUTATION OF ORGAN ACQUISITION FOR A TRANSPLANT HOSPITAL WITH A				PROV	IDER CCN:	PERIOD: FROM	WORKSHEET D-4, PART II		
TRANSPLANT PROGRAM	r mad e			OPO	CCN:	то			
	LIVER LUNG	[] PANCREAS [] INTESTINE	[] ISLET				l		
PART II - COMPUTATION OF ORGAN AO ANCILLARY SERVICE COSTS)	EQUISITION CO	STS (OTHER THAN INPA	ATIENT ROUTINE A	AND					
Computation of the Cost of Inpatient Services of Interns and Residents Not			Average Cost Per Day (from Wkst. D-2,		Organ	Organ Acquisition Costs			
In Approved Teaching Program	,,			,	Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)		
42 Adults & Pediatrics (General routine	e care)			2	1	2	3	42	
43 Intensive Care Unit	care)			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	7)							48	

	Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program		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	1
49	Rural Health Clinic (RHC)		21			49
50	Federally Qualified Health Center (FQHC)		22			50
51	Clinic		23			51
52	Emergency		24			52
53	Observation Beds		25			53
54	Other Outpatient Service (specify)		26			54
55	TOTAL (sum of lines 49 through 54)			-		55

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

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03-23	FORM CN	MS-2552-10			4090) (Cont.)
COMPU	TATION OF ORGAN ACQUISITION COSTS AND CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR A	TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED			FROM	PARTS III & IV	
TRANS	PLANT PROGRAM		OPO CCN:	то		
Check	[]HEART []LIVER []PANCREAS	[] ISLET				
applicab		[]ISELI				
	II - SUMMARY OF COSTS AND CHARGES					
			Cost	C	harges	Т
		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 (see instructions)					61
				•	_	_
			Usable Organs			
		1	2	3	4	
62	Total usable organs (see instructions)					62
63	Medicare usable organs (see instructions)					63
64	Ratio of Medicare usable organs to total usable organs (see instructions)					64
		1	Cost	C	harges	_
		Part A	Part B	Part A	Part B	_
		ran A	2	3	4	-
65	Medicare Cost and Charges (see instructions)	1	2	,	+	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 I	V - STATISTICS					
			Living Related	Cadaveric	Revenue	
			1	2	3	
70	Organs excised in provider (1)					70
71	Organs purchased from other transplant hospitals (2)					71
72	Organs purchased from non-transplant hospitals					72
73	Organs purchased from OPOs (see instructions)					73
74	Total (sum of lines 70 through 73)					74
75	Organs transplanted					75
75.01	Organs transplanted into Medicare beneficiaries					75.01
75.02	Kidneys transplanted into MA beneficiaries					75.02
75.03	Organs transplanted, Medicare secondary payer				-	75.03
75.04	Organs transplanted, Other (see instructions)					75.04
76	Organs sold to other hospitals					76
77	Organs sold to OPOs				+	77
78 79	Organs sold to MRTC without an accomment on VA hospitals		-		+	78 79
79.01	Organs sold to MRTC without an agreement or VA hospitals Kidneys sold to MRTC with an agreement			+	+	79.01
79.01	Organs sold to MKTC with an agreement Organs sold outside the U.S.			+	+	79.01
81	Organs sort 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

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

APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART I			
Check at	pplicable box: [] Hospital Staff [] Medical Staff							
PART I	- REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS I	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	
I 1	General Practitioner Family Practice	3	4	5	6	/	8	
	Internal Medicine							+
	Surgery					+	+	+
3	Pediatrics				+	 	+	+
	Obstetrics-Gynecology					+	_	+
6	Radiology					+	_	+
7	Psychiatry					+	+	
8	Anesthesiology					+	+	—
	Pathology					 		
	All Other					+		10
	Total					+		1
		· ·		I.	- I			
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	
	General Practitioner Family Practice							
	Internal Medicine							
	Surgery							
	Pediatrics							4
	Obstetrics-Gynecology							
	Radiology							
	Psychiatry							<u> </u>
	Anesthesiology							
	Pathology					<u> </u>		<u> </u>
	All Other					<u> </u>		10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)	I	I	1			I	1 1

	NMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART II
neck plicable x:	[] Hospital [] IPF [] IRF	•		
ART II - A	PPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	L FOR COST REPORTING F	PERIODS ENDING BEF	ORE JUNE 30, 2014
		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)
1 I A	ljusted Cost of Physician's Direct Medical and Surgical Services	1	2	3
	tal Inpatient Days and Outpatient Visit Days			
	verage Per Diem (line 1 ÷ line 2)			
- 1	g((
HI	EALTH CARE PROGRAM REIMBURSABLE DAYS			
	tle V - Inpatient			
	tle V - Outpatient			
	tle XVIII - Part A			
	tle XVIII - Part B			
	tle XIX - Inpatient			
	tle XIX - Outpatient			
	patient and Outpatient Kidney Acquisition			
	patient and Outpatient Liver Acquisition			
	patient and Outpatient Heart Acquisition			
	patient and Outpatient Lung Acquisition			
	patient and Outpatient Pancreas Acquisition			
	patient and Outpatient Intestine Acquisition			
	patient and Outpatient Islet Acquisition			
17 Ot	her Organ Acquisition			
	EALTH CARE PROGRAM REIMBURSABLE COST	1	•	
	tle V - Inpatient (line 3 x line 4)			
	tle V - Outpatient (line 3 x line 5)			
	tle XVIII - Part A (line 3 x line 6)			
	tle XVIII - Part B (line 3 x line 7)			
	tle XIX - Inpatient (line 3 x line 8)			
	tle XIX - Outpatient (line 3 x line 9) patient and Outpatient Kidney Acquisition (line 3 x line 10)			
	patient and Outpatient Liver Acquisition (line 3 x line 11) patient and Outpatient Heart Acquisition (line 3 x line 12)			+
	patient and Outpatient Heart Acquisition (line 3 x line 12)		+	
	patient and Outpatient Lung Acquisition (line 3 x line 13) patient and Outpatient Pancreas Acquisition (line 3 x line 14)		1	+
	patient and Outpatient Pancreas Acquisition (line 3 x line 14) patient and Outpatient Intestine Acquisition (line 3 x line 15)		1	+
	patient and Outpatient Intestine Acquisition (line 3 x line 13)			+
	patient and Outpatient Siet Acquisition (line 3 x line 10)			+
J1 III	patient and outpatient other organ Acquisition (time 3 x time 17)		1	

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

JUCUT	Cont.)		1 Oldivi Civib-2332	-10					0)-1-
APPOR	FIONMENT :	OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-5, PART III	
							ТО		
PART II	I - REASON	ABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS I	ENDING ON OR AFTER	JUNE 30, 2014					
						Physician/		5 Percent	
	Wkst. A		Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
	Line #	Cost Center / Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	1
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total							200
		•	•	•		•	•	•	
			Cost of		Cost of			Adjust Cost	
			Membership	Professional	Physician	Professional		of Physician's	
	Wkst. A		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
	Line #	Cost Center / Physician Identifier	Education	Share of Column 11	Insurance	Share of Column 13	RCE Limit	Surgical Services	
	9	10	11	12	13	14	15	16	1
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

APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-5, PART IV
Check applicab box:	[] Hospital [] IPF [] IRF	•	1	
PART I	V - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPIT.	AL FOR COST REPORTING	PERIODS ENDING	G ON OR AFTER JUNE 30, 2014
	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				9
10				10
11	Inpatient and outpatient liver acquisition			11
12				12
13				13
14				14
15	Inpatient and outpatient intestine acquisition			15
16	Inpatient and outpatient 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				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		<u> </u>		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

Y ACQUISITION			M CMS-2552-10				04-2
Y ACQUISITION	COSTS			PROVIDER CCN:	PERIOD:	WORKSHEET D-6,	
-					FROM	PARTS I & II	
					ТО		
ILLARY SERVIC	ES CELI	LULAR THERAPY ACQU	JISITION COSTS	•		•	
Routine Services			Inpatient				T
Acquisition		Per Diem Costs	Acquisition	Acquisition Costs			
1	D-1	2	3	4	1		
	38		-				
	43						
	44						П
	45						
	46						П
	47						
							П
						•	
			Inpatient	Outpatient	Inpatient	Outpatient	T
		Ratio of Cost	Ancillary Services	Ancillary Services	Ancillary Services	Ancillary Services	1
		to Charges	Acquisition	Acquisition	Acquisition	Acquisition	
	(f				•	•	
		1	2		4		1
	50						1
	51						1
	52						
							1
							1
							1
							1
							1
	58						1
	59						1
	60						T
gram Only							1
							T
							T
8							1
							1
							1
							1
	75						1
	76						1
	90						1
	Routine Services Acquisition Charges 1 gram Only ells ssing	Routine Services Acquisition Charges 1 D-1 38 43 44 44 45 46 47	Routine Services Acquisition Per Diem Costs (see instructions)	Acquisition Per Diem Costs (see instructions) Days	Per Diem Costs Acquisition Acquisition Acquisition Costs (see instructions) Days (col. 2 x col. 3)	Routine Services Acquisition Charges Cost See instructions Charges Cost Routin Services Acquisition Charges Ch	

			Average Cost Per Day	Inpatient	Inpatient Part B		
			(from Wkst. D-2,	Acquisition	Acquisition Costs		
Inter	Interns and Residents Not in Approved Teaching		Pt. I, col. 4)	Days	(col. 1 x col. 2)		
Prog	ram Acquisition Costs	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

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

PART IV - STATISTICS

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SETTLEM Check app	ATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
Check ann	MENT		FROM	PART A	
Check app		COMPONENT CCN:	то		
	plicable box: [] Hospital [] PARHM Demonstration				
	- INPATIENT HOSPITAL SERVICES UNDER IPPS				
	DRG amounts other than outlier payments				1
1.01 D	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02 D	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1.02
1.03 D	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instr			1.03	
1.04 D	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see in	structions)			1.04
	Outlier payments for discharges (see instructions)				2
	Outlier reconciliation amount				2.01
	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
	Outlier payments for discharges occurring prior to October 1 (see instructions)				2.03
	Outlier payments for discharges occurring on or after October 1 (see instructions)				2.04
	Annaged care simulated payments				3
	Bed days available divided by number of days in the cost reporting period (see instructions) ndirect Medical Education Adjustment Calculation for Hospitals				4
	TE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/3	1/1006 (see instructions)			5
	TE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)	1/1990 (see ilistructions)			5.01
	TE 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
	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 202		113.77(0)		6.26
	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)	21 (bee instructions)			7
	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report s	traddles July 1, 2011, see	instructions.		7.01
	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with				7.02
	programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				
	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in	accordance			8
	vith 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				
8.01 T	he amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddle	es July 1, 2011, see instru	ctions.		8.01
8.02 T	2 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)				
8.21 T	1 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				8.21
9 S	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus	s/minus line 8,			9
	dus lines 8.01 through 8.27 (see instructions)				
	TE count for allopathic and osteopathic programs in the current year from your records				10
	TE count for residents in dental and podiatric programs				11
	Current year allowable FTE (see instructions)				12
	Total allowable FTE count for the prior year				13
	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter	r zero.			14
	Sum of lines 12 through 14 divided by 3				15 16
	Adjustment for residents in initial years of the program (see instructions) Adjustment for residents displaced by program or hospital closure				17
	Adjusted rolling average FTE count				18
	Current year resident to bed ratio (line 18 divided by line 4)				19
	Prior year resident to bed ratio (see instructions)				20
	Enter the lesser of lines 19 or 20 (see instructions)				21
	ME payment adjustment (see instructions)				22
	ME payment adjustment - Managed Care (see instructions)				22.01
	ndirect Medical Education Adjustment for the Add-on for §422 of the MMA			•	•
	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).				23
	ME FTE resident count over cap (see instructions)				24
25 If	f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
	Resident to bed ratio (divide line 25 by line 4)				26
27 IN	ME payments adjustment factor (see instructions)				27
	ME add-on adjustment amount (see instructions)				28
28 IN	ME add-on adjustment amount - Managed Care (see instructions)				28.01
28.01 IN	Total IME payment (sum of lines 22 and 28)				29
28.01 IN 29 To					
28.01 IN 29 To 29.01 To	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
28.01 IN 29 To 29.01 To D	Otal IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment				
28.01 IN 29 To 29.01 To D 30 Po	Otal IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30
28.01 IN 29 To 29.01 To D 30 Po 31 Po	Otal IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions)				30 31
28.01 IN 29 To 29.01 To D 30 Po 31 Po 32 So	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Sum of lines 30 and 31				30 31 32
28.01 IN 29 To 29.01 To 30 Po 31 Po 32 So 33 A	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Form of lines 30 and 31 Mlowable disproportionate share percentage (see instructions)				30 31 32 33
28.01 IN 29 T: 29.01 T: 30 P: 31 P: 32 S: 33 A 34 D	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Form of lines 30 and 31 Unlowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)		Prior to October 1	On or after October 1	30 31 32
28.01 IN 29 T: 29.01 T: D: 30 P: 31 P: 32 S: 33 A: 34 D: Ut	Cotal IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Sum of lines 30 and 31 Unlowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Incompensated Care Payment Adjustment		Prior to October 1	On or after October 1	30 31 32 33 34
28.01 IN 29 To 29.01 To 30 Po 31 Po 32 So 33 A 34 D U1 35 To	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Usum of lines 30 and 31 Usum of lines are adjustment (see instructions) Disproportionate share adjustment (see instructions) Incompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		Prior to October 1	On or after October 1	30 31 32 33 34 35
28.01 IN 29 To 29.01 To 30 Po 31 Po 32 So 33 A 34 D Un 35 To 35.01 Fo	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Form of lines 30 and 31 Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Incompensated Care Payment Adjustment Total uncompensated care amount (see instructions) Forctor 3 (see instructions)		Prior to October 1	On or after October 1	30 31 32 33 34 35 35 35.01
28.01 IN 29 T 29.01 T D 30 P 31 P 32 S 33 A 34 D U 35 T 35.01 F 35.02 H	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patien		Prior to October 1	On or after October 1	30 31 32 33 34 35 35.01 35.02
28.01 IN 29 T. 29.01 T. 29.01 T. D 30 P. 31 P. 32 S. 33 A 34 D U1 35.01 F. 35.02 H 35.03 P.	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Put of lines 30 and 31 Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Proportionate Share adjustment (see instructions) Proportionate Share adjustment Total uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions) Proportionate Share adjustment (see instructions)		Prior to October 1	On or after October 1	30 31 32 33 34 35 35.01 35.02 35.03
28.01 IN 29 Tr 29.01 T D 30 Pr 31 Pr 32 Si 33 A 34 D Ur 35 T 35.01 Fr 35.03 Pr 35.04 Pr	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days to total patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patient days (see instructions) Percentage of Medicaid patien		Prior to October 1	On or after October 1	30 31 32 33 34 35 35.01 35.02

07-23	FORM CMS-2332-10			4090	(Cont.)
CALCU	JLATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
	EMENT		FROM	PART A (Cont.)	
		COMPONENT CCN:	то		
		COMI ONLIVI CCIV.	10		
Cl l	I I Hawisal I I BARIM Demonstration				
	applicable box: [] Hospital [] PARHM Demonstration				
PARI	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)				
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
	Total Medicare discharges (see instructions)				40
	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
	Total payment for inpatient operating costs (see instructions)				49
	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)				50
	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).				52
	Nursing and allied health managed care payment				53
	Special add-on payments for new technologies				54
					54.01
-	Islet isolation add-on payment				
55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)				55
	Cellular therapy acquisition cost (see instructions)				55.01
56	Cost of physicians' services in a teaching hospital (see instructions)				56
	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
	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
70.75	N95 respirator payment adjustment amount (see instructions)				70.75
	Demonstration payment adjustment amount before sequestration				70.87
	SCH or MDH volume decrease adjustment (contractor use only)				70.88
	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
	HSP bonus payment HVBP adjustment amount (see instructions)				70.90
	HSP bonus payment HRR adjustment amount (see instructions)				70.91
-	Bundled Model 1 discount amount (see instructions)				70.92
	HVBP payment adjustment amount (see instructions)				70.93
	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)				_
	Low volume adjustment for federal fiscal year (yyyy)				70.97
	HAC adjustment amount (see instructions)				70.99
	Amount due provider (see instructions)				71
	Sequestration adjustment (see instructions)			_	71.01
	Demonstration payment adjustment amount after sequestration				71.02
71.03	Sequestration adjustment-PARHM pass-throughs				71.03
	Interim payments				72
	Interim payments-PARHM				72.01
73	Tentative settlement (for contractor use only)				73
	Tentative settlement-PARHM (for contractor use only)				73.01
	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)				74
74.01	Ralance due provider/program-PARHM (see instructions)	·	·	<u> </u>	74.01

