12-2-				1 (JICIVI CIVIS-2332-	-10) 000F	Cont.			
			42 USC 1395g; 42 CFR 413.20(b)). Ining of the cost reporting period being					FORM APPROVE OMB NO. 0938-00 EXPIRES 09-30-2	050			
			TTAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S				
	EX COST ETTLEMEN		ORT CERTIFICATION JMMARY				FROM TO	PARTS I, II & III				
	COST RE							•				
Provider	use only		Electronically prepared cost re Manually prepared cost report		Date:	Time:						
		3. [] If this is an amended report er	nter the number of times the pro-		ost report						
Contracto	or 5. [] Medicare Utilization. Enter " t Report Status	6. Date Received:	ior no.	10. NPR Date:						
use only			Submitted	11. Contractor's Vend	or Code: mn 1, is 4: Enter number	n of						
			led without audit led with audit	 [] Initial Report for t [] Final Report for th 		times reopene	· ·	1 01				
			pened									
PART II		_	ended ON BY A CHIEF FINANCIAL (OFFICER OR ADMINISTRA	TOR OF PROVIDER(S)						
ACTION THE PA' IMPRISO	I, FINE AN YMENT DI ONMENT I	D/OR REC MAY		DERAL LAW. FURTHERM IICKBACK OR WERE OTHE	ORE, IF SERVICES ID ERWISE ILLEGAL, CR	ENTIFIED IN THIS R	EPORT WERE PROVI	DED OR PROCURED TH				
	CERTIFIC.	ATIO	N BY CHIEF FINANCIAL OFF	TICER OR ADMINISTRATOR	R OF PROVIDER(S)							
			TIFY that I have read the above of									
			port and the Balance Sheet and S riod beginning	and ending			_{Provider Name(s) and report and statement are					
			pared from the books and records									
	and regulat		ons regarding the provision of he	attn care services, and that the	services identified in this	s cost report were provi	ded in compliance with	such laws				
I	SIGNAT	URE	OF CHIEF FINANCIAL OFFIC	ER OR ADMINISTRATOR	CHECKBOX	1	ELECTRONIC					
	SIGIVIII	OKL	1	ER OR ADMINISTRATION	2		SIGNATURE STATEM					
1						_	ronic signature on this	cation statement. I certify certification be the legally	1			
	2 Signatory Printed Name: 3 Signatory Title:											
	Signature of								3			
PART III	I - SETTLE	MEN	T SUMMARY		TITL	E XVIII	T	1				
				TITLE V	PART A	PART B	НІТ	TITLE XIX				
1				1	2	3	4	5				
1	HOSPITA	L							1			
1.01	HOSPITA	L-PAI	RHM						1.01			
2	SUBPROV	/IDEF	R - IPF					_	2			
3	SUBPROV	/IDEF	R - IRF					_	3			
4	SUBPROV	/IDEF	R (OTHER)						4			
5	SWING-B	ED S	NF						5			
5.01	SWING-B	ED P	ARHM (CAH ONLY)						5.01			
6	SWING-B	ED N	F						6			
7	SNF								7			
8	NF, ICF/II	D							8			
9	HOME HE	EALT	H AGENCY						9			
10	HOSPITA	L-BA	SED RHC						10			
			SED FQHC						11			
	PROVIDE		REHABILITATION ecify)						12			
200	TOTAL								200			

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete this information collection 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.

40-503

1070 (COM.)	1 01011 01115 2552 10			
HOSPITAL AND HOSPITAL HEALTH CARE		PROVIDER CCN:	PERIOD	WORKSHEET S-2
COMPLEX IDENTIFICATION DATA			FROM	PART I
			mo	