75 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2

	(Cont.)	CIVIS 2552 10		Tanaran		01 23
	JLATION OF REIMBURSEMENT	PRO	VIDER CCN:	PERIOD:	WORKSHEET E,	
SETTL	EMENT			FROM	PART A	
		COM	PONENT CCN:	ТО		
Check a	applicable box: [] Hospital [] PARHM Demonstration					
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 instruction	tions)				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" f	or 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) (li	ine 212 minus line 213) (see ins	tructions)			218

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4090 ((Cont.) FORM CMS	S-2552-10			02-24
	ILATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
REIMB	URSEMENT SETTLEMENT	COMPONENT CCN:	FROM TO	PART B	
		COMI ONENT CCN.	10		
Check	[] Hospital [] Subprovider (Other)		-	•	
applicab					
box: PART B	[] IRF				
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
4	OPPS or REH payments Outlier payment (see instructions)				3 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
8	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)				7 8
9	Ancillary service other pass through costs including REH direct graduate medical education	on 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) COMPUTATION OF LESSER OF COST OR CHARGES				11
	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) Customary charges				14
15	Aggregate amount actually collected from patients liable for payment for services on a charge	ge basis			15
16	Amounts that would have been realized from patients liable for payment for services on a ch	harge			16
	basis had such payment been made in accordance with 42 CFR §413.13(e)				15
17	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)				17
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	3) (see instructions)			20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)				22
24	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25 26	Deductibles and coinsurance amounts (see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (see instructions)				25 26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23	31 (see instructions)			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
28.50	REH facility payment amount (see instructions)				28.50
30	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50, and 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
- 22	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			22
33	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)				33
35	Adjusted reimbursable bad debts (see instructions)				35
36	,				36
37	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R				37
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.75	N95 respirator payment adjustment amount (see instructions)				39.75
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)				39.97 39.98
39.99	Recovery of Accelerated depreciation				39.99
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				40.01
40.02	Sequestration adjustment-PARHM pass-throughs				40.02
41	Interim payments				41
41.01	Interim payments-PARHM				41.01
42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractors use only)				42.01
43	Balance due provider/program (see instructions)				43
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, cha	anter L 8115.2		1	44

CALCU	CALCULATION OF PROVIDER CCN: PERIOD:							
REIMBU	RSEMENT SETTLEMENT		FROM	PART B (Cont.)				
		COMPONENT CCN:	ТО					
Check	Check [] Hospital [] Subprovider (Other)							
applicabl	cable [] IPF [] SNF							
box:	[] IRF [] PARHM Demonstration							
PART B	PART B - MEDICAL AND OTHER HEALTH SERVICES							
	TO BE COMPLETED BY CONTRACTOR							
90	Original outlier amount (see instructions)				90			
91	91 Outlier reconciliation adjustment amount (see instructions)							
92	92 The rate used to calculate the Time Value of Money							
93	93 Time Value of Money (see instructions)							
94								

	F PAYMENTS TO PROV	/IDERS					PROVIDER CCN:	PERIOD:	WORKSHEET E-1,	
FOR SERVICE	ES RENDERED						COMPONENT CCN:	FROM TO	PART I	
Check applicable box:	[] Hospital [] IPF [] IRF	[] Subprovider (Other) [] SNF [] Swing-Bed SNF	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF						1	
	·					Inpa Pai	atient	n		T
						mm/dd/yyyy	Amount	Part B mm/dd/yyyy Amount		_
Descript	tion					1 1	2	3	4	-
	l interim payments paid to	provider				1	-	3		1
		dividual bills, either submitted or to be	submitted to the intermediary							2
		t reporting period. If none, write "NON								
	separately each retroactive			Program to Provider	.01				1	3.01
lump	sum adjustment amount b	pased			.02					3.02
on su	absequent revision of the				.03				1	3.03
interi	im rate for the cost reporting	ng period.			.04					3.04
Also	show date of each paymen	nt.			.05				1	3.05
If nor	If none, write "NONE" or enter a zero. (1)	Provider to Program	.50					3.50		
			.51				Ί	3.51		
					.52					3.52
					.53					3.53
					.54					3.54
		9 minus sum of lines 3.50-3.98)			.99					3.99
	l interim payments (sum of								A	4
	sfer to Wkst. E or Wkst. E	-3, line								
and c	column as appropriate)									
							•	7		
	separately each tentative se			Program to Provider	.01					5.01
	nent after desk review. Also	o show			.02				<u> </u>	5.02
	of each payment.	(4)			.03					5.03
If nor	ne, write "NONE" or enter	a zero. (1)		Provider to Program	.50					5.50
					.51					5.51
					.52					5.52
		9 minus sum of lines 5.50 -5.98)		n , n ::	.99				4	5.99
	rmined net settlement amo			Program to Provider	.01					6.01
	based on the cost report (1 l Medicare program liabilit			Provider to Program	.02				+	6.02
	l Medicare program liabilit ne of Contractor	y (see instructions)				Contractor Number		NPR Date (Month/Da	v/Vaan)	7 8
o Nam	ie of Contractor					Contractor Number		NEK Date (Month/Da	// i cai j	8
										1

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

CALCU	LCULATION OF REIMBURSEMENT PROVIDER CCN: PERIOD: WORK					
SETTLE	MENT FOR HIT		FROM	PART II		
		COMPONENT CCN:	TO			
Check	[] Hospital					
applicab	e []CAH					
box:						
HEALT	HINFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1	Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)				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, I	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.

4090 (Cont.)	FC	RM CMS-2552-10				07-23
CALCU	LATION	OF REIMBURSEME	ENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-2	
SETTLE	EMENT -	- SWING BEDS			GOV MONIENTE CON	FROM		
					COMPONENT CCN:	10		
Check		[] Title V	[] Swing-Bed SNF				I.	
applicab	le	[] Title XVIII	[] Swing-Bed NF					
boxes:		[] Title XIX	[] PARHM CAH Swing-Bed SNF			1	1	
						PART A	PART B	
	COMPI	JTATION OF NET CO	OST OF COVERED SERVICES			1	2	1
1	_		ing bed-SNF (see instructions)			-	_	1
2			ing bed-NF (see instructions)					2
3			D-3, col. 3, line 200, for Part A; and sum of V					3
3.01			t B) (For CAH and swing-bed pass-through, s nent-PARHM (see instructions)	ee instructions)				3.01
	_		esidents not in approved teaching program (se	e instructions)				3.01
5			estacins not in approved teaching program (se	e instructions)				5
6			proved teaching program (see instructions)					6
7			compensation - SNF optional method only					7
8	_	d (sum of lines 1 through						8
9 10	_	y payer payments (see in al (line 8 minus line 9)	instructions)					9 10
11			patients (exclude amounts applicable to physic	ian professional services)				11
12		d (line 10 minus line 1	11 13	ian professional services)				12
13		`	patients (from provider records) (exclude coin	surance for physician profession	onal services)			13
14		Part B costs (line 12 x	80%)					14
15		al (see instructions)						15
16		djustments (specify) (16
16.50 16.55			ayment adjustment (see instructions) nonstration project (§410A Demonstration) pay	ment adjustment (see instructi	ions)			16.50 16.55
16.99			ment amount before sequestration	ment adjustment (see instructi	ions)			16.99
17		ble bad debts (see inst	-					17
17.01		ed reimbursable bad del	,					17.01
18			eligible beneficiaries (see instructions)					18
19		see instructions)	:					19.01
19.01 19.02	_	tration adjustment (see	ment amount after sequestration					19.01
		tration adjustment-PAF						19.03
19.25			pased amounts (see instructions)					19.25
20	_	payments						20
20.01	_	payments-PARHM						20.01
21.01		ve settlement (for contr	actor use only) (for contractor use only)					21.01
21.01			(for contractor use only) (line 19 minus lines 19.01, 19.02, 19.25, 20, a	nd 21)				22
22.01	_		a-PARHM (see instructions)					22.01
23			ble cost report items) in accordance with CMS	Pub. 15-2, chapter 1, §115.2				23
200			monstration Project (§410A Demonstration) A		H C H27H C	T		200
200		he first year of the curr imbursement	ent 5-year demonstration period under the 21st	Century Cures Act? Enter "Y	" for yes or "N" for no.	<u> </u>		200
201			atient routine service costs (from Wkst. D-1, P	t. II. line 66 (title XVIII hospit	al))	I		201
202			atient ancillary service costs (from Wkst. D-3,					202
203	Total (sum of lines 201 and 2	02)	•				203
204			harges (see instructions)					204
205			Target Amount Limitation (N/A in first year o	f the current 5-year demonstra	tion period)	1		205
205 206		re swing-bed SNF targ	et amount atient routine cost cap (line 205 times line 204	1				205
200			Swing-Bed SNF Inpatient Reimbursement	1		1		200
207			the §410A Demonstration (see instructions)					207
208	Medica	re swing-bed SNF inpa	atient service costs (from Wkst. E-2, col. 1, sur	m of lines 1 and 3)				208
209	,	,	g-bed SNF PPS payments (see instructions)					209
210		ed for future use	ot Daimhyusamant					210
215		rison of PPS versus Cos	st Reimbursement swing-bed SNF PPS payment (line 209 plus li	ne 210) (see instructions)		I		215
413	i Otai at	ajasunent to Medicale	54 mg coa 5141 115 payment (nine 209 plus ii	ne 210) (see instructions)		<u> </u>		213

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

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

1	Inpatient hospital services (see instructions)	
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)	2
4	Subtotal (sum of lines 1 through 3)	4
5	Primary payer payments	5
6	Subtotal (line 4 less line 5).	(
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

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4090 ((Cont.) FORM C	CMS-2552-10			04-20
CALCU	JLATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN		WORKSHEET E-3,	
			FROM	PART II	
		COMPONENT CO	CN: TO		
Check	[] Hospital	l		<u> </u>	
applicab					
box:					
PART II	I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER I	IPF PPS			
				1	
	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education paymen	nts)			1 2
3	1 /				3
4	1 5	afora Novambar 15, 2004 (see instruct	one)		4
					4.01
4.01	that would not be counted without a temporary cap adjustment under 42 CFR §412.42-				4.01
5	New teaching program adjustment (see instructions)	(4)(1)(II)(1)(1) (1) (2) (see histraction	15)		5
6		vth period			6
Ü	of a "new teaching program" (see instructions)	rui period			0
7	Current year unweighted I&R FTE count for residents within the new program growth	neriod			7
,	of a "new teaching program" (see instructions)	. period			,
8)			8
9		•			9
10					10
11					11
12					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					19
20	Subtotal (line 18 minus line 19)				20
21					21
22	,				22
23	1 /				23
24	j ,				24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)				25
26	,				26
27		ns)			27
28					28
29	1 7				29
30	J (1 5) (/				30
30.50 30.99					30.50
30.99	Demonstration payment adjustment amount before sequestration				30.99
31.01	1 2 1 \				31.01
31.01	1 3 \				31.02
	1 , ,				31.02
33	1 7				33
34	7/				34
	1 1 5 (2 chanter 1 8115.2			35
22	13-13-13-13-13-13-13-13-13-13-13-13-13-1	-,p, 3		1	- 55

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

04-20	FORM CM	S-2552-10		4090 (Cont.)
CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART III
		COMPONENT CCN:	то	
Check	[] Hospital			I
applicab				
box:				
PART II	II - 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				4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending	2		5
	on or prior to November 15, 2004 (see instructions)			
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were dis			5.01
	closure, that would not be counted without a temporary cap adjustment under 42 CFR §41.	2.424(d)(1)(iii)(F)(1) or (2)		
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth p	eriod		7
0	of a "new teaching program" (see instructions)			8
8	Current year unweighted I&R FTE count for residents within the new program growth per	nod		8
9	of a "new teaching program" (see instructions) Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)			10
11				11
12	Teaching Adjustment (see instructions)			12
13				13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	· ·			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 28	Subtotal (sum of lines 23 and 25)			27
29	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions) 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, ch	hapter 1, §115.2		36
	TO BE COMPLETED BY CONTRACTOR			
50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)			50
50	organic court inform trade 2.5, 1 t. III, line 7 (see instructions)			50

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)	1	53

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

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1 Net Federal PPS payment (see instructions)			
1.02 Short stay outlier standard payment amount 1.02	1	Net Federal PPS payment (see instructions)	1
1.03 Site neutral payment amount - Cost	1.01		1.01
1.04 Site neutral payment amount - IPPS comparable 1.04 2 2 2 2 2 2 2 2 2	1.02	Short stay outlier standard payment amount	1.02
2 Outlier payments	1.03	Site neutral payment amount - Cost	1.03
3 Total PPS payments (sum of lines 1 and 2) 3 4 Nursing and allied health managed care payments (see instructions) 4 5 5 7 7 7 7 7 7 7 7	1.04	1 7	1.04
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 ? 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 (exclude bad debts (see instructions) 15 16 Allowable bad debts for dual eligible beneficiaries (see instructions) 16 17 Subtotal (sum of lines 13 and 15) 16 18 Direct graduate medical education payments (from Wkst. E-4, line 49) 18 19 Other pays 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 22.01 Sequestration adjustment (see instructi	2	1 7	
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 9 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) 15 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 22.01 Sequestration adjustment (see instructions) 22.02 22.02 Demonstration payment adjustment manual thefore sequestration	3		
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 22.01 Demonstration payment adjustment (see instructions) 21.50 22.02 Demonstration payment adjustment amount after sequestration 22.01 22.03 Interim payments 22.01	4		
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 Poincer ACO demonstration payment adjustment (see instructions) 21 22.01 Sequestration adjustment amount before sequestration 21.50 22.01 </td <td>5</td> <td>Ç î</td> <td>5</td>	5	Ç î	5
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 (see instructions) 21.50 22.01 Sequestration adjustment (see instructions) 22.01 22.02 Demonstration payment adjustment amount after sequestration 22.02 22.02 Interim payments 23 31 Interim payments 23	6	Cost of physicians' services in a teaching hospital (see instructions)	6
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) 15 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 Other adjustments (specify) (see instructions) 21 21 Demonstration payment adjustment adjustment (see instructions) 21 22 Total amount payable to the provider (see instructions) 22.0 22 Total amount payable to the provider (see instructions)	7	Subtotal (see instructions)	7
10 Deductibles	8	Primary payer payments	8
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 22.01 Sequestration adjustment (see instructions) 22.01 22.02 Demonstration payment adjustment amount after sequestration 22.02 23 Interim payments 22.02 24 Tent	9	Subtotal (line 7 less line 8)	9
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 22.02 Demonstration payment adjustment amount after sequestration 22.02 23 Interim payments 22.02 24 Tentative settlement (for contractor use only) 23 25 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24) 25	10	Deductibles	10
13 Subtotal (line 11 minus line 12) 14 Allowable bad debts (exclude bad debts for professional services) (see instructions) 15 Adjusted reimbursable bad debts (see instructions) 16 Allowable bad debts for dual eligible beneficiaries (see instructions) 17 Subtotal (sum of lines 13 and 15) 18 Direct graduate medical education payments (from Wkst. E-4, line 49) 19 Other pass through costs (see instructions) 20 Outlier payments reconciliation 21 Other adjustments (specify) (see instructions) 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 21.50 Pioneer ACO demonstration payment adjustment (see instructions) 21.50 Pomenstration payment adjustment mount before sequestration 21.99 Demonstration payment adjustment (see instructions) 22 Total amount payable to the provider (see instructions) 22 Total amount payable to the provider (see instructions) 22 Total amount payable to the provider (see instructions) 22 Total amount payable to the provider (see instructions) 23 Interim payments 24 Tentative settlement (for contractor use only) 25 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24)	11	Subtotal (line 9 minus line 10)	11
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 22.02 Demonstration payment adjustment amount after sequestration 22.01 22.02 Total amount payable to the provider (see instructions) 22.01 22.02 Interim payments 22.01 23 Interim payments 23 24 Tentative settlement (for contractor use only) 24 25 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24) 25	12	Coinsurance	12
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 21.90 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 22.02 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	13	Subtotal (line 11 minus line 12)	13
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 22.01 22.01 Interim payments 22.01 22 Interim payments 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	14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14
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 22.01 22.01 Interim payments 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	15	Adjusted reimbursable bad debts (see instructions)	15
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 22.01 23 Interim payments 22.02 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	16	Allowable bad debts for dual eligible beneficiaries (see instructions)	16
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 22.02 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	17	Subtotal (sum of lines 13 and 15)	17
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 22.02 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	18	Direct graduate medical education payments (from Wkst. E-4, line 49)	18
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 22.01 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	19	Other pass through costs (see instructions)	19
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 22.01 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	20	Outlier payments reconciliation	20
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	21	Other adjustments (specify) (see instructions)	21
22 Total amount payable to the provider (see instructions) 22 22.01 Sequestration adjustment (see instructions) 22.01 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	21.50	Pioneer ACO demonstration payment adjustment (see instructions)	21.50
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	21.99	Demonstration payment adjustment amount before sequestration	21.99
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	22	Total amount payable to the provider (see instructions)	22
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	22.01	Sequestration adjustment (see instructions)	22.01
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	22.02	Demonstration payment adjustment amount after sequestration	22.02
25 Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24) 25	23		23
	24	Tentative settlement (for contractor use only)	24
26 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	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

CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET E-3, PART V
Check applicab box:	[] Hospital [] PARHM Demonstration	•		
PART V	- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES	- COST REIMBURSEN	MENT	
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
8	Ancillary service charges Organ acquisition charges, net of revenue			8
	Total reasonable charges			10
- 10	Customary charges			10
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis			11
12	Amounts that would have been realized from patients liable for payment for services on			12
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
13	Ratio of line 11 to line 12 (not to exceed 1.000000)			13
14	Total customary charges (see instructions)			14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instruct	tions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instruct	tions)		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
26	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)			25
27	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)			20
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		<u> </u>	30.03
31	Interim payments			31
31.01	Interim payments-PARHM			31.01
32	Tentative settlement (for contractor use only)			32
32.01	Tentative settlement-PARHM (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 (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)	2		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: PERI	NIOD: WORKSHEET E-3,
	FRO.	DM PART VI
	COMPONENT CCN.: TO	

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

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

07 23			1 Oldvi C	7115 2552 10			1070 (Cont.
CALCULATIO	N OF REIMBURSEMI	ENT SETTLEMENT			PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
						FROM	PART VII
					COMPONENT CCN.:	TO	
Check	[] Title V	[] Hospital	[] NF	[] PPS			
applicable	[] Title XIX	[] Subprovider	[] ICF/IID	[] TEFRA			
boxes:		[] SNF		[] Other			

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

Inpatient Outpatient Title V or Title V or		
Title XIX Title XIX	COMPUTATION OF NET COST OF COVERED SERVICES	
	Inpatient hospital/SNF/NF services	1
	Medical and other services	2
	Organ acquisition (certified transplant programs only)	
	Subtotal (sum of lines 1, 2 and 3)	
	Inpatient primary payer payments	
		6
	Subtotal (line 4 less sum of lines 5 and 6)	7
	COMPUTATION OF LESSER OF COST OR CHARGES	
	Reasonable Charges	
	Routine service charges	8
	Ancillary service charges	9
	8 1 8 /	
		12
	CUSTOMARY CHARGES	
	Amount actually collected from patients liable for payment for services on a charge basis	13
	Amounts that would have been realized from patients liable for payment for services	14
	on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	
	Ratio of line 13 to line 14 (not to exceed 1.000000)	15
	Total customary charges (see instructions)	16
	Excess of customary charges over reasonable cost (complete only if line 16	17
	exceeds line 4) (see instructions)	
		18
		19
	` /	
	Cost of covered services (enter the lesser of line 4 or line 16)	
	PROSPECTIVE PAYMENT AMOUNT	
		22
		27
		28
		_
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
		30
- - 	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	
- - 		
- - 		
	Allowable bad debts (see instructions)	34
		35
		37
		38
		40
 		41
	Interim payments	41
	Balance due provider/program (line 40 minus line 41)	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	43

4090 (Cont.) FOR	M CMS-2552-10				07-23
DIRECT	GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRE	OUTPATIENT DIRECT MEDICAL			FROM		
EDUCA	TION COSTS			ТО		
Check	[] Title V [] Hospital		[] CAH-Based IPF			
applicab	le [] Title XVIII [] PARHM	Demonstration	[] CAH-Based IRF			
box:	[] Title XIX					
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				_	
1	Unweighted resident FTE count for allopathic and osteopathic programs f	or cost reporting periods er	nding 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 413.7					2
2.26	Rural track program FTE cap limitation adjustment after the cap-building	window closed under §127	of the CAA 2021 (see instr	uctions)		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			3.01
	for cost reporting periods straddling 7/1/2011)					
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitati			are GME		3.02
	affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (Aug	gust 10, 2022) (see instruct	ions)			
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic	programs due to a Medicar	e GME			4
	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost					4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instruct					4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §					4.21
5	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through	1 2.49, minus lines 3 and 3.	01, plus or minus line 3.02, j	olus or minus		5
	line 4, plus lines 4.01 through 4.27	·				
7	Unweighted resident FTE count for allopathic and osteopathic programs for Enter the lesser of line 5 or line 6	or the current year from yo	ur records (see instructions)			7
	Effet the lesser of time 3 of time o		Primary Care	Other	Total	
			1	2	3	-
- 8	Weighted FTE count for physicians in an allopathic and osteopathic progr	am for	•		<u> </u>	8
	the current year					
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply lin	e 8 times				9
	the result of line 5 divided by the amount on line 6. For cost reporting per					
	on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", se	e instructions.				
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 in	nstructions)				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 clo	sure				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 Additional unweighted allopathic and osteopathic direct GME FTE reside		42 (412 70(-)(4)			19 20
21		iii cap siois received under	42 9413.79(0)(4)			21
22	Direct GME FTE unweighted resident count over cap (see instructions) Allowable additional direct GME FTE resident count (see instructions)					22
23	Enter the locality adjustment national average per resident amount (see in	etructions)				23
24	Multiply line 22 time line 23	on actions;				24
25	Total direct GME amount (sum of lines 19 and 24)				<u> </u>	25
	one amount (sum of mics 17 and 21)	Inpatient Part	A Managed Care	Managed Care	Total	1 23
		inpution I ait	Prior to 1/1	On or after 1/1	101111	1
	COMPUTATION OF PROGRAM PATIENT LOAD	1	2	2.01	3	1
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 I	RATE - TITLE XVIII ONI	Y (NURSING PROGRAM	AND		
	PARAMEDICAL EDUCATION COSTS)					
	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of		d 94)			32
	, , , , ,	of lines 74 and 94)				33
	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)					34
35	Medicare outpatient ESRD charges (see instructions)	15)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 3	(5)			l	36

DIRECT	DIRECT GRADUATE MEDICAL EDUCATION (GME)			PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRE	OUTPATIENT	Γ DIRECT MEDICAL			FROM		
EDUCA	TION COSTS			<u> </u>	TO		
Check		[] Title V	[] Hospital	[] CAH-Based IPF			
applicab	ole	[] Title XVIII	[] PARHM Demonstration	[] CAH-Based IRF			
box:		[] Title XIX					
	APPORTIONN	MENT OF MEDICARE REASONABLE C	OST OF GME				
	Part A Reasona	ible Cost					
37	Reasonable cos	st (see instructions)					37
38	Organ acquisiti	ion and HSCT acquisition costs (see instruc	etions)				38
39	Cost of physici	ians' services in a teaching hospital (see ins	ructions)				39
40	Primary payer p	payments (see instructions)					40
41	Total Part A re	asonable cost (sum of lines 37 through 39 n	ninus line 40)				41
	Part B Reasona	ble Cost					
42	Reasonable cos	st (see instructions)					42
43	Primary payer p	payments (see instructions)					43
44	Total Part B rea	asonable cost (line 42 minus line 43)					44
45	Total reasonab	le cost (sum of lines 41 and 44)					45
46	Ratio of Part A	reasonable cost to total reasonable cost (lin	e 41 ÷ line 45)				46
47	Ratio of Part B	reasonable cost to total reasonable cost (lin	e 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 Medicar	re GME payment (line 46 x 48) (title XVIII	only) (see instructions)	_			49
50							50

Rev. 21 40-599

サリノリ	(Cont.)	2-10			07-23
OUTLI	ER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-5	
			TO_	_	
	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

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).					OMB NO. 0938-1425 EXPIRES 02-28-2025	
PAYMENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED			PROVIDER CCN:	PERIOD:	WORKSHEET E-95	
SURGICAL N95 RESPIRATORS				FROM		
				ТО		
PART I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAY	MENT ADJUSTMENT	ELIGIBILITY AND I	DATA			
				DOMESTIC	NON-DOMESTIC	
				RESPIRATORS	RESPIRATORS	
				1	2	
1 Did the hospital or hospital healthcare complex purchase domestic (column 1)	or non-domestic (colum	n 2) respirators? Enter	"Y" for yes or			1
"N" for no in each column. If "Y" for either column, complete line 2.			•			
		DOMESTIC	RESPIRATORS	NON-DOMESTI	C RESPIRATORS	
		TOTAL	NUMBER	TOTAL	NUMBER	
		COST	PURCHASED	COST	PURCHASED	
		1	2	3	4	
2 Enter the total cost of domestic respirators purchased in column 1 and the num	ber of domestic					2
respirators purchased in column 2.						
Enter the total cost of non-domestic respirators purchased in column 3 and the	number of					
non-domestic respirators purchased in column 4.						
PART II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-A	APPROVED SURGICA	L N95 RESPIRATOR	S			
			DOMESTIC	NON-DOMESTIC	COST	
			DOMESTIC RESPIRATORS	NON-DOMESTIC RESPIRATORS	COST DIFFERENTIAL	
Total cost of NIOSH-approved surgical N95 respirators purchased				RESPIRATORS	DIFFERENTIAL	1
Total cost of NIOSH-approved surgical N95 respirators purchased Number of NIOSH-approved surgical N95 respirators purchased				RESPIRATORS	DIFFERENTIAL	1 2
				RESPIRATORS	DIFFERENTIAL	
2 Number of NIOSH-approved surgical N95 respirators purchased				RESPIRATORS	DIFFERENTIAL	2
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator				RESPIRATORS	DIFFERENTIAL	2
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators				RESPIRATORS	DIFFERENTIAL	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators	SH-APPROVED SURG	SICAL N95 RESPIRA	RESPIRATORS 1	RESPIRATORS	DIFFERENTIAL	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators	SH-APPROVED SURG	SICAL N95 RESPIRA	RESPIRATORS 1	RESPIRATORS	DIFFERENTIAL	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators	SH-APPROVED SURC HOSPITAL	GICAL N95 RESPIRA HOSPITAL	RESPIRATORS 1 TORS	RESPIRATORS 2	DIFFERENTIAL	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators	HOSPITAL	HOSPITAL	RESPIRATORS 1 TORS IPF SUBPROVIDER	RESPIRATORS 2 IRF SUBPROVIDER	DIFFERENTIAL 3	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators		HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO	HOSPITAL	HOSPITAL	RESPIRATORS 1 TORS IPF SUBPROVIDER	RESPIRATORS 2 IRF SUBPROVIDER	DIFFERENTIAL 3	2 3 4 5
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO	HOSPITAL	HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4 5
Number of NIOSH-approved surgical N95 respirators purchased Average cost per respirator Hospital-specific unit cost differential for domestic respirators Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO Medicare routine/ancillary costs 1.01 Medicare acquisition costs	HOSPITAL	HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4 5
2 Number of NIOSH-approved surgical N95 respirators purchased 3 Average cost per respirator 4 Hospital-specific unit cost differential for domestic respirators 5 Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO 1 Medicare routine/ancillary costs 1.01 Medicare acquisition costs 1.02 Cost of physicians' services in a teaching hospital	HOSPITAL	HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4 5
2 Number of NIOSH-approved surgical N95 respirators purchased 3 Average cost per respirator 4 Hospital-specific unit cost differential for domestic respirators 5 Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO 1 Medicare routine/ancillary costs 1.01 Medicare acquisition costs 1.02 Cost of physicians' services in a teaching hospital 1.15 Total Medicare reasonable costs	HOSPITAL	HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4 5 1 1.01 1.02 1.15
2 Number of NIOSH-approved surgical N95 respirators purchased 3 Average cost per respirator 4 Hospital-specific unit cost differential for domestic respirators 5 Total cost differential for domestic respirators PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIO 1 Medicare routine/ancillary costs 1.01 Medicare acquisition costs 1.02 Cost of physicians' services in a teaching hospital	HOSPITAL	HOSPITAL PART B	TORS IPF SUBPROVIDER PART B	RESPIRATORS 2 IRF SUBPROVIDER PART B	DIFFERENTIAL 3 TOTAL	2 3 4 5

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-1425. The time required to complete this information collection is estimated to be 0.50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Officer. 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.

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	(Cont.)	FORM CMS-2552-10					
BALAN	ICE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G		
(If you a	are nonproprietary and do not maintain fund-type			FROM			
accounti	ing records, complete the General Fund column only)			то	_		
			Specific				
		General	Purpose	Endowment	Plant		
	Assets	Fund	Fund	Fund	Fund		
	(Omit cents)	1	2	3	4		
	CURRENT ASSETS						
1	Cash on hand and in banks					1	
2	Temporary investments					2	
3	Notes receivable					3	
4	Accounts receivable					4	
5	Other receivables					5	
6	Allowances for uncollectible notes and					6	
	accounts receivable						
7	Inventory					7	
- 8	Prepaid expenses					8	
9	Other current assets					9	
10	Due from other funds					10	
11	Total current assets (sum of lines 1 through 10)					11	
	FIXED ASSETS						
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	•		T	1		
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	

10-12		FORM CMS-2552-10 409				
BALANCE SHEET			PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are no	onproprietary and do not maintain fund-type			FROM	(CONT.)	
accounting re	ecords, complete the General Fund column only)		-	ТО		
			Specific			
Li	abilities and Fund	General	Purpose	Endowment	Plant	
	Balances	Fund	Fund	Fund	Fund	
	(Omit cents)	1	2	3	4	
CUR	RENT LIABILITIES					
	counts payable					3
	aries, wages, and fees payable					3
39 Pay	roll taxes payable					3
	tes and loans payable (short term)					4
41 Def	ferred income					4
	celerated payments					4
43 Due	e to other funds					4
44 Oth	er current liabilities					4
45 Tota	al current liabilities (sum of					4
line	es 37 thru 44)					
	TERM LIABILITIES rtgage payable				1	4
	tes payable					4
	secured loans					4
-	ner long term liabilities					4
	al long term liabilities (sum of					5
	es 46 thru 49)					
	al liabilities (sum of lines 45 and 50)					5
	,					
	PITAL ACCOUNTS neral fund balance					
	ecific purpose fund					5
	nor created - endowment fund					5
	ance - restricted					-
	nor created - endowment fund					5
	ance - unrestricted					3
	verning body created - endowment					5
	d balance					
	nt fund balance - invested in plant					5
	nt fund balance - invested in plant					5
	provement, replacement, and expansion					
	al fund balances (sum of lines 52 thru 58)					5
	al liabilities and fund balances (sum of					6
	es 51 and 59)					0

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

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

PART I - PATIENT REVENUES

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

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)			29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30 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

	MENT OF REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-3
AND E	XPENSES		FROM	
			TO	
	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			
	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				10
11				11
12				12
13				13
14	1 7 8			14
	Revenue from rental of living quarters			15
16	Revenue from sale of medical and surgical supplies to other than patients			16
17				17
18	Revenue from sale of medical records and abstracts			18
19				19
20				20
21	6			21
22				22
23	11 1			23
24	Other (specify)			24
	COVID-19 PHE Funding			24.50
25	. ,			25
26	(-1			26
27				27
	Total other expenses (sum of line 27 and subscripts)			28
20	Net income (or loss) for the period (line 26 minus line 28)	· · · · · · · · · · · · · · · · · · ·	·	29

	YSIS OF HOSPITAL-BASED							PROVIDER CCN:	PERIOD:	WOI	RKSHEET H	
HOME	HEALTH AGENCY COSTS								FROM			
								HHA CCN:	ТО			
				TRANSPOR-	CONTRACTED/				RECLASSIFIED		NET	
		SALARIES	EMPLOYEE	TATION	PURCHASED		TOTAL		TRIAL		EXPENSES FOR	
	COST CENTER DESCRIPTIONS		BENEFITS	(see	SERVICES		(sum of cols.	RECLASS-	BALANCE		ALLOCATION	
	(omit cents)			instructions)		OTHER COSTS	1 thru 5)	IFICATIONS	(col. 6 + col. 7)	ADJUSTMENTS		
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related-Bldgs. and Fixtures											1
	Capital Related-Movable Equipment											2
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
	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
	Drugs											13
	DME											14
	HHA NONREIMBURSABLE SERVICES											
15	Home Dialysis Aide Services											15
	Respiratory Therapy											16
	Private Duty Nursing											17
	Clinic											18
	Health Promotion Activities											19
	Day Care Program											20
	Home Delivered Meals Program											21
	Homemaker Service	 										22
	All Others											23
	Total (sum of lines 1 through 23)			 	ł			1			1	24

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

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1050 (Cont.)		10	1011 01110 2002 1	. 0						11 10
COST ALLOCATION - HHA GENERAL SERVICE COST						PROVIDI HHA CC		PERIOD: FROM TO	WORKSHEET H-1 PART I	
	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)		ITAL D COSTS MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRAN PORTA		SUBTOTA (cols. 0-4)) & GENERA	TOTAL L (cols. 4a + 5)	
GENERAL SERVICE COST CENTERS	0	l	2	3	4		4a	5	6	_
1 Capital Related-Bldgs. and Fixtures										,
Capital Related-Bidgs, and Fixtures Capital Related-Movable Equipment										1
										2
3 Plant Operation & Maintenance 4 Transportation (see instructions)										3
5 Administrative and General										5
HHA REIMBURSABLE SERVICES										3
6 Skilled Nursing Care										6
7 Physical Therapy				-	.					7
8 Occupational Therapy										/ 0
9 Speech Pathology										0
10 Medical Social Services										10
11 Home Health Aide				-	.					11
12 Supplies (see instructions)										12
13 Drugs										13
14 DME										14
HHA NONREIMBURSABLE SERVICES										11
15 Home Dialysis Aide Services										15
16 Respiratory Therapy										16
17 Private Duty Nursing					 					17
18 Clinic					1					18
19 Health Promotion Activities					 					19
20 Day Care Program					1					20
21 Home Delivered Meals Program					1					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: FROMTO	WORKSHEET H-1, PART II	
		DOTAL DOCOSTS MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATION & MAINTENANCE (SQUARE FEET) 3	TRANS- PORTATION (MILEAGE)	RECONCIL- IATION 5a	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	
GENERAL SERVICE COST CENTERS	1	2	,	'	34	3	
Capital Related-Bldgs. and Fixtures							1
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							ϵ
7 Physical Therapy			İ			i i	7
8 Occupational Therapy						i i	8
9 Speech Pathology						i i	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							20

40-607

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

01-22					ron	IVI CIVIS-233	2-10					4090 ((Cont.)
	ATION OF GENERAL SERVICE TO HHA COST CENTERS									PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART I (CONT.)	
	HHA COST CENTER (omit cents)	HOUSE KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Home Health Aide												7
8	Supplies												8
9	Drugs												9
10	DME												10
11	Home Dialysis Aide Services												11
12	Respiratory Therapy												12
13	Private Duty Nursing												13
14	Clinic												14
15	Health Promotion Activities												15
16	Day Care Program												16
17	Home Delivered Meals Program												17
	Homemaker Service												18
	All Others												19
20	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1, dir line 20, minus column 26, line 1, rounded												21

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

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

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

07-13	1	JIGWI CIVIS-2552-	10					(Cont.)
ALLOCATION OF GENERAL SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	
COSTS TO HHA COST CENTERS						FROM	PART II	
STATISTICAL BASIS					HHA CCN:	TO	_	
		ITAL						
		ED COST	EMPLOYEE		ADMINIS-	MAIN-		
	BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
HHA COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
	1	2	4	4A	5	6	7	<u> </u>
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

T070 (1.	OKWI CIVIS-2332	-10					07-13
COSTS	ATION OF GENERAL SERVICE TO HHA COST CENTERS TICAL 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) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
1.1	Administrative and General	*	· ·		-	-		 			1
	Skilled Nursing Care										2
	Physical Therapy										3
	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
9	Drugs										9
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
	Private Duty Nursing										13
	Clinic										14
	Health Promotion Activities										15
	Day Care Program										16
	Home Delivered Meals Program										17
	Homemaker Service										18
	All Others										19
	Totals (sum of lines 1-19)										20
	Total cost to be allocated										21
22	Unit Cost Multiplier										22

01-22	1	OICIVI CIVID-2332	10			T	4070 ((Cont.
ALLOCATION OF GENERAL SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	
COSTS TO HHA COST CENTERS						FROM	PART II (CONT.)	
STATISTICAL BASIS					HHA CCN:	ТО	_	
-	1	1	NON-	1			PARA-	т—
			PHYSICIAN		INTERNS	& RESIDENTS	MEDICAL	
	SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
HHA COST CENTER	SERVICE	GENERAL	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	
IIIIA COSI CENTER	(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
	SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	
	17	18	19	20	21	22	23	4
1 Administrative and General	1/	10	1)	20	21	22	23	+
2 Skilled Nursing Care								1
3 Physical Therapy								1
4 Occupational Therapy								
5 Speech Pathology								1
6 Medical Social Services								
7 Home Health Aide								
8 Supplies								
9 Drugs								
10 DME								10
11 Home Dialysis Aide Services								1
12 Respiratory Therapy								1
13 Private Duty Nursing								1.
14 Clinic								1.
15 Health Promotion Activities								1:
16 Day Care Program								10
17 Home Delivered Meals Program							-	1
18 Homemaker Service								1
19 All Others								19
20 Totals (sum of lines 1-19)								20
21 Total cost to be allocated								2
22 Unit Cost Multiplier								22

4090	(Cont.)					FORM	CMS-2	2552-10)						01-22
APPOR	TIONMENT OF PATIENT SERV	ICE COST:	S						P	ROVIDER CC	N:	PERIOD:		WORKSHE	ET H-3,
												FROM		Parts I & II	
									H	IHA CCN:		ТО			
Check a	pplicable box:	[] Title V	/ [] Title	XVIII	[] Title	XIX									
PARTI	COMPUTATION OF THE AGGREGA	ATE PROGRA	M COST												
	r Visit Computation	TETROGR	IN CODI						Program Vi	sits		Cost	of Services		
	•				Total				Pa	art B		Pa	rt B		
		From,	Facility	Shared	HHA		Average		Not			Not		Total	
		Wkst.	Costs	Ancillary	Costs		Cost		Subject to	Subject to		Subject to	Subject to	Program	
		H-2,	(from	Costs	(sum of		Per Visit		Deductibles	Deductibles		Deductibles	Deductibles	Cost	
		Part I,	Wkst. H-2,	(from	col. 1	Total	(col. 3		&	&		&	&	(sum of	
	Patient Services	col. 28,	Part I)	Part II)	+ col. 2)	Visits	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	cols. 9-10)	
		line	1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
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 Visit	s		
									<u> </u>				Part B		
											N	lot Subject to		bject to	
												Androtibles &		actibles &	

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

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

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

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

12 22	I Oldivi Civis 255	2 10		1070 (Cont.
CALCULATION OF HHA	A REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET H-4,	
SETTLEMENT			FROM	Parts I & II	
		HHA CCN:	TO		
Check applicable box:	[] Title V [] Title XVIII [] Title XIX		•	•	
PART I - COMPUTATION	N OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARC	GES			
			P	art B	
			Not Subject to	Subject to	
			Deductibles	Deductibles	
		Part A	& Coinsurance	& Coinsurance	
Description		1	2	3	
Reasonable Cost of	of Part A & Part B Services				
1 Reasonable cost of	of services (see instructions)				1
2 Total charges					2
Customary Charge	es				
3 Amount actually	collected from patients liable for payment for services on a				3
charge basis (from	n your records)				
4 Amount that wou	ld have been realized from patients liable for payment for services on a				4
charge basis had	such payment been made in accordance with 42 CFR 413.13(b)				
5 Ratio of line 3 to	line 4 (not to exceed 1.000000)				5
6 Total customary of	charges (see instructions)				6

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

9 Primary payer amounts

Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)
 Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)

12 Total PPS Reimbursen 13 Total PPS Reimbursen 14 Total PPS Reimbursen 15 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable				
11 Total PPS Reimbursen 12 Total PPS Reimbursen 13 Total PPS Reimbursen 14 Total PPS Reimbursen 15 Total PPS Cuttier Reir 16 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bill 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable		1	2	
12 Total PPS Reimbursen 13 Total PPS Reimbursen 14 Total PPS Reimbursen 15 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable	,			10
13 Total PPS Reimbursen 14 Total PPS Reimbursen 15 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	ent - Full Episodes without Outliers			11
14 Total PPS Reimbursen 15 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	ent - Full Episodes with Outliers			12
15 Total PPS Outlier Reir 16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bill 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minu: 25 Coinsurance billed to p 26 Net cost (line 24 minu: 27 Allowable bad debts (127.01) 27.01 Adjusted reimbursable	ent - LUPA Episodes			13
16 Total PPS Outlier Reir 17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bill 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable	ent - PEP Episodes			14
17 Total Other Payments 18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	bursement - Full Episodes with Outliers			15
18 DME Payments 19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	bursement - PEP Episodes			16
19 Oxygen Payments 20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable				17
20 Prosthetic and Orthotic 21 Part B deductibles bille 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable				18
21 Part B deductibles bills 22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (1 27.01 Adjusted reimbursable				19
22 Subtotal (sum of lines 23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	Payments			20
23 Excess reasonable cost 24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (t 27.01 Adjusted reimbursable	d to Medicare patients (exclude coinsurance)			21
24 Subtotal (line 22 minus 25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable	0 thru 20 minus line 21)			22
25 Coinsurance billed to p 26 Net cost (line 24 minus 27 Allowable bad debts (1 27.01 Adjusted reimbursable	(from line 8)			23
26 Net cost (line 24 minus 27 Allowable bad debts (f 27.01 Adjusted reimbursable	line 23)			24
27 Allowable bad debts (f 27.01 Adjusted reimbursable	rogram patients (from your records)			25
27.01 Adjusted reimbursable	line 25)			26
	om your records)			27
	bad debts (see instructions)			27.01
28 Allowable bad debts for	r dual eligible (see instructions)			28
29 Total costs - current co	st reporting period (see instructions)			29
30 Other adjustments (see	instructions) (specify)			30
30.50 Pioneer ACO demonst	ation payment adjustment (see instructions)			30.50
30.99 Demonstration paymer	t adjustment amount before sequestration			30.99
31 Subtotal (see instruction	ns)			31
31.01 Sequestration adjustme	nt (see instructions)			31.01
31.02 Demonstration paymer	adjustment amount after sequestration			31.02
31.75 Sequestration adjustme	nt for non-claims based amounts (see instructions)			31.75
32 Interim payments (see	nstructions)			32
33 Tentative settlement (for a settlement)	r contractor use only)			33
	rogram (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)			34
35 Protested amounts (nor	allowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			35

40-615

BASEI	YSIS OF PAYMENTS TO HOSPITAL- D HHAS FOR SERVICES ERED TO PROGRAM BENEFICIARIES				PROVIDER CCN:	PERIOD:	WORKSHEET H-5	
						EDOM		
REND	ERED TO PROGRAM BENEFICIARIES					FROM		
					HHA CCN:	ТО		
				1				
				p.	art A		Part B	
	Description			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	-
	Description			1	2	3	4	1
1	Total interim payments paid to provider			•	_	J		1
2	Interim payments payable on individual bills eitl	her submitted or						2
	to be submitted to the intermediary for services	rendered in the						
	cost reporting period. If none, write "NONE" o	r enter a zero.						
3	List separately each retroactive lump sum	Program	.01					3.01
	adjustment amount based on subsequent revision	to	.02					3.02
	of the interim rate for the cost reporting period.	Provider	.03					3.03
	Also show date of each payment. If none, write		.04					3.04
	"NONE" or enter a zero.(1)		.05					3.05
		Provider	.50					3.50
		to	.51					3.51
		Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum							
	of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3							4
	(transfer to Wkst. H-4, Part II, column as approp	priate, line 32)						
	TO BE COMPLETED BY INTERMEDIARY							
		•	_		•	•	•	
5	1 1		.01					5.01
	after desk review. Also show date of each	to	.02					5.02
	payment. If none, write "NONE" or enter	Provider	.03					5.03
	a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum							
	of lines 5.50-5.98)	Tn.	.99					5.99
6	Determine net settlement amount (balance due)		.01					
	based on the cost report (see instructions) to Provider							6.01
								6.01
		Provider to	02					
		.02					(02	
7	TOTAL MEDICARE PROGRAM LIABILITY	Program	1					6.02
/	(see instructions)							1 ′
8	Name of Contractor	Contractor Number			NPR Date: Month, Da	v Vear		8
0	rame of Contractor	Contractor (Valider			THE Date. World, Do	ı, 1 cai		

⁽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.

ANALY	SIS OF RENAL I	DIALYSIS DEPARTMENT COSTS			PROVIDER CCN:	PERIOD: FROM	WORKSHEET I-1	()
Charles	pplicable box:	Renal Dialysis Department	[] Home Program Dialy			ТО		
Спеск а	ppiicable box:	[] Renai Diaiysis Department	[] Home Program Diary	TOTAL	1	I	FTEs per	т —
				COSTS	BASIS	STATISTICS	2080 Hours	
			<u> </u>	1	DASIS	3	4	4
1	Registered Nurse	ag .		1	Hours of Service	3	7	1
2	Licensed Practica				Hours of Service			2
3		ai ivuises			Hours of Service			3
	Technicians				Hours of Service			4
	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				Accumulated Cost			9
		,			Salary			10
11		Costs-Bldgs. & Fixtures			Square Feet			11
12		Costs-Mov. Equip.			Percentage of Time			12
					Percentage of Time			13
14	Supplies	терин			Requisitions			14
	Pediatric Medica	1 Supplies			Requisitions			14.01
15	Drugs				Requisitions			15
16	Other				Accumulated Cost			16
17	Subtotal (sum of	lines 9-16)*						17
18	Capital Related C	Costs-Bldgs. & Fixtures			Square Feet			18
19	Capital Related C	Costs-Mov. Equip.			Percentage of Time			19
20	Employee Benefi	its Department			Salary			20
21	Administrative as	nd General			Accumulated Cost			21
22	Maint./Repairs-C	peration-Housekeeping			Square Feet			22
23	Medical Education	on Program Costs						23
24	Central Services				Requisitions			24
25	Pharmacy				Requisitions			25
26	Other Allocated	Costs			Accumulated Cost			26
27	Subtotal (sum of	lines 17-26)*						27
28	Laboratory (see i	nstructions)			Charges			28
29	Respiratory Ther	apy (see instructions)			Charges			29
30	Other (see instruc	ctions)			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.