COMIT	LA IDENTIFICATION DATA							TO	TAKTT	
	- HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX INDENTIFICATION DATA	A								
Hospita	and Hospital Health Care Complex Address:									
1	Street:	P.O. Box:								1
	City:	State:	ZIP Code:	County:						2
Hospita	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	
	Hospital									3
	Subprovider- IPF									4
5										5
6										6
7	0									7
	Swing Beds-NF									8
9	I I									9
10										10
	Hospital-Based OLTC									11
	Hospital-Based HHA									12
13										13
	Hospital-Based Hospice Hospital-Based Health Clinic-RHC									14
										15
	Hospital-Based Health Clinic-FQHC		 							16 17
17 18	Hospital-Based (CMHC, CORF and OPT) Renal Dialysis		 							17
	Other		 							18
20		F	To:							20
	Type of control (see instructions)	From:	10:							20
							1 1	1 2	3	21
	t PPS Information Does this facility qualify and is it currently receiving payments for disproportionate share hospita	l adjustment in accorda	noo with 42 CED 412 10	62 In column 1 onter "V	/" for you or "N" for no		1	2	3	22
22	Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter			o: in column 1, enter 1	i for yes or in for no.					22
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting per			no for the nortion of the	aget reporting period agen	rring prior to Ostobar	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			no 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 settlements.			or yes 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 o				ober 1					22.02
22.03	Did this hospital receive a geographic <i>redesignation</i> from urban to rural as a result of the OMB									22.03
22.03	"N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "					(see instructions)				22.03
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with				iring on or uncer october 1.	(see instructions)				
22 04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revise				nter in column 1 "Y" for y	ves or "N" for				22.04
22.0.	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for y									22.0.
	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, en									23
	Is the method of identifying the days in this cost reporting period different from the method used				' for no.					
	, , , , , , , , , , , , , , , , , , , ,		21	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 M	ledicaid unpaid days in co	olumn 2, out-of-state	1			1	Ì	1	24
	Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medica	id HMO paid and eligibl	e but unpaid days in							
	column 5, and other Medicaid days in column 6.		• •	<u> </u>			<u> </u>		<u> </u>	_L
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid el	igible unpaid days in col	umn 2, out-of-state							25
	Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid	d HMO paid and eligible	but unpaid days in colu	mn 5.						
							1	2	3	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost repo									26
27		period. Enter in column	1, "1" for urban or "2" f	or rural.						27
	If applicable, enter the effective date of the geographic reclassification in column 2.									
35				-						35
	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of peri						Beginning:	Ending:		36
	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in el									37
	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, s	subscript this line for the	number of periods in ex	cess 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	harges 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)									

	AL AND HOSPITAL HEALTH CARE EX IDENTIFICATION DATA			PROVIDER CCN:	PERIOD FROM	WORKSHEET S-2 PART I (CONT.)	
					TO	****	
Dunamantia	ve Payment System (PPS)-Capital			V	XVIII	XIX 3	-
	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)			1		<u> </u>	45
	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, P	Pt. I, through Pt. III.					46
	Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no.	, 8					47
	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						48
Teaching	Hospitals			1	2	3	
	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 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 GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	ed in training residents in	1				56
	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME or "N" for no in column 1. If column 1 is "V", did residents start training in the first month of this cost reporting period? Enter "V" for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413 of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E	column 2 is "Y", complet 3.77(e)(1)(iv) and (v), r	e Wkst. E-4.				57
	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	у-т.					58
	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						59
				NAHE 413.85	NAHE MA		
				1	2	3	
60	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	"N" for no in column 1.	If column 1 is "Y", are y	ou			60
					Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1	2	3	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)	T	1			ni on m	60.01
		Y/N			IME	Direct GME	_
	Dil I i i I i I I I I I I I I I I I I I I	I	2	3	4	5	(1
01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				IME	Direct GME	61
				1	1ME 2	3	-
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			1	2	3	61.01
	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
	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)	see ilistructions)					61.03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)						61.04
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line	e 61 03) (see instruction	16)				61.05
	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)	c or.os). (see instruction	13)				61.06
01.00	that the should offer 1,5000 white that is compared to eap tener should 1.120 that the should have been general outget; (see including the should be should				Unweighted	Unweighted	01.00
			Program Name	Program Code	IME FTE Count	Direct GME FTE Count	
			1	2	3	4	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE	E unweighted count.					61.10
	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)						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 FTE	E unweighted count.					
	visions Affecting the Health Resources and Services Administration (HRSA)					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
	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see	instructions)					62.01
	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 ins	structions)					63
						T 2011	_
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 ÷ (col. 1 + col. 2))	
64	504 of the ACA Base Year FTE Residents in Nonprovider Settings.—This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 20 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 rotation to column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.		provider settings.	1	2	3	64
	Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	T	T	Hamaichted PTP	Hamaiahtad PTP	Datia (aal 1 :	+
		Duo outous Nover	Duo onome Co. 1:	Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	1
		Program Name	Program Code 2	Nonprovider Site	in Hospital	(col. 3 + col. 4)) 5	-1
65	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary	1	<u> </u>	3	4	3	65
	Enter in column 1, it line 05 is yes, or your facility trained residents in the base year period, the program name associated with primary care F1Es for each primary care F2Es for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care F2Es that trained in your base its 1. Enter in column 3 divided by (column 3 + column 4). (see instructions)						63