ALLOC.	ATION OF RENAL DEPARTMENT CO	STS TO TREAT	MENT MODALIT	TIES	101	dvi Civis-255	2 10				PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET I-2	03-23
Check at	oplicable box: [] Renal Dialysis	s Department	[] Home Progra	ım Dialysis										
	TIENT SERVICES		[]g-											$\overline{}$
	SITE PAYMENT RATE		AL AND D COSTS	DIRECT CARE S		EMPLOYEE BENEFITS		MEDICAL	PEDIATRIC MEDICAL	ROUTINE ANCILLARY	SUBTOTAL (sum of		TOTAL (col. 9 +	
		BUILDING		RNs	OTHER	DEPARTMENT	DRUGS	SUPPLIES	SUPPLIES	SERVICES	cols. 1-8)	OVERHEAD	col. 10)	
		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
	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

Check applicable host	DIRECT	AND INDIRECT RE	ENAL DIALYSIS COST ALI	LOCATION -								PROVIDER CCN:	PERIOD:	WORKSHEET I-3	
Check applicable Not	STATIS	TICAL BASIS											FROM		
CAPTAL AND RELATED COSTS BILLIDING EQUIMENT CARE SALARY EMPLOYEE EMSPETS SUPPLIES													ТО	_	
RELATION COMPOSITE PAYMINT SERVICES COM	Check a	pplicable box:	[] Renal Dialysis Department	[] Home	Program Dialysis							•			
RILLIDNE GUIPMENT SERVICES GUIPMENT SERVICES GUIPMENT GU				CAPITA	AL AND										1
COMPOSITE PAYMENT SERVICES FOST FROM HOURS HOURS HOURS HOURS GALARY DRUGS REPUIST RE				RELATE	D COSTS	DIRECT	PATIENT	EMPLOYEE			PEDIATRIC	ROUTINE			
FEET TIMES				BUILDING	EQUIPMENT	CARE S	SALARY	BENEFITS		MEDICAL	MEDICAL	ANCILLARY		OVERHEAD	
Total Renal Department Costs		COMPOSITE PAYM	MENT SERVICES	(SQUARE	(% OF	RNs	OTHERS	DEPARTMENT	DRUGS	SUPPLIES	SUPPLIES	SERVICES	SUB-	(ACCUM.	
1 Total Renal Department Costs				FEET)	TIME)	(HOURS)	(HOURS)	(SALARY)	(REQUIST.)	(REQUIST.)	(REQUIST.)	(CHARGES)	TOTAL	COST)	
MINTENANCE				1	2	3	4	5	6	7	7.01	8	9	10	1
2 Hemodalysis	1	Total Renal Departm	nent Costs												1
AKI-Henofalayisis		MAINTENANCE													
Remodalysis-Pedataric	2	Hemodialysis													2
Remodalysis-Pedataric	2.01	AKI-Hemodialysis													2.01
3 Intermittent Peritoneal	2.02	Hemodialysis-Pediat	tric												2.02
3.02 PD-Pedatric	3	Intermittent Peritone	eal												
3.02 PD-Pedatric	3.01	AKI- Intermittent Pe	eritoneal												3.01
TRAINING	3.02	IPD-Pediatric													
Hemodialysis Hemo															
Hemodialysis-Pediatric	4														4
S Intermittent Perioneal			tric												4.01
FOR Populating FOR															
6 CAPD 6.01 CAPD-Pediatric 7 CCDP 7.01 CCPD-Pediatric HOME 8 Hemodialysis Pediatric 9 Intermittent Peritoneal 10 CAPD 10 CAPD 11 CCCDP 11 CCCDP 11 CCCDP 12 Inpatient Dialysis Treatments 12 Inpatient Dialysis Treatments 13 Method II Homo Patient 14 ESAS 15 ARANIESP (see instructions) 16 Other 17 Total Statistical Basis 1															
CAPD-Pediatric COPD															
7 CCDP 7.01 CCPD-Pediatric															
7.01 CCPD-Pediatric															
HOME															
Remodialysis Remodialysis Remodialysis Rediatric Remodialysis Remodialysis Rediatric Remodialysis Rediatric Remodialysis Remodialysis Remodiatric Re	- ,,,,,,														
Remodialysis-Pediatric Remodiatric Remodiatric Remodiatric Re	8														8
9 Intermittent Peritoneal 9 9.01 IPD-Pediatric 9 10 CAPD 9.01 CAPD 9.01 11 CCPD-Pediatric 9 11.01 CCPD-Pediatric 9			tric												
9.01 IPD-Pediatric								1							
10 CAPD															
10.01 CAPD-Pediatric															
11 CCDP 1															
11.01 CCPD-Pediatric															
OTHER BILLABLE SERVICES 6 6 6 12 Inpatient Dialysis Treatments 12 12 Inpatient Dialysis Treatments 12 12 12 13 Method II Home Patient 13 13 14 13 14															
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	11.01		ESERVICES												11.01
13 Method II Home Patient 13 14 ESAs 14 15 ARANESP (see instructions) 15 16 Other 16 17 Total Statistical Basis 17	12														12
14 ESAs 14 15 ARANESP (see instructions) 15 16 Other 16 17 Total Statistical Basis 17															
15 ARANESP (see instructions) 15 16 Other 16 Other 17 Total Statistical Basis 17			iont												
16 Other 16 Other 17 Total Statistical Basis 17 Other			ructions)												
17 Total Statistical Basis			iucionsj												
			ie					 							
							l	1				 			

.0,0	(001111)				1 011	01.10 20									00 -0
COMPU	UTATION OF AVERAGE COST PER TREATMENT									PROVIDER O	CCN:	PERIOD:		WORKSHEET	Γ I-4
FOR O	UTPATIENT RENAL DIALYSIS											FROM		İ	
												TO		İ	
Check a	applicable box: [] Renal Dialysis Department	[] Home Program	m Dialysis							-					
				Average Cost				Total				Average	1	1	
			Total Cost	of				Program				Payment	Average	Average	İ
		Number	(from	Treatments	Number	Number	Number	Expenses	Total	Total	Total	Rate	Payment Rate	Payment Rate	İ
		of Total	Wkst. I-2,	(col. 2 ÷	of Program	of Program	of Program	(see	Program	Program	Program	(col. 6 ÷	(col. 6.01 ÷	(col. 6.02 ÷	İ
		Treatments	col. 11)	col. 1)	Treatments	Treatments	Treatments	instructions)	Payment	Payment	Payment	col. 4)	col. 4.01)	col. 4.02)	İ
		1	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	İ
1	Maintenance - Hemodialysis											1			1
1.01	Maintenance - AKI Hemodialysis												1	1	1.01
2	Maintenance - Peritoneal Dialysis												1	1	2
2.01	Maintenance - AKI Peritoneal Dialysis												1	1	2.01
3	Training - Hemodialysis												1	1	3
4	Training - Peritoneal Dialysis												1	1	4
5	Training - CAPD														5
6	Training - CCPD														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis														8
		Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks					T	1		
	Home Program - CAPD													<u> </u>	9
	Home Program - CCPD														10
11	Totals (sum of lines 1 through 8, cols. 1 and 4)														11
	(sum of lines 1 through 10, cols. 2, 5, and 6)														İ
	(see instructions)														
12	Total treatments (sum of lines 1 through 8														12
	plus (sum of lines 9 and 10 times 3))														1
	(see instructions)														1

12-22	FORM CM	IS-2552-10		4090 (Cont.)
CALCU	ILATION OF REIMBURSABLE	PROVIDER CCN:	PERIOD:	WORKSHEET I-5
BAD DI	EBTS - TITLE XVIII - PART B		FROM	
			ТО	
	Description	•		•
	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 re	ecoveries for		5.01
5.02	services rendered on or after 1/1/2011 but before 1/1/2012 Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt re	anavanias fan		5.02
3.02	services rendered on or after 1/1/2012 but before 1/1/2013	ecoveries for		3.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt re	ecoveries for		5.03
5.05	services rendered on or after 1/1/2013 but before 1/1/2014	ecoveries for		5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for			5.04
	services rendered on or after 1/1/2014			
5.05	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
	II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE	Е		
	Total allowable expenses (see instructions)			12
13	Total composite costs (from Wkst. I-4, col. 2, line 11) Facility specific composite cost percentage (line 13 divided by line 12)			13
14	racinty specific composite cost percentage (line 13 divided by line 12)			14
PART	III - ESRD PAYMENTS - INFORMATION ONLY			
	Low volume payment amount (see instructions)			15
	TDAPA			16
	TPNIES			17
18				18
19	HDPA			19
20	PPA			20

	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART I	
PARTI	- ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMUNITY	MENTAL HEALTH	CENTER COST CEN	ΓERS			<u> </u>			
	MPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.)	CAI	PITAL ED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	Administrative and General	U	1	2	4	4A	5	0	/	8	1
	Skilled Nursing Care										2
	Physical Therapy										3
4	Occupational Therapy										4
- 5	Speech Pathology										5
	Medical Social Services										6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
	Group Therapy										10
	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
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

01-22					FO:	RM CMS-25	52-10					4090	(Cont.)
	CATION OF GENERAL SERVICE COSTS UNITY MENTAL HEALTH CENTERS	ТО								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET J-1, PART I (CONT.)	
PART I	- ALLOCATION OF GENERAL SERVICE	E COSTS TO COM	MUNITY MENT	AL HEALTH CE	NTER COST CEN	TERS					<u> </u>		
cc	OMPONENT COST CENTER (omit cents)	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	
	Administrative and General	9	10	11	12	13	14	13	10	1 /	10	19	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
	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others											1	21
22	Totals (sum of lines 1-21)(1)												22

23 Unit Cost Multiplier (see instructions)

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

COMMUNITY MENTAL HEALTH CENTERS								PROVIDER CCN: COMPONENT CCN:	FROM PAI		WORKSHEET J-1, PART I	
PARTI	- ALLOCATION OF GENERAL SERVICE CO	STS TO COMMUNITY	V MENTAL HEALTH	CENTER COST CENT	TERS							
COMPONENT COST CENTER (omit cents)		NURSING PROGRAM		RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 4A-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJ. 25	SUBTOTAL (sum of cols. 24 ± 25) 26	ALLOCATED COMPONENT A&G (see Part II) (2)	TOTAL (sum of cols. 26 ± 27)		
1	Administrative and General										1	
2	Skilled Nursing Care										2	
	Physical Therapy										3	
4	Occupational Therapy										4	
5	Speech Pathology										5	
	Medical Social Services										6	
7	Respiratory Therapy										7	
	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	
	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.

	CATION OF GENERAL SERVICE COSTS TO				514.1 61.15 2002			PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART II	(001111
COMIN	IUNITY MENTAL HEALTH CENTERS							COMPONENT CCN:	TO	- PARTII	
DADTI	I - ALLOCATION OF GENERAL SERVICE CO	OCTO TO COMM	INITEN MENTAL HEAL	TH CENTED COST CEN	TEDE CTATICTICAL	DACIC					
PARTI	1 - ALLOCATION OF GENERAL SERVICE CO	JS1S 10 COMMU		IH CENTER COST CEI PITAL	NIERS - STATISTICAL	BASIS	T		T		
				ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
			BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN	
	CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	SERVICE	
	(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	
	(onit cens)		FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	
		0	1	2	4	4A	5	6	7	8	†
	Administrative and General	Ü			·	12.2	, and the second	v	,	<u> </u>	1
	Skilled Nursing Care										2
	Physical Therapy										3
	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)									<u> </u>	22
	Total Cost to be Allocated									<u> </u>	23
24	Unit Cost Multiplier (see instructions)				ĺ						24

	CATION OF GENERAL SERVICE COSTS TO IUNITY MENTAL HEALTH CENTERS									PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART II (CONT.)	
COMM	IONITY MENTAL HEALTH CENTERS									COMPONENT CCN:		- PART II (CONT.)	
PARTI	I - ALLOCATION OF GENERAL SERVICE C	COSTS TO COMM	UNITY MENTA	L HEALTH CEN	TER COST CEN	TERS - STATISTI	CAL BASIS				l		
	. Tibbeenfilest of obstantib blickfeld o				MAIN-		Di Ibio					NON-	T
					TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
		HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
	CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
	(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
		SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
		9	10	11	12	13	14	15	16	17	18	19	1
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											1	7
	Psychiatric/Psychological Services												8
	Individual Therapy												9
	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
	Diagnostic Services												13
14	Approved Patient Training & Education												14
	Prosthetic and Orthotic Devices												15
	Drugs and Biologicals												16
	Medical Supplies												17
	Medical Appliances												18
	Durable Medical Equipment-Rented												19
	Durable Medical Equipment-Sold												20
	All Others												21
	Totals (sum of lines 1-21)					ĺ						1	22
	Total Cost to be Allocated					ĺ						1	23
	Unit Cost Multiplier (see instructions)											1	24

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS				ORIVI CIVIS-2332	10		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART II (CONT.)	(Cont.)
PART II - ALLOCATION OF GENERAL SERVICE O	COSTS TO COMMUNITY	V MENTAL HEALTH C	ENTED COST CENTER	DS STATISTICAL DAS	EIS					
CORF COST CENTER (omit cents)	NURSING PROGRAM (ASSIGNED TIME)		RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	24			27	28	
1 Administrative and General	20	21	22	23	24	25	26	21	28	1
2 Skilled Nursing Care										1 2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

4090	(Cont.)			1.0	JKWI CIVIS-2332.	-10					01-22
COMP	JTATION OF COMMUNITY MENTAL HE	EALTH CENTER PROV	TIDER COSTS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-2, PART I	
								COMPONENT CCN:	TO	_	
PART I	- APPORTIONMENT OF CMHC COST CE		1		7	•		•	•		
		(From		Ratio of		Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Pt. I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
		col. 28)	Charges	(col. 1 ÷ col. 2)	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapy										11
	Family Counseling										12
	Diagnostic Services										13
14	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
17	Medical Supplies										17
	Medical Appliances										18
	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.

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

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

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

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

4090 (Cont.)		FORM CMS-2552-10						
		OF REIMBURSEMENT SETTLEMENT COMMUNITY TH CENTER PROVIDER SERVICES		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-3			
Check applicable box:	le	[] Title V [] Title VIII [] Title XIX			•	-			
		()				PROGRAM COST			
1	Cost of	component services (from Wkst. J-2, Pt. II, line 29)					1		
2		ments received excluding outliers					2		
3	Outlier	payments					3		
4	Primary	payer payments					4		
5	Total re	asonable cost (see instructions)					5		
6	Total cl	narges for program services					6		
	CUSTO	MARY CHARGES							
7	Aggreg	ate amount actually collected from patients liable for services	s on a charge basis				7		
8	Amoun	that would have been realized from patients liable for paym	nent for services on a charge				8		
	basis ha	d such payment been made in accordance with 42 CFR 413.	.13(e)				8		
9	Ratio of	f line 7 to line 8 (not to exceed 1.000000) (see instructions)					9		
10	Total cu	stomary charges (see instructions)					10		
	Excess		11						
12	Excess	of reasonable cost over customary charges (see instructions))				12		
	COMP	JTATION OF REIMBURSEMENT SETTLEMENT							
13		asonable cost (from line 5)					13		
14	Part B	leductible billed to program patients					14		
15		t (line 13 minus line 14)					15		
		of reasonable cost over customary charges (from line 12)					16		
		l (line 15 minus line 16)					17		
18		ent of costs (80% of line 17) (see instructions)					18		
19		coinsurance billed to program patients (from provider record	s)				19		
20		t less actual billed coinsurance (line 17 minus line 19)					20		
21		ble bad debts (from provider records) (see instructions)					21		
22		d reimbursable bad debts (see instructions)					22		
23		ble bad debts for dual eligible beneficiaries (see instructions	(3)				23		
24		nbursable amount (see instructions)					24		
25		djustments (see instructions) (specify)					25		
25.50		ACO demonstration payment adjustment (see instructions)					25.50		
25.99		stration payment adjustment amount before sequestration					25.99		
26		est (see instructions)					26		
26.01		ration adjustment (see instructions)					26.01		
		stration payment adjustment amount after sequestration					26.02		
27	Interim	payments (see instructions)					27		

28 Tentative settlement (for contractor use only)

29 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)
30 Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)

11-16]	ORM CMS-2552	2-10			4090) (Cont.)
	TO HOSPITAL-BASED COMMUNITY MENTAI ENDERED TO PROGRAM BENEFICIARIES	HEALTH	PROVIDER	CCN:	PERIOD: FROM	WORKSHEET J-4	
			COMPONE	NT CCN:	то		
Check						l .	
applicable	[] Title XVIII						
boxes:							
	•				Pa	urt B	
DESCRIPTION					1	2	
					mm/dd/yyyy	Amount	
1 Total interim paymen	ts paid to providers						1
2 Interim payments pay	rable on individual bills, either						2
	bmitted to the intermediary, for						
	he cost reporting periods. If						
none, write "NONE",							
3 List separately each r				.01			3.01
lump sum adjustment			Program	.02			3.02
based on subsequent the interim rate for the			to Provider	.03			3.03
			Provider	.04			3.04
cost reporting period. date of each payment				.50			3.03
If none, write "NONI			Provider	.51			3.51
or enter zero (1).	· ,		to	.52			3.52
of effect zero (1).			Program	.53			3.53
			Trogram	.54			3.54
Subtotal (sum of line	s 3 01-3 49			.51			3.31
minus sum of lines 3.				.99			3.99
	ts (sum of lines 1, 2, and 3.99)						4
(transfer to Workshee							
	<i>'</i>				•	•	
	D BY INTERMEDIARY						
5 List separately each to			Program	.01			5.01
settlement payment a			to	.02			5.02
Also show date of each			Provider	.03			5.03
If none, write "NONI	Ε,"		Provider	.50			5.50
or enter zero (1).			to	.51			5.51
			Program	.52			5.52
Subtotal (sum of line							
sum of lines 5.50-5.9				.99			5.99
6 Determine net settlen			Program				
(balance due) based of			to				6.01
report (see instruction	ns). (1)		Provider	.01			6.01
			Provider				
			to Duo onom	02			6.02
7 Total Medicare liabil	ity		Program	.02			6.02
(see instructions)	пу						/
8 Name of Contractor		Contractor Number		NIDD I	Date (Month, Day, Year)		8
o Ivanic of Contractor		Contractor Number		INIKI	Jace (Wollin, Day, 1 cal)		°
				I			

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

ANALY	SIS OF HOSPITAL-BASED E COSTS								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET K	
COS	T CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER 5	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	3	0	/	8	9	10	+
1	Capital Related Costs-Bldg and Fixt.											1
	Capital Related Costs-Movable Equip.											2
	Plant Operation and Maintenance											3
	Transportation - Staff											4
	Volunteer Service Coordination											5
	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
	Nursing Care											10
	Nursing Care-Continuous Home Care											11
	Physical Therapy											12
	Occupational Therapy											13
	Speech/ Language Pathology											14
	Medical Social Services											15
	Spiritual Counseling											16
	Dietary Counseling											17
	Counseling - Other											18
	Home Health Aide and Homemaker											19
	HH Aide & Homemaker - Cont. Home Care											20
	Other											21
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
	Analgesics											23
	Sedatives / Hypnotics											25
	Other - Specify											25
	Durable Medical Equipment/Oxygen			1	1			1	1			26
	Patient Transportation			1	1			1	1			27
	Imaging Services											28
	Labs and Diagnostics											29
30	Medical Supplies			1	1			1	1			30
	Outpatient Services (including E/R Dept.)			1	1			1	1			31
	Radiation Therapy											32
33	Chemotherapy											33
	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

	E COMPENSATION ANALYSIS IES AND WAGES							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-1	()
COS	T CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES	ALL OTHER	TOTAL (1)	
	GENERAL SERVICE COST CENTERS	1		,	т	,	0		8		
	Capital Related Costs-Bldg and Fixt.										
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
- 0	INPATIENT CARE SERVICE										─ Ŭ
7	Inpatient - General Care										7
	Inpatient - Respite Care										8
- 0	VISITING SERVICES										─ Ŭ
9	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services										15
	Spiritual Counseling										16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker										19
	HH Aide & Homemaker - Cont. Home Care										20
	Other										21
21	OTHER HOSPICE SERVICE COSTS										21
22	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
2.1	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services					 					28
	Labs and Diagnostics					t					29
	Medical Supplies					t					30
	Outpatient Services (including E/R Dept.)					 					31
	Radiation Therapy					 					32
	Chemotherapy					 					33
	Other					t					34
51	HOSPICE NONREIMBURSABLE SERVICE										1 37
35	Bereavement Program Costs										35
	Volunteer Program Costs					†				1	36
	Fundraising					†				1	37
	Other Program Costs		1	1	1	1			1		38
	Total (sum of lines 1 thru 38)									İ	39

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE							PROVIDER CCN:	PERIOD:	WORKSHEET K-2	
BENEFITS (PAYROLL RELATED)								FROM	_	
							COMPONENT CCN:	ТО	_	
		T				1				
			MEDICAL							
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
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	1									29
30 Medical Supplies									+	30
31 Outpatient Services (including E/R Dept.)										31
32 Radiation Therapy										32
33 Chemotherapy	1									33
34 Other			-	+	+					34
HOSPICE NONREIMBURSABLE SERVICE										34
35 Bereavement Program Costs										35
36 Volunteer Program Costs	+									36
36 Volunteer Program Costs 37 Fundraising										36
- v										
38 Other Program Costs										38
39 Total (sum of lines 1 thru 38)			<u>l</u>	l .	l .]]		39

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

09-13			FC	JKM CMS-2332	-10				4090 (Cont.
HOSPICE COMPENSATION ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-3	
CONTRACTED SERVICES/PURCHASED SERVICES								FROM	_	
							COMPONENT CCN:	то	_	
			MEDICAL						+	T
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
(onit cens)	1	2	3	4	5	6	7	8	9	1
GENERAL SERVICE COST CENTERS		2	J	·	3	Ů	,			
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										
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.)	.		ļ	ļ				ļ	4	31
32 Radiation Therapy										32
33 Chemotherapy										33 34
34 Other										34
HOSPICE NONREIMBURSABLE SERVICE										2.0
35 Bereavement Program Costs									_	35 36
36 Volunteer Program Costs									+	
37 Fundraising 38 Other Program Costs					-			-	+	37
38 Other Program Costs 39 Total (sum of lines 1 thru 38)								+	+	38
39 Total (sum of lines 1 thru 38)				l .						35

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

COST ALLOCATION - HOSPICE GENERAL SERVIC	E COST			7KW CW3 2332			PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-4, PART I	071.
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	CAPITAL RE BUILDINGS & FIXTURES	LATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICES COORDI- NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
GENERAL SERVICE COST CENTERS	0	1	2	3	4	5	5A	6	7	_
Capital Related Costs-Bldg and Fixt.										
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										
INPATIENT CARE SERVICE										`
7 Inpatient - General Care										1
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							1			2:
26 Durable Medical Equipment/Oxygen							1			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						1	1	1	1	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: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-4, PART II	(
		CAPITAL RE BUILDINGS	LATED COST MOVABLE	PLANT OPERATION	TRANS-	VOLUNTEER SERVICES		ADMINIS- TRATIVE &	
COST CENTER DI	ESCRIPTIONS	& FIXTURES (SQ. FT.)	EQUIPMENT (\$ VALUE) 2	& MAINT. (SQ. FT.)	PORTATION (MILEAGE) 4	COORDINATOR (HOURS)	RECONCIL- IATION 6A	GENERAL (ACC. COST)	
GENERAL S	ERVICE COST CENTERS	·				J	Ų, į	Ů	
1 Capital Relate	ed Costs-Bldg and Fixt.								1
2 Capital Relate	ed Costs-Movable Equip.								2
3 Plant Operation	on and Maintenance								3
4 Transportation									5
5 Volunteer Ser	vice Coordination								5
6 Administrativ	e and General								6
INPATIENT	CARE SERVICE								
7 Inpatient - Ge	eneral Care								7
8 Inpatient - Re									8
VISITING SE									
9 Physician Ser									9
10 Nursing Care									1(
11 Nursing Care-	-Continuous Home Care								11
12 Physical Thera									12
13 Occupational									13
14 Speech/ Lang									14
15 Medical Socia									15
16 Spiritual Cour									16
17 Dietary Couns									17
18 Counseling -									13
	Aide and Homemaker								19
	Iomemaker - Cont. Home Care								20
21 Other									2.1
	SPICE SERVICE COSTS								
	gical and Infusion Therapy								22
23 Analgesics									2.
24 Sedatives / Hy									24
25 Other - Specif									2:
26 Durable Medi	ical Equipment/Oxygen								20
27 Patient Transp				1	1	1		1	27
28 Imaging Servi	ices								28
29 Labs and Diag 30 Medical Supp									30
21 Outputiont S.	rvices (including E/R Dept.)								31
32 Radiation The	avices (metuding E/K Dept.)			 	-	-		+	32
								+	33
33 Chemotherapy 34 Other	y							+	34
	ONREIMBURSABLE SERVICE								34
	Program Costs								35
36 Volunteer Pro									36
37 Fundraising	gram Cosis								37
38 Other Program	m Coete			1		1			38
	n Costs llocated (per Wkst. K-4, Part I)			1		+		+	39
	nocaica (per vykšt. IX=4, 1 dll 1)	ı				1			33

40-637

4090	(Cont.)			г	JKWI CWIS-2332	-10					09-1
	CATION OF GENERAL SERVICE							PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
COSTS	TO HOSPICE COST CENTERS							GOV POVENER GOV	FROM	PART I	
								COMPONENT CCN:	10	-	
DADTI	- ALLOCATION OF GENERAL SERVICE COST	S TO HOSDICE	COST CENTERS								
FARII	- ALLOCATION OF GENERAL SERVICE COST	3 TO HOSPICE C	JOST CENTERS								Т
		From	HOSPICE	CAP	ITAL						
1	HOSPICE COST CENTER	Wkst. K-4	TRIAL		D COSTS	EMPLOYEE		ADMINIS-	MAIN-		
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	
	(omit cents)	col. 7,	(1)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	
		line	0	1	2	4	4A	5	6	7	1
	Administrative and General	6	,	·	-	·			Ů	<i>'</i>	+
2	Inpatient - General Care	7									1
- 3	Inpatient - Respite Care	8									1
4	Physician Services	9									1
	Nursing Care	10									1
	Nursing Care-Continuous Home Care	11									
	Physical Therapy	12									_
	Occupational Therapy	13									7
9		14									
10		15									10
11	Spiritual Counseling	16									1
12	Dietary Counseling	17									1:
13	Counseling - Other	18									1:
14	Home Health Aide and Homemaker	19									1-
15	HH Aide & Homemaker - Cont. Home Care	20									1:
16	Other	21									10
17	Drugs, Biological and Infusion Therapy	22									1
	Analgesics	23									1
	Sedatives / Hypnotics	24									15
	Other - Specify	25									20
	Durable Medical Equipment/Oxygen	26									2
	Patient Transportation	27									2.
	Imaging Services	28									2.
	Labs and Diagnostics	29									2
	Medical Supplies	30									2:
	Outpatient Services (including E/R Dept.)	31									2
	Radiation Therapy	32									2
	Chemotherapy	33									2
	Other	34									2
	Bereavement Program Costs	35									31
	Volunteer Program Costs	36									3
	Fundraising	37									32
	Other Program Costs	38									3:
34	Totals (sum of lines 1-33) (2)			1	l	I	ľ		1	I	34

35 Unit Cost Multiplier (see instructions)

⁽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.

	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS								PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET K-5, PART I (Cont.)	
PART I	- ALLOCATION OF GENERAL SERVICE COSTS T	TO HOSPICE COST	CENTERS						L	<u> </u>		
	HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
1	Administrative and General											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
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (including E/R Dept.)											26
27	Radiation Therapy											26 27
28	Chemotherapy											28
	Other											29
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
	Fundraising					i				1		32
	Other Program Costs											33
	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.

	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS									PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART I (Cont.)	
PART I	- ALLOCATION OF GENERAL SERVICE COS	TS TO HOSPICE	E COST CENTER	S	•			•					_
	HOSPICE COST CENTER (omit cents)	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & SALARY & FRINGES	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
	Inpatient - General Care												2
	Inpatient - Respite Care												3
	Physician Services											<u> </u>	4
	Nursing Care												5
	Nursing Care-Continuous Home Care												6
	Physical Therapy											<u> </u>	7
	Occupational Therapy												8
	Speech/ Language Pathology												-
	Medical Social Services Spiritual Counseling												10 11
	Dietary Counseling												11
													13
	Counseling - Other Home Health Aide and Homemaker												
	HH Aide & Homemaker - Cont. Home Care											 	14
	Other												15 16
	Drugs, Biological and Infusion Therapy	-							-				17
	Analgesics											+	18
	Sedatives / Hypnotics											 	19
	Other - Specify												20
	Durable Medical Equipment/Oxygen											 	21
	Patient Transportation												22
	Imaging Services											+	23
	Labs and Diagnostics											+	24
	Medical Supplies											 	25
	Outpatient Services (including E/R Dept.)												26
	Radiation Therapy												27
	Chemotherapy												28
	Other	1									İ	1	29
30	Bereavement Program Costs												30
	Volunteer Program Costs												31
	Fundraising	1									İ	1	32
33	Other Program Costs												33
	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.

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

	ATION OF GENERAL SERVICE COSTS TO E COST CENTERS STATISTICAL BASIS							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET K-5, PART II	
PARTII	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE	COST CENTERS -	STATISTICAL BA	212		I					
THE I	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	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.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1	Administrative and General										1
2	Inpatient - General Care										2
3	Inpatient - Respite Care										3
	Physician Services										4
	Nursing Care										5
	Nursing Care-Continuous Home Care										6
	Physical Therapy										7
	Occupational Therapy										8
	Speech/ Language Pathology										9
	Medical Social Services										10
11	Spiritual Counseling										11
	Dietary Counseling										12
	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
	Other - Specify										20
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
	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
	Bereavement Program Costs										30
31	Volunteer Program Costs										31
	Fundraising										32
33	Other Program Costs										33
	Totals (sum of lines 1-33) (2)										34
35	Total cost to be allocated										35
27	Wild Mile ()										26

	ATION OF GENERAL SERVICE COSTS TO CE COST CENTERS STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-5, PART II	
						COMPONENT CCN:		-	
PART I	I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS			I					
		SOCIAL	OTHER	NON- PHYSICIAN ANES-	NURSING	INTERNS &	k RESIDENTS PROGRAM	PARA- MEDICAL EDUCATION	
	HOSPICE COST CENTER	SERVICE (TIME SPENT)	GENERAL SERVICE (SPECIFY)	THETISTS (ASSIGNED TIME)	SCHOOL (ASSIGNED TIME)	FRINGES (ASSIGNED TIME) 21	COSTS (ASSIGNED TIME) 22	(SPECIFY) (ASSIGNED TIME) 23	_
1	Administrative and General						1		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							1	13
14	Home Health Aide and Homemaker							1	14
15	HH Aide & Homemaker - Cont. Home Care							1	15
16	Other							1	16
17	Drugs, Biological and Infusion Therapy							1	17
18	Analgesics							1	18
19	Sedatives / Hypnotics								19
20	Other - Specify							1	20
21	Durable Medical Equipment/Oxygen							1	21
22	Patient Transportation							1	22
23	Imaging Services							1	23
24	Labs and Diagnostics							1	24
25	Medical Supplies							1	25
	Outpatient Services (including E/R Dept.)							1	26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
	Fundraising								32
33	Other Program Costs							T	33
	Totals (sum of lines 1-33) (2)						1	1	34
	Total cost to be allocated						1	1	35
36	Unit Cost Multiplier (see instructions)								36

1070 ((Cont.)	1 01011 01115 2552 10				10 12
APPOR	TIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
				FROM	PART III	
			COMPONENT CCN:	ТО		
PART I	II - COMPUTATION OF TOTAL HOSPICE SHARED COSTS					
				Total	Hospice	
		Wkst. C,		Hospice	Shared	
		Part I,	Cost to	Charges	Ancillary	
		col. 9,	Charge	(Provider	Costs	
	COST CENTER	line	Ratio	Records)	(cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	66				1
2	Occupational Therapy	67				2
3	Speech/ Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73				4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60				6
7	Medical Supplies	71				7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	76				10
11	Totals (sum of lines 1-10)					11

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CALCU	JLATION OF HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-6	
			COMPONENT CCN:	то		
			l ———			
	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	1
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.