HOSPI	AL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPI	EX IDENTIFICATION DATA				FROM	PART I (CONT.)	
				Unweighted FTEs	TOUnweighted 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 of FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	of unweighted non-prir	nary care resident				66
	FTES that trained in your nospital. Either in column 3, the fatho of (column 1 divided by (column 1 + column 2)). (see instructions)			Unweighted FTEs	Unweighted FTEs	Ratio (col. 3/	1
		Program Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	j
		1	2	3	4	5	
67	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of						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 202. t Psychiatric Facility PPS	3 IPPS Final Rule, 87 F	R 49065-49072 (August	10, 2022)?	2	2	68
	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
1	If line 70 is yes:						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 no	o. (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) t Rehabilitation Facility PPS			1	2	3	
	Reinaumation Facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.			1	<u> </u>	,	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 o	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 T	erm 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
meen .							
	Providers 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
	is this a new indepth and the 2 CFR 413-40(f) (f) ITAX: Enter 1 for year of 18 for 10						86
	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "\" for yes or "\" for no.						87
					Approved for	Number of	
					Permanent	Approved Permanent	
					Adjustment (Y/N)	Adjustments 2	4
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 li	ine 89 (see instructions)		I	Δ	88
	Column 2: Enter the number of approved permanent adjustments.		,				
						Approved Permanent	
				****		Adjustment Amount	
				Wkst. A Line No.	Effective Date	Per Discharge 3	-
89	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.			1	2	,	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.						
T'41. 37	LVIV Coming				V	XIX	4
	and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.				1	2	90
	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.						91
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						92
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.						93
	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.						94
	If line 94 is "Y", enter the reduction percentage in the applicable column.						95 96
	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.						96
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 col	column 2 for title XIX				98	
	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no inclumn 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no inclumn 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title V or XIX follow Medicare (title XVIII) for the reporting of charges on West, C, Pt. I? Enter "Y" for yes or "N" for no in column 2 for title V, and the column 3 for title V, and the column 4 for titl		101 title 11111				98.01
98.02			2 for title XIX.				98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in colun		olumn 2 for title XIX.				98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in c		137				98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title V, and in column 2 for title V, and in column 3 for title V, and in column 4 for title V, and		IA.				98.05 98.06
98.06							

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

12-24 FORM CMS-2552-10 4000 (Cont.)

The Conference of the Confer	12-24	FORM CMS-2552-10			4090) (Cont.)
Procedure Company Procedure Company	HOSPIT.	AL AND HOSPITAL HEALTH CARE	PROVIDER CCN:	PERIOD	WORKSHEET S-2	
The Provider The International Content of the C	COMPLI	EX IDENTIFICATION DATA		FROM	PART I (CONT.)	
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193 Does the temporal quarks or an CAMP 195 This finding quarks are a complete from the CAMP 195 This finding quarks are a	Rural Pro	aviders		T 1	7	
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118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 118.02 What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year. 120 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 122 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. 123 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. 124 Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according			1	2	3	
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	127					12.
	124					124

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4090 (Cont.)	FORM CMS-2	2552-10						12-24
HOSPIT	AL AND HOSPITAL HEALTH CARE EX IDENTIFICATION DATA					PROVIDER CCN:	PERIOD FROM	WORKSHEET S-2 PART I (CONT.)	
							ТО		
								•	
	Transplant Center Information	. 1. () (/11/	\1.1				1	2	105
	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no. If yes, enter certifica								125 126
	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if a If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if a						+	_	126
	If this is a Medicare certified liver transplant program, enter the certification date in column 1 and termination date, if a								128
	If this is a Medicare certified lung transplant program, enter the certification date in column 1 and termination date, if a								129
	If this is a Medicare certified pancreas transplant program, enter the certification date in column 1 and termination date, it all this is a Medicare certified pancreas transplant program, enter the certification date in column 1 and termination date,		12						130
	If this is a Medicare certified intestinal transplant program, enter the certification date in column 1 and termination date.								131
	If this is a Medicare certified islet transplant program, enter the certification date in column 1 and termination date, if an								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 of	date, if applicable, in colu	umn 2.						134
All Provi							1	2	
	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or	or "N" for no in column 1.							140
	If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)								
If this for	cility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter th	ha hama affica contracto	r name and contractor nur	ahar					
	Name:	ne nome office contracto	Contractor's Name:	iloet.		Contractor's Number:			141
	Street:	P. O. Box:	Contractor's Ivanic.			Contractor's runnocr.			142
143		State:	Zip Code:						143
1.0	<u>Cay</u>	Ditt.	Esp code:						113
							1	2	
144	Are provider based physicians' costs included in Worksheet A?								144
145	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes o	or "N" for no in column 1	1.						145
	If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes								
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in	n column 1. (See CMS P	ub. 15-2, chapter 40, §402	0)					146
	If yes, enter the approval date (mm/dd/yyyy) in column 2.								
	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147
	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								149
					Tiel	XVIII	1		_
Does this	s facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges?				Part A	Part B	Title V	Title XIX	
	" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13)				1	2.	3	4	
	Hospital				•		,	7	155
	Subprovider - IPF								156
	Subprovider - IRF								157
158	Subprovider - Other								158
159	SNF								159
160									160
161	CMHC								161
Multican									
	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or		E/G : 1 5 /						165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in column 3,	, CBSA in column 4, FTI	E/Campus in column 5. (s		State	7: C. 1.	CBSA	ETE/C	166
ŀ	Name 0			County	State	Zip Code	CBSA 4	FTE/Campus 5	
ŀ	V			1	2	3	7		
					1	1	1		
Health Ir	nformation Technology (HIT) incentive in the American Recovery and Reinvestment Act						1	2	
	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.							_	167
	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	e instructions)						168
	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70			instructions)					168.01
	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (se			<u> </u>					169
	Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yyyy)								170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported	ed on Wkst. S-3, Pt. I, lin	ne 2, col. 6? Enter "Y" for	yes and "N" for no in col	umn 1.				171
	If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						I		1

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

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Title:

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

Cost Report Preparer Contact Information

41 First name:

42 Employer:

43 Phone number:

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

Last name:

E-mail Address:

40 If line 36 is yes, did the provider render services to the home office? If yes, see instructions

39

40

41

42

43

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

						Inpatie	nt Days / Ou	tpatient Visit	s / Trips	Full	Time Equiva	lents		Disc	harges		
		Worksheet A Line	No. of	Bed Days	CAH/REH		Title	Title	Total All	Total Interns &	Employees On	Nonpaid		Title	Title	Total All	
	Component	No.	Beds 2	Available 3	Hours 4	Title V	XVIII 6	XIX 7	Patients 8	Residents 9	Payroll 10	Workers 11	Title V 12	XVIII 13	XIX 14	Patients 15	-
1	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							·									1
2	HMO and other (see instructions)																2
3	HMO IPF Subprovider																3
4	HMO IRF Subprovider																4
- 5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds. Swing Bed NF																6
7	Total Adults and Peds. (exclude observation beds) (see instructions)																7
8	Intensive Care Unit																8
9	Coronary Care Unit																9
10	Burn Intensive Care Unit																10
11	Surgical Intensive Care Unit																11
12	Other Special Care																12
13	Nursery																13
14	Total (see instructions)																14
15	CAH visits																15
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)	1															23
24	Hospice (Distinct Part)																24
24.10	Hospice (non-distinct part)																24.10
25	CMHC	1															25
26	RHC/FQHC (specify)	1															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
	Employee discount days - IRF																31
	Labor & delivery (see instructions)																32
	Total ancillary labor & delivery room																32.01
	outpatient days (see instructions)																1
33																	33
33.01	LTCH site neutral days and discharges																33.01
	Temporary Expansion COVID-19 PHE Acute Care																34