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CALCU	LATION OF CAPITAL PAYMENT			PROVIDER CCN:	PERIOD:	WORKSHEET L	
					FROM		
				COMPONENT CCN:	ТО		
Check	[] Title V	[] Hospital	[] PPS		<u>l</u>		
applicable		PARHM Demonstration	[] Cost Met	thod			
boxes:	Title XIX		.,				
PART I	- FULLY PROSPECTIVE METHOD	•	•				
	CAPITAL FEDERAL AMOUNT						
1	Capital DRG other than outlier						1
1.01	Model 4 BPCI Capital DRG other than or	utlier					1.01
2	Capital DRG outlier payments						2
2.01	Model 4 BPCI Capital DRG outlier paym						2.01
3	Total inpatient days divided by number of	f days in the cost reporting period (see in	structions)				3
4	Number of interns & residents (see instru	ictions)					4
5	Indirect medical education percentage (se	ee instructions)					5
6		,					6
7	Percentage of SSI recipient patient days to	1 /	eet E, Part A line 30)	(see instructions)			7
- 8		tal days (see instructions)					8
9	Sum of lines 7 and 8						9
10							10
11	Disproportionate share adjustment (see in						11
12	Total prospective capital payments (see in						12
PARTI	I - PAYMENT UNDER REASONABLE C						
1	Program inpatient routine capital cost (se						1
2	Program inpatient ancillary capital cost (s						2
3	Total inpatient program capital cost (line	* /					3
5	Capital cost payment factor (see instruction						5
	Total inpatient program capital cost (line : II - COMPUTATION OF EXCEPTION PA						
PART I	Program inpatient capital costs (see instru						1
2						+	2
3		• •				+	3
4	Applicable exception percentage (see ins	<u> </u>				+	4
- 5	Capital cost for comparison to payments (7					5
- 6	Percentage adjustment for extraordinary c						6
7	Adjustment to capital minimum payment		ne 2 x line 6)				7
- 8	Capital minimum payment level (line 5 pl	•				1	8
9	Current year capital payments (from Part	I, line 12 as applicable)					9
10	Current year comparison of capital minim	num payment level to capital payments (li	ne 8 less line 9)				10
11	Carryover of accumulated capital minimu		/				11
	(from prior year Worksheet L, Part III, lin	ne 14)					
12	Net comparison of capital minimum payn	nent level to capital payments (line 10 plu	us line 11)				12
13	Current year exception payment (if line 12	2 is positive, enter the amount on this line	e)				13
14	Carryover of accumulated capital minimu	m payment level over capital payment					14
	for the following period (if line 12 is negative	ative, enter the amount on this line)					
15	Current year allowable operating and cap	pital payment (see instructions)					15
16		,					16
17	Current year exception offset amount (see	e instructions)					17

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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		ITAL D COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	U	1	Z	ZA	4	3	0	/	
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
										60
	PBP Clinical Laboratory Service-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Ç, Ç,									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis ASC (Non-Distinct Part)									74
	Other Ancillary (specify)									75 76
	Allogeneic HSCT Acquisition									77
	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									/8
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
	Other Outpatient (specify)									93
	Partial Hospitalization Program									93.99

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		TTAL ED COSTS						
•	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	2A	4	5	6	7	
	OTHER REIMBURSABLE COST CENTERS									0.4
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition									108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross Foot Adjustments									200
201	Negative Cost Centers									201
202	Total (sum of line 118 and lines 190 through 201)									202
203	Total Statistical Basis									203
204	Unit Cost Multiplier									204

Cost Center Descriptions	OCATION OF ALLOWABLE COSTS I LAORDINARY CIRCUMSTANCES	OR							PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART I (Cont.)	
GENERAL SERVICE COST CENTERS	Cost Center Descriptions	& LINE SERVIC	HOUSE KEEPING	G DIETARY		TENANCE OF PERSONNEL	ADMINIS- TRATION	SERVICES & SUPPLY		RECORDS & LIBRARY	SERVICE	
1 Capital Related Costs-Buildings and Fatures	GENERAL SERVICE COST CENT		9	10	11	12	13	14	15	16	17	+-
2 Capital Related Costs Monable Equipment 4 Employee Benefits Department 5 Administrative and General 6 Maintenance and Repairs 7 Operation of Plant 8 Landry and Linen Service 9 Housekeeping 10 Dietery 11 Caffetria 12 Manatemance of Personnel 13 Nustaine Administration 14 Central Services and Supply 15 Plantense 16 Plantense 17 Plantense 18 Plantense 19 Nondropkain Ameditedusts 18 Other General Service (specify) 19 Nondropkain Ameditedusts 20 Nustaine Program 19 Nondropkain Ameditedusts 20 Nustaine Program 20 Intern & Res. Service-Salary & Fringes (Approved) 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Service Salary & Fringes (Approved) 23 Parameteral Ed. Program (specify) 10 Intern & Res. Service Salary & Fringes (Approved) 24 Intern & Res. Other Program Costs (Approved) 25 Parameteral Ed. Program (specify) 16 Intern & Res. Service Salary & Fringes (Approved) 17 Intern & Res. Other Program Costs (Approved) 18 Interns & Res. Other Program Costs (Approved) 19 Interns & Res. Other Program Costs (Approved) 27 Interns & Res. Other Program Costs (Approved) 28 Interns & Res. Other Program Costs (Approved) 29 Interns & Res. Other Program Costs (Approved) 30 Adults and Pedatries (General Routine Carre) 31 Internsive Care Unit 32 Subprovider IP 33 Subprovider IP 34 Subprovider IP 35 Subprovider IP												_
4 Employee Banefits Department 5 Administrative and General 6 Maintenance and Repairs 7 Operation of Plant 8 Laundry and Linen Service 9 Hossekeeping 11 Cateleria 12 Maintenance of Personnel 13 Nursing Administration 14 Certal Services and Supply 15 Plantracy 16 Medical Records & Medical Records Library 17 Social Service 18 Other General Service (specify) 19 Nopalpysician Anashetists 10 Nopalpysician Anashetists 10 Nopalpysician Anashetists 10 Nursing Program 11 Intern & Res. Service-Solary & Fringes (Approved) 12 Intern & Res. Service-Solary & Fringes (Approved) 13 Internsive Care Unit 14 Intensive Care Unit 15 Plantracy 16 Intensive Care Unit 17 Social Service 18 Intensive Care Unit 19 Nopalpysician Anashetists 19 Nopalpysician Anashetists 10 Intensive Care Unit 10 Intensive Care Unit 11 Intensive Care Unit 12 Supprovider Intensive Care Unit 13 Supprovider IRF 14 Subprovider IRF 15 Subprovider IRF 16 Subprovider IRF 17 Subprovider IRF 18 Subprovider IRF												
S. Administrative and General		pinem										-
6 Maintenance and Repuirs 7 Operation of Plant 8 Laundry and Linen Service 9 Housekeeping 10 Decay 11 Cafeteria 12 Maintenance of Personnel 13 Nursing Administration 14 Certail Services and Supply 15 Pharmacy 16 Medical Records & Medical Records Library 17 Social Service 18 Other General Service (specify) 19 Nonphysician Anasthetists 10 Nursing Program 10 Linet & Res. Service-Salary & Fringes (Approved) 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Ed. Program (specify) 24 Nopara Program (specify) 25 Nopara Res. Other Program Costs (Approved) 26 Intern & Res. Other Program (cost (Approved) 27 Social Service (specify) 38 Nopara Res. Other Program Costs (Approved) 39 Nopara Res. Other Program Costs (Approved) 31 Intensive Care Unit 32 Coronary Care Unit 33 Sur Intensive Care Unit 34 Surjectal Intensive Care Unit 35 Other Special Care Unit 36 Subprovider (IFF 37 Subprovider (IFF 38 Subprovider (IFF 39 Subprovider (IFF 40 Subprovider (IFF 41 Subprovider (IFF 42 Subprovider 43 Subprovider 44 Skille Nursing Facility	1 2											
7 Operation of Plant												
S. Laundry and Linen Service												\vdash
Housekeeping												-
10 Dietary												
1 Cafeteria					=							
Maintenance of Personnel												
13 Nursing Administration												
14 Central Services and Supply								1				
15 Pharmacy									1			
Medical Records & Medical Records Library	5 Pharmacy											
17 Social Service	6 Medical Records & Medical Record	s Library										
10 Nonphysician Anesthetists		·										
Nursing Program	8 Other General Service (specify)											
21 Intern & Res. Service-Salary & Fringes (Approved)	9 Nonphysician Anesthetists											
22 Intern & Res. Other Program (Specify)	0 Nursing Program											
Paramedical Ed. Program (specify)												
INPATIENT ROUTINE SERVICE COST CENTERS 30 Adults and Pediatrics (General Routine Care) 31 Intensive Care Unit 32 Coronary Care Unit 33 Burn Intensive Care Unit 34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF 42 Subprovider 43 Nursery 44 Skilled Nursing Facility		Approved)										
30 Adults and Pediatrics (General Routine Care)												
31 Intensive Care Unit												
32 Coronary Care Unit	0 Adults and Pediatrics (General Rout	ne Care)										
33 Burn Intensive Care Unit												
34 Surgical Intensive Care Unit												
35 Other Special Care Unit (specify)												
40 Subprovider IPF												
41 Subprovider IRF												
42 Subprovider												
43 Nursery Skilled Nursing Facility 44 Skilled Nursing Facility Skilled Nursing Facility												
44 Skilled Nursing Facility												
45 Nursing Facility												╧
46 Other Long Term Care												\perp

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES								PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART I (Cont.)	(Con-
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
ANCILLARY SERVICE COST CENTERS	0	9	10	11	12	13	14	13	10	17	_
50 Operating Room											
51 Recovery Room											
52 Labor Room and Delivery Room											
53 Anesthesiology											
54 Radiology-Diagnostic											
55 Radiology-Therapeutic											:
56 Radioisotope											
57 Computed Tomography (CT) Scan											
58 Magnetic Resonance Imaging (MRI)											•
59 Cardiac Catheterization											:
60 Laboratory											(
61 PBP Clinical Laboratory Service-Program Only											(
62 Whole Blood & Packed Red Blood Cells											•
63 Blood Storing, Processing, & Trans.											(
64 Intravenous Therapy											(
65 Respiratory Therapy											•
66 Physical Therapy											
67 Occupational Therapy											
68 Speech Pathology											(
69 Electrocardiology											,
70 Electroencephalography											
71 Medical Supplies Charged to Patients											
72 Implantable Devices Charged to Patients											,
73 Drugs Charged to Patients											
74 Renal Dialysis											
75 ASC (Non-Distinct Part)											
76 Other Ancillary (specify)					ļ						
77 Allogeneic HSCT Acquisition					ļ						
78 CAR T-Cell Immunotherapy											,
OUTPATIENT SERVICE COST CENTERS											4—
88 Rural Health Clinic (RHC)				1							8
89 Federally Qualified Health Center (FQHC)											9
90 Clinic											9
91 Emergency 92 Observation Beds											9
											9
93 Other Outpatient (specify)				1							93
93.99 Partial Hospitalization Program											9.

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

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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I (Cont.)	
EAIKA	ORDINARY CIRCUMSTANCES								TO	PARTI (Cont.)	
						Г					_
	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	4
	ANCILLARY SERVICE COST CENTERS	10	17	20	21	22	23	27	23	20	
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
57	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
	PBP Clinical Laboratory Service-Program Only										61
	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										7
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy OUTPATIENT SERVICE COST CENTERS										78
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds										92
	Other Outpatient (specify)										93
	Partial Hospitalization Program										93.9

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

1070	(Cont.)	1,	O1011 C1115 2552	10					12 22
	UTATION OF PROGRAM INPATIENT ROUTINE SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET L-1, PART II	
Check applicabl 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)	Swing Bed Adjustment	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6)	
(11)	INPATIENT ROUTINE SERVICE COST CENTERS	·	2	J		, and the second			
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

		F PROGRAM INPATIENT AN OR EXTRAORDINARY CIRC		CE	1 914.1 91.13 2002			PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART III	(00111
								COMPONENT CCN:		-	
Check applicable boxes:		[] Hospital		[] Title V [] Title XVIII, Part A [] Title XIX				1	1		
	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 4	Program Extraordinary Capital Cost (col. 3 x col. 4)	
(A)	ANCHIAD	RY SERVICE COST CENTERS	c			1	2	3	4	3	-
	Operating R		8								50
	Recovery R									 	51
		n and Delivery Room									52
	Anesthesiol									 	53
	Radiology-I										54
	Radiology-T										55
	Radioisotop										55 56
		Tomography (CT) Scan									57
		esonance Imaging (MRI)									58
59	Cardiac Cat	theterization									59
60	Laboratory									1	60
61	PBP Clinica	al Laboratory Service-Program	Only								61
62	Whole Bloo	od & Packed Red Blood Cells									62
63	Blood Storia	ing, Processing, & Trans.									63
64	Intravenous	Therapy									64
65	Respiratory	Therapy									65
66	Physical Th	erapy									66
	Occupationa										67
	Speech Path										68
	Electrocardi										69
70	Electroence	phalography									70
		pplies Charged to Patients									71
		Devices Charged to Patients									72
		ged to Patients									73
	Renal Dialy										74
		Distinct Part)									75
		llary (specify)									76
77	Allogeneic 9	Stem Cell Acquisition							1	1	77

⁽A) Worksheet A line numbers

.0,0 (001	101)		1 014.1 01	2002 10					· ·
COMPUTAT	ION OF PROGRAM INPAT	FIENT ANCILLARY SERVICE				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
CAPITAL CO	OSTS FOR EXTRAORDINA	ARY CIRCUMSTANCES					FROM	PART III (CONT.)	
						COMPONENT CCN:	ТО		
Check	[] Hospital	[] Title V							
applicable		[] Title XVIII, Part A							
boxes:		[] Title XIX							
				Capital Cost for					
				Extraordinary				Program	
				Circumstances	Total Charges	Ratio of Cost		Extraordinary	
Cost	Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)				1	2	3	4	5	
	TPATIENT SERVICE COST	T CENTERS							
	al Health Clinic (RHC)								88
	erally Qualified Health Cente	er (FQHC)							89
90 Clin									90
91 Em									91
	ervation Beds								92
	er Outpatient (specify)								93
	ial Hospitalization Program								93.99
	IER REIMBURSABLE COS	ST CENTERS							
	ne Program Dialysis								94
	bulance Services								95
	able Medical Equipment-Ren								96
	able Medical Equipment-Solo	d							97
	er Reimbursable (specify)								98
200 Tota	al (sum of lines 50 through 19	99)			1				200

⁽A) Worksheet A line numbers

ANALY	SIS OF HOSPITAI	L-BASED RHC/FQHC COSTS					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET M-1	
Chaols or	pplicable box:	[] Hospital-based RHC [] Hospital-based FQHo	C							
CHECK a	орисане вох.	Hospital-oased KITC Hospital-oased (QITC	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	
		TH CARE STAFF COSTS								
	Physician								_	1
	Physician Assistan								 	2
3	Nurse Practitioner								 	3
	Visiting Nurse								+	4
5	Other Nurse	tu.							+	5
7	Clinical Psycholog Clinical Social Wo								+	7
7.10	Marriage and Fan						+		 	7.10
	Mental Health Con								 	7.11
7.11	Laboratory Techni						+		 	8
		lth Care Staff Costs							+	9
10	Subtotal (sum of li								+	10
	COSTS UNDER A	,								- 10
11	Physician Services									11
		sion Under Agreement					_		+	12
	Other Costs Under								+	13
	Subtotal (sum of li								+	14
	OTHER HEALTH									
	Medical Supplies									15
16	Transportation (He	ealth Care Staff)								16
17	Depreciation-Med									17
18	Professional Liabi								1	18
19	Other Health Care	Costs							1	19
20	Allowable GME C	Costs								20
21	Subtotal (sum of li	ines 15-20)							1	21
22	Total Cost of Heal	th Care Services							T	22
	(sum of lines 10, 1									
		HAN RHC/FQHC SERVICES								
	Pharmacy									23
	Dental									24
25	Optometry									25
25.01										25.01
25.02										25.02
26	All other nonreimb									26
27										27
		sable Costs (sum of lines 23-27)								28
	FACILITY OVER	HEAD								4
	Facility Costs								 	29
	Administrative Co									30
		rhead (sum of lines 29 and 30)					+		+	31
47						1	1		1	1 27

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.

	CATION OF OVERHEAD			PROVIDER CCN:	PERIOD:	WORKSHEET M-2	
TO HO	SPTIAL-BASED RHC/FQHC SERVICES			COMPONENT CCN:	FROM TO		
Check a	applicable box: [] Hospital-based RHC [] F	Hospital-based FQHC			<u> </u>		
VISITS	AND PRODUCTIVITY						
		Number			Minimum	Greater of	
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
		Personnel	Visits	Standard (1)	x col. 3)	col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1 through 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8	Total FTEs and Visits (sum of lines 4 through 7)						8
9	Physician Services Under Agreements						9
DETER	MINATION OF ALLOWABLE COST APPLICABLE TO		RHC/FQHC SERVI	CES			
10							10
11	Total nonreimbursable costs (from Worksheet M-1, column						11
12	(6)(12
13							13
14			e 31)	<u> </u>			14
15	Parent provider overhead allocated to facility (see instructi	ons)		<u> </u>			15
16	Total overhead (sum of lines 14 and 15)			<u> </u>			16
17	Allowable Direct GME overhead (see instructions)	•		•	•		17
18							18
19	Overhead applicable to hospital-based RHC/FQHC service	es (line 13 x line 18)		•	•		19
20	Total allowable cost of hospital-based RHC/FOHC service	s (sum of lines 10 and	110)	·	·		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.