4090 (Cont.) FORM	CMS-2	552-10					12-24
	AL WAGE INDEX INFORMATION				PROVIDER CCN:	PERIOD FROMTO	WORKSHEET PART II	Γ S-3
Part II -	Wage Data						_ !	
		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	GAY ARVEG	1	2	3	4	5	6	
	SALARIES To the state of the st							
1	Total salaries (see instructions)							2
3	Non-physician anesthetist Part A							3
3	Non-physician anesthetist Part B							
4.01	Physician-Part A - Administrative Physician-Part A - Teaching							4.01
4.01	, ,							
	Physician and Non Physician-Part B							5
6	Non-physician-Part B for hospital-based RHC and FQHC services							7
7.01	Interns & residents (in an approved program)							
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
- 11	OTHER WAGES AND RELATED COSTS							- 11
11	Contract labor: Direct Patient Care							11
12	Contract labor: Top level management and other management and							12
	administrative services							1.2
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							
15	Home office: Physician Part A - Administrative							15 15.01
15.01	Home office Physicians Part A - Administrative							
15.02	Home office contract Physicians Part A - Administrative							15.02
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 WAGE-RELATED COSTS							16.02
17	Wage-related costs (core) (see instructions)	-						17
18								18
19	Wage-related costs (other) (see instructions) Excluded areas			+	 			18
				+				20
20	Non-physician anesthetist Part A Non-physician anesthetist Part B			+				20
22				+				21
22.01	Physician Part A - Administrative Physician Part A - Teaching			+				22.01
22.01	Physician Part A - Teaching Physician Part B			+	-			22.01
23	Wage-related costs (RHC/FQHC)			+				23
25								25
25.50	Interns & residents (in an approved program)							25.50
	Home office wage-related (core)							
25.51 25.52	Related organization wage-related (core)							25.51 25.52
	Home office: Physician Part A - Administrative - wage-related (core)							25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)							23.33

11-10		FUKI	VI CIVIS-23	32-10			4090 (1	Cont.)
HOSPI	FAL WAGE INDEX INFORMATION				PROVIDER CCN:	PERIOD FROMTO	WORKSHEET PART II & III	S-3
Part II -	Wage Data				L	1		
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department	4						26
27	Administrative & General	5						27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7						30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10						34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13						38
39	Central Services and Supply	14						39
40	Pharmacy	15						40
41	Medical Records & Medical Records Library	16						41
42	Social Service	17						42
43	Other General Service	18						43
Part III -	- Hospital Wage Index Summary							
1	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)							3
4	Subtotal other wages and related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)							6
7	Total overhead cost (see instructions)							7

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4090 (Con	it.)	FORM CMS-2552-1	0			11-16
HOSPITAL W	VAGE RELATED COSTS		PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-3 PART IV	
Part IV - Wag	e Related Cost				•	
D	***					
Part A - Core	List					T
					Amount	
					Reported	
					•	
RET	TREMENT COST					
1 401k	Employer Contributions					1
2 Tax	Sheltered Annuity (TSA) Employer Contribution					2
3 None	qualified Defined Benefit Plan Cost (see instructions)					3
	lified Defined Benefit Plan Cost (see instructions)					4
PLA	N ADMINISTRATIVE COSTS (Paid to External Orga	nization):				
5 401k	/TSA Plan Administration fees					5
	al/Accounting/Management Fees-Pension Plan					6
	loyee Managed Care Program Administration Fees					7
	ALTH AND INSURANCE COST					
	th Insurance (Purchased or Self Funded)					8
	th Insurance (Self Funded without a Third Party Admin					8.01
	th Insurance (Self Funded with a Third Party Administra	ator)				8.02
	th Insurance (Purchased)					8.03
	cription Drug Plan					9
	tal, Hearing and Vision Plan					10
	Insurance (If employee is owner or beneficiary)					11
	dent Insurance (If employee is owner or beneficiary)					12
	bility Insurance (If employee is owner or beneficiary)					13
	g-Term Care Insurance (If employee is owner or benefic	nary)				14
	kers' Compensation Insurance		v 1.2 2.3			15
16 Retir	rement Health Care Cost (Only current year, not the extr	raordinary accrual required by FASB 106	Noncumulative portion)		16
	A-Employers Portion Only					1.7
	icare Taxes - Employers Portion Only					17
	mployment Insurance					18 19
	1 7					20
20 State	e or Federal Unemployment Taxes					20
	cutive Deferred Compensation (Other Than Retirement Compensation)	Cost Papartad on lines 1 through 4 shave	Vesa instructions)			21
	Care Cost and Allowances	Cost Reported on lines 1 unough 4 above	(see instructions)			22
ZZ Day	Care Cost and Allowalices				1	

25	Other Wage Related Costs (specify)

Tuition Reimbursement

24 Total Wage Related cost (Sum of lines 1 through 23)

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

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

4090 (Cont.)	FORM CMS-2552-	10						10-12
HOSPIT	CAL-BASED HOME HEALTH AGENCY		PROVIDE	R CCN:	PERIOD:	DD: WORKSH		EET S-4	
STATIS	TICAL DATA				FROM				
			HHA CCN	:	TO				
	HOME HEALTH AGENCY STATISTICAL DATA				County	:			
	HOME READIN NOENCE STATISTICAL DATA				County				
				Title V	Title XVIII	Title XIX	Other	Total	
	Description			1	2	3	4	5	
1	Home Health Aide Hours								1
2	Unduplicated Census Count (see instructions)								2
	HOME HEALTH AGENCY - NUMBER OF EMPLOYE	EES							
						Nun	nber of Empl	oyees	
	Enter the number of hours in					(Full	Time Equiv	alent)	
	your normal work week					Staff	Contract	Total	1
	· —					1	2	3	1
3	Administrator and Assistant Administrator(s)								3
4	Director(s) and Assistant Director(s)								4
5	Other Administrative Personnel								5
6	Direct Nursing Service								6
7	Nursing Supervisor								7
8	Physical Therapy Service								8
9	Physical Therapy Supervisor								9
10	Occupational Therapy Service								10
11	Occupational Therapy Supervisor								11
12	Speech Pathology Service								12
13	Speech Pathology Supervisor								13
14	Medical Social Service								14
15	Medical Social Service Supervisor								15
16	Home Health Aide								16
17	Home Health Aide Supervisor								17
18	Other (specify)								18
	HOME HEALTH AGENCY CBSA CODES								
	Enter the number of CBSAs where you provided services								19
20	List those CBSA code(s) serviced during this cost reporting	ing period (line 20 contains the first code)).						20
	PPS ACTIVITY								
	FFS ACTIVITY			Full F	pisodes			Total	
				Without	With	LUPA	PEP only	(columns 1	
				Outliers	Outliers	Episodes	Episodes	through 4)	
				1	2	3	4	5	ĺ
21	Skilled Nursing Visits			1		,		,	21
22	Skilled Nursing Visit Charges								22
	Physical Therapy Visits								23

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

	TAL RENAL DIALYSIS DEPA				PROVIDER CCN:	FROM TO	WORKSHEET S-5	
	RENAL DIALYSIS STATIST	Outpa	atient	Tra	ining	Н	ome	T .
		Regular	High Flux	Hemo- dialysis	CAPD CCPD	Hemo- dialysis	CAPD CCPD	
1	DESCRIPTION Number of patients in	1	2	3	4	5	6	1
1	program at end of cost reporting period							1
2	Number of times per week patient receives							2
	dialysis							<u> </u>
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8								8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10
	EGD D DDG							7
10.01	ESRD PPS Is the dialysis facility approved	l as a low-volume facility	y for this cost reporting	neriod?		1	2	10.01
10.01	Enter "Y" for yes or "N" for no		y for this cost reporting	periou:				10.01
10.02	Did your facility elect 100% P. (See instructions for "new" pro	PS effective January 1, 2	011? Enter "Y" for yes	or "N" for no.				10.02
10.03	If you responded "N" to line 10 enter in column 2 the year of to	0.02, enter in column 1 to			l and			10.03
	•	•	December 31. (see his	siructions)		<u> </u>	<u> </u>	
11	TRANSPLANT INFORMATI Number of patients on transpla						1	11
	Number of patients transplants		ng period					12
	EDOETH							
13	EPOETIN Net costs of Epoetin furnished	to all maintenance dialy	sis nationts by the provi	der			1	13
	Epoetin amount from Worksho			uci				14
15	Number of EPO units furnishe	d relating to the renal di	alysis department					15
16	Number of EPO units furnishe	ed relating to the home di	ialysis department					16
	ARANESP							
17	1	hed to all maintenance d	ialysis patients by the pr	rovider				17
	ARANESP amount from Wor		1 0					18
19 20								19 20
20	Number of ARANESP units for	urnished relating to the n	ome diarysis departmen	ι			l	20
	PHYSICIAN PAYMENT ME		plicable method(s))					
21	MCP	INITIAL METHOD		Net Cost of	Net Cost of	Number of ESA	Number of ESA	21
			ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
			Description	Renal Patients	Home Patients	Dialysis Dept.	Dialysis Dept.	1
22	Enter in column 1 the ESA des		1	2	3	4	5	22
22	Enter in column 1 the ESA det Enter in column 2 the net costs	*						22
	to all renal dialysis patients.							
	Enter in column 3 the net cost	of ESAs furnished						
	to all home dialysis program p							
	Enter in column 4 the number furnished to patients in the ren							
	department.	ai diaiysis						
	Enter in column 5 the number	of units furnished						
	to patients in the home dialysis							
	(see instructions)							
						CCN	Treatments	l
	LOW VOLUME					1	2	1
23	If line 10.01 is yes, enter in co	lumn 1 the CCN for each	n renal dialysis facility li	sted on Worksheet S-2,	Part I, line 18, and			23

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

		Staff	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

10-12		FORM CMS-2552-10		4090	(Cont.
PROSP	ECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7	
STATIS	STICAL DATA		FROM	_	
			_ TO		
			Y/N	Date	T
			1	2	1
1	If this facility contains a hospital-based SNF, were all patients und	der managed care or was there no Medicare utilization?			1
	Enter "Y" for yes and do not complete the rest of this worksheet.				
2	Does this hospital have an agreement under either section 1883 or	r 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.			
			•		
		SNF	Swing Bed SNF	TOTAL	

		SNF	Swing Bed SNF	TOTAL	
	Group	Days	Days	(sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3 4 5 6 7 8 9
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11 12	RLX RUC				11
13	RUB				11 12 13
13	RUA				1.4
15	RVC		+		15
16	RVB				15
17	RVA				14 15 16 17
18	RHC				19
19	RHB				18
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
40	LDI				40
41	LC2				41 42 43 44
42	LC1				42
43	LB2				43
44	LBI				44
45	CE2				45 46 47
46	CE1				46
47	CD2				47
48 49	CD1				48
50	CC2				49
50	CC1 CB2		+		50 51 52 53 54
52	CB2 CB1				52
53	CA2		+	!	52
53	CA2 CA1		+	-	55
54	CAI				54

	TIVE PAYMENT FOR SNF CAL DATA	PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET S-7 (CONT.)	
	Group	SNF Days	Swing Bed SNF Days	TOTAL (sum of col. 2 + 3)	
H		Days 2	Jays 3	(sum of col. 2 + 3)	
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	VICES				
			CBSA at	CBSA on/after	
			Beginning of	October 1 of the	
			Cost Reporting	Cost Reporting	
			Period	Period (if applicable)	
			1	2	
201 E	nter in column 1 the SNE CDSA code, or 5 character non CDSA co	do if a mural facility, in affact at the beginning of the			201

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

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

cost reporting period.

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)

PROVIDER CCN:

PERIOD:

WORKSHEET S-9

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

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

2 Hospice Routine Home Care
3 Hospice Inpatient Respite Care
4 Hospice General Inpatient Care
5 Total Hospice Days

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

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

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

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

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

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

25.01

27.01

26 27

28

29

30

31

Charges for insured patients' liability (see instructions)

Cost of uncompensated care (line 23, col. 3, plus line 29)

31 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

27 Medicare reimbursable bad debts (see instructions)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

27.01

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4090 (Cont.) FORM CMS-25	52-10			12-22
HOSPIT	AL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10,	
CARE D	ATA		FROM	PART II	
			ТО	_	
PART II	- HOSPITAL DATA			•	
Uncompe	ensated and Indigent Care Cost-to-Charge Ratio				
1	Cost to charge ratio (see instructions)				1
Madiania	(
	(see instructions for each line)				2
	Net revenue from Medicaid				2
	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				3 4
	If line 4 is no, enter DSH and/or supplemental payments from Medicaid				5
	Medicaid charges				6
	Medicaid cost (line 1 times line 6)				7
	Difference between net revenue and costs for Medicaid program (see instructions)				8
	,				
	s Health Insurance Program (CHIP) (see instructions for each line)				
	Net revenue from stand-alone CHIP				9
	Stand-alone CHIP charges				10
	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 sta	te or local government indigent care program (see instructions for each line)				
	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)				13
	Charges for patients covered under state or local indigent care program (not included in lines 6	or 10)			14
	State or local indigent care program cost (line 1 times line 14)	,			15
	Difference between net revenue and costs for state or local indigent care program (see instruction