02-24	FORM CMS-25	52-10		4090	(Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERV	/ICES	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET M-3	
Check [] Hospital-based RHC applicable [] Hospital-based FQHC boxes: DETERMINATION OF RATE FOR HOSPITAL-BASED RH	[] Title V [] Title XVIII [] Title XIX C/FOHC SERVICES				
1 Total allowable cost of hospital-based RHC/FQHC se	ervices (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 (least or control of the cost excluding injections or control of the cost excluding injections or control of the cost excluding injections or cost excluding injections.)	ne 1 minus line 2)				3
4 Total visits (from Worksheet M-2, column 5, line 8)					4
5 Physicians visits under agreement (from Worksheet N	1-2, 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)		1
		Payment Limit	Payment Limit	Payment Limit	1
		Period 1	Period 2	Period 3	
		1	2	3	

			Calculation of Limit (1)		
		Payment Limit	Payment Limit	Payment Limit	1
		Period 1	Period 2	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
CALCU	LATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)				10
11	Program cost excluding costs for mental health services (line 9 x line 10)				11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)				16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)				16.04
16.05	Total program cost (see instructions)				16.05
17	Primary payer amounts				17
18	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19
20	Net program cost excluding injections/infusions (see instructions)				20
21	Program cost of injections/infusions and their administration (from Worksheet M-4, line 16)				21
21.50	Total program IOP OPPS payments (see instructions)				21.50
21.55	Total program IOP costs (see instructions)				21.55
21.60	Program IOP coinsurance (see instructions)				21.60
22	Total reimbursable program cost (sum of lines 20, 21, 21.50, minus line 21.60)				22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				25.50
25.99	Demonstration payment adjustment amount before sequestration				25.99
26	Net reimbursable amount (see instructions)				26
26.01	Sequestration adjustment (see instructions)				26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments				27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program line 26 minus lines 26.01, 26.02, 27, and 28				29
30	Protested amounts (nonallowable cost report items) in accordance with CMS				30
	Pub. 15-2, chapter 1, section 115.2				

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

,	TATION OF HOSPITAL-BASED RHC/FQHC VACO		1011 01115 2332 10	PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-4	02 21
				COMPONENT CCN:	TO TO		
Check applicab boxes:	[] Hospital-based RHC [] Hospital-based FQHC	[] Title V [] Title XVIII [] Title XIX					
	•		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES 2	COVID-19 VACCINES 2.01	MONOCLONAL ANTIBODY PRODUCTS 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						2
	health care staff time						
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 (fr	om					6
	Worksheet M-1, column 7, line 22)						
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
	Total injection/infusion costs and their						10
10	administration costs (sum of lines 5 and 9)						10
11	Total number of injections/infusions						11
11	(from your records)						11
12	Cost per injection/infusion (line 10/line 11)						12
13	Number of injection/infusion administered						13
13	to Program beneficiaries						13
13.01	Number of COVID-19 vaccine injections/infusions						13.01
13.01	administered to MA enrollees						13.01
14	Program cost of injections/infusions and their adminis	tration					14
	costs (line 12 times the sum of lines 13 and 13.01, as a						
		,		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION		•	•
	Imate a contract of the contract		1	2			
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2	02 line 10)					15
	(transfer this amount to Worksheet M-3, line 2)	.02, nne 10)					
16	Total Program cost of injections/infusions and their						16
10	administration costs (sum of columns 1, 2, 2.01, and 2	.02. line 14)					10
	(transfer this amount to Worksheet M-3, line 21)						

02-24	FORM	1 CMS-2552-10		4090	(Cont.)
ANALYSIS OF PAYMENTS TO HOS	PITAL-BASED	PROVIDER CC	N: PERIOD:	WORKSHEET M-5	
RHC/FQHC FOR SERVICES RENDER	RED		FROM		
TO PROGRAM BENEFICIARIES		COMPONENT O	CCN: TO		
Check applicable box: []	Hospital-based RHC [] Hospital-based FQl	HC	1		
DESCRIPTION			1	Part B	_
DESCRIPTION			1 mm/did/ivy	Amount	-
1 Total interim payments paid to	hospital-based RHC/FOHC		mm/did/ivy	Amount	1
2 Interim payments payable on in					2
submitted or to be submitted to					
services rendered in the cost re	porting periods. If				
none, write "NONE", or enter	zero.				
3 List separately each retroactive			.01		3.01
lump sum adjustment amount		Program	.02		3.02
based on subsequent revision of	ıf	to	.03		3.03
the interim rate for the		Provider	.04		3.04
cost reporting period. Also sho	W		.05		3.05
date of each payment.			.50		3.50
If none, write "NONE",		Provider	.51		3.51
or enter zero (1).		to	.52		3.52
		Program	.53		3.53
S-1-4-4-1 (10		.54		3.54
4 Total interim payments (sum o	9 minus sum of lines 3.50-3.98)		.99		3.99
(transfer to Worksheet M-3, lin					4
(transfer to worksheet W-3, in	10 27)				
TO BE COMPLETED BY CO	NTRACTOR				
5 List separately each tentative		Program	.01		5.01
settlement payment after desk	review.	to	.02		5.02
Also show date of each payme	nt.	Provider	.03		5.03
If none, write "NONE,"		Provider	.50		5.50
or enter zero (1).		to	.51		5.51
		Program	.52		5.52
	9 minus sum of lines 5.50-5.98)		.99		5.99
6 Determine net settlement amou		Program			
(balance due) based on the cos	t	to			
report (see instructions). (1)		Provider	.01		6.01
		Provider			
		to	02		6.00
7 7 114 1 114 ()		Program	.02		6.02
7 Total Medicare liability (see in 8 Name of Contractor	structions)		Contractor Number	NPR Date	7 8
o Ivanie of Contractor			Contractor Number	(Month/Day/Year)	8
				(Month Day 1 cal)	
			ĺ		I

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.

	ASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES HOSPITAL-BASED FQHC						CN:		
cos	T CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
GENER	AL SERVICE COST CENTERS		_	,				,	$\overline{}$
	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
	Transportation								11
12	Other General Service								12
	Subtotal - Total Overhead								13
	T CARE COST CENTERS								
	Physician								23
	Physician Services Under Agreement								24
	Physician Assistant								25
	Nurse Practitioner								26
	Visiting Registered Nurse								27
	Visiting Licensed Practical Nurse								28
	Certified Nurse Midwife								29 30
	Clinical Psychologist								30
	Clinical Social Worker								31
	Marriage and Family Therapist								31.10
	Mental Health Counselor								31.11
	Laboratory Technician								32 33
	Reg Dietician/Cert DSMT/MNT Educator								33
	Physical Therapist								34
	Occupational Therapist								35
	Other Allied Health Personnel								36
37	Subtotal - Direct Patient Care Services								37

	LASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES . HOSPITAL-BASED FQHC						PERIOD: FROM: TO:	WORKSHEET N-1	<u> </u>
COST	CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
REIMBLIR	RSABLE PASS THROUGH COSTS	1	2	3	4	,	0	/	_
	Pneumococcal Vaccines & Med Supplies								47
	nfluenza Vaccines & Med Supplies								48
	COVID-19 Vaccine & Med Supplies								48.10
	Monoclonal Antibody Products								48.11
	Subtotal - Reimbursable Pass through Costs								49
	OHC SERVICES								
60 N	Medicare Excluded Services								60
61 E	Diagnostic & Screening Lab Tests								61
62 R	Radiology - Diagnostic								62
63 P	Prosthetic Devices								63
64 L	Ourable Medical Equipment								64
65 A	Ambulance Services								65
66 T	Celehealth								66
	Drugs Charged to Patients								67
	Chronic Care Management								68
69 C									69
	Subtotal - Other FQHC Services								70
NONREIN	MBURSABLE COST CENTERS								
	Retail Pharmacy								77
	Other Nonreimbursable								78
	Subtotal - Non-Reimbursable Costs								79
100 T	OTAL (sum of lines 13, 37, 49, 70, and 79)								100

4090 (Cont.) 02-24

	()															
CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT											PROVIDER CCN:			IOD:	WORKSHEET N-2	
														OM		
											COMPON	ENT CCN:		TO		
				Total M		er Direct Care										
			Direct Cost	Mental	Health,	Costs &					Averag					
		Wkst. N-1,	by Practitioner	& IOP	Visits Ph	armacy Costs	General	Service Cost	Tota	al Costs	Per '	/isit				
		col. 7,	from Wkst. N-1	by Pract	titioner (see	instructions)	(see in	structions)	by Pra	actitioner	by Prac	titioner				
Positions		line:	1	2	2	3		4		5	(
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
9.10	Marriage and Family Therapist	31.10														9.10
9.11	Mental Health Counselor	31.11		1												9.11
10	Reg Dietician/Cert DSMT/MNT Educator	33		1												10
11	Totals															11
12	Unit Cost Multiplier															12
13	Total Cost Per Visit															13
							_									
			Total Visits					Title XVIII Visits						Title XVIII Costs		
Positions			Mental	Health				Mental H	ealth					Mental Health		
		Medical V	Visits (Non IOF) Visits	IOP Visits	Medical	Visits	(Non IOP)	Visits	IOP Vi	sits	Medical Vis	its	(Non IOP) Visits	IOP Visits	
		by Practit	ioner by Pract	itioner	by Practitioner	by Practi	tioner	by Practiti	ioner	by Practit	ioner	by Practition	ner	by Practitioner	by Practitioner	
		7	8		8.01	9		10		10.0	1	11		12	12.01	1
1	Physician															1
2	Physician Services Under Agreement															2
3	Physician Assistant															3
4	Nurse Practitioner								i							4
5	Visiting Registered Nurse								i							5
6	Visiting Licensed Practical Nurse															6

7 Certified Nurse Midwife 8 Clinical Psychologist 9 Clinical Social Worker 9.10 Marriage and Family Therapist 9.11 Mental Health Counselor

12 Unit Cost Multiplier

13 Total Cost Per Visit

11 Totals

10 Reg Dietician/Cert DSMT/MNT Educator

9.11

10

11

12

13

02-24	TOR	CM CMS-2552-10			4090 (Co		
COMPU	TATION OF HOSPITAL-BASED FQHC VACCINE COST		PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-3		
			COMPONENT CCN:	TO:			
				ı			
		PNEUMOCOCCAL	INFLUENZA	COVID-19	MONOCLONAL ANTIBODY		
		VACCINES	VACCINES 2	VACCINES 2.01	PRODUCTS 2.02	-	
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)	1	2	2.01	2.02	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	
0	Overhead cost - injections/infusions (line 7 x line 8)					9	
10	Total cost of injections/infusions and their					10	
10	administration (sum of lines 5 and 9)					10	
11	Total number of injections/infusions (from your records)					11	
12	Cost per injection/infusion (line 10 / line 11)					12	
13	Number of injections/infusions administered to Medicare beneficiaries					13	
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees					13.01	
14	Cost of injections/infusions and their administration costs furnished to Medicare/MA beneficiaries					14	
	(line 12 times the sum of lines 13 and 13.01, as applicable)						
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10)					15	
16	Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Worksheet N-4, line 2)					16	

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

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

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

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

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

1 070 (C	ont.)	1.	OKIVI CIVIS-2332	-10					05-10
	IS OF HOSPITAL-BASED HOSPICE COSTS 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 I	PATIENT CARE SERVICE COST CENTERS								
25 I	npatient Care - Contracted								25
	Physician Services								26
27 N	Nurse Practitioner								27
	Registered Nurse								28
29 L	_PN/LVN								29
	Physical Therapy								30
31 (Occupational Therapy								31
32 S	Speech/ Language Pathology								32
33 N	Medical Social Services								33
34 S	Spiritual Counseling								34
35 I	Dietary Counseling								35
36 C	Counseling - Other								36
37 I	Hospice Aide and Homemaker Services								37
	Durable Medical Equipment/Oxygen								38
39 P	Patient Transportation								39
40 I	maging Services								40
41 I	Labs and Diagnostics								41
42 N	Medical Supplies-Non-routine								42
42.50 I	Drugs Charged to Patients								42.50
43 (Outpatient Services								43
44 P	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
	Other Patient Care Svc								46
100 T	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								ORKSHEET O-2	
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)		
	SALARIES	2	3	4	5 5	6	(coi. 3 ± coi. 6)	4	
DIRECT PATIENT CARE SERVICE COST CENTERS	1	2	3	4	3	0	/	_	
25 Inpatient Care - Contracted								25	
26 Physician Services								26	
27 Nurse Practitioner						1		27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								3	
32 Speech/ Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								3:	
36 Counseling - Other								30	
37 Hospice Aide and Homemaker Services								3	
38 Durable Medical Equipment/Oxygen								3	
39 Patient Transportation								3	
40 Imaging Services								4	
41 Labs and Diagnostics								4	
42 Medical Supplies-Non-routine								42	
42.50 Drugs Charged to Patients								42.5	
43 Outpatient Services								4.	
44 Palliative Radiation Therapy								44	
45 Palliative Chemotherapy								4:	
46 Other Patient Care Svc								40	
100 Total *								100	

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

	SIS OF HOSPITAL-BASED HOSPICE COSTS CE INPATIENT RESPITE CARE	PROVIDER CCN: PERIOD: WORKSHEE FROM TO		WORKSHEET O-3	ET O-3				
-				SUBTOTAL (col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	(col. 5 ± col. 6)	1
		1	2	3	4	5	6	7	
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
	Speech/ Language Pathology								32
	Medical Social Services								33
	Spiritual Counseling								34
	Dietary Counseling								35
	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
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

	SIS OF HOSPITAL-BASED HOSPICE COSTS DE GENERAL INPATIENT CARE	PROVIDER CCN:	FROM						
						HOSPICE CCN:	то		
				SUBTOTAL		 			Т
				(col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(\text{col. } 5 \pm \text{col. } 6)$	
		1	2	3	4	5	6	7	1
DIRECT	PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
	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
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
	Drugs Charged to Patients								42.50
	Outpatient Services								43
	Palliative Radiation Therapy								44
	Palliative Chemotherapy							-	45
	Other Patient Care Svc								46
100	Total *								100

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

4090 ((Cont.) FORM	CMS-2552-10			10-18
COST	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET E	XPENSES FOR ALLOCATION		FROM		
		HOSPICE CCN:	то		
			GENERAL		
		HOSPICE	SERVICE		
		DIRECT	EXPENSES	TOTAL	
		EXPENSES	FROM WKST B, PART I	EXPENSES	
		(see instructions)	(see instructions)	(sum of cols. $1+2)$	
	Descriptions	1	2	3	
	AL SERVICE COST CENTERS				
	Cap Rel Costs-Bldg & Fixt				1
2	Cap Rel Costs-Mvble Equip				2
3	Employee Benefits				3
4	Administrative & General				4
5	Plant Operation and Maintenance				5
6	Laundry & Linen Service				6
7	Housekeeping				7
- 8	Dietary				8
9	Nursing Administration				9
10	Routine Medical Supplies				10
11	Medical Records				11
12	Staff Transportation				12
13	Volunteer Service Coordination				13
14	Pharmacy				14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
LEVEL	OF CARE				
50	Hospice Continuous Home Care				50
	Hospice Routine Home Care				51
	Hospice Inpatient Respite Care				52
	Hospice General Inpatient Care				53
NONRE	EIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
	Fundraising				62
	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 HOSPIC	CE GENERAL SERVICE	COSTS	10	ACIVI CIVIS-2332	. 10	PROVIDER CCN:		PERIOD:		WORKSHEET O)-6
									FROM	_	PART I	
							HOSPICE CCN:		то			
			CAP REL	CAP REL	EMPLOYEE		ADMINIS-	PLANT	LAUNDRY	HOUSE-	DIETARY	
		TOTAL	BLDG	MVBLE	BENEFITS		TRATIVE &	OP &	& LINEN	KEEPING		
		EXPENSES	& FIX	EQUIP	DEPARTMENT	SUBTOTAL	GENERAL	MAINT				
	Descriptions	0	1	2	3	3A	4	5	6	7	8	
	AL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
LEVEL	OF CARE											
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
NONRE	EIMBURSABLE COST CENTERS											
60	Bereavement Program			1								60
61	Volunteer Program											61
62	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
67	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center						†		1	 	1	99
	Total						†				+	100

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

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

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

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

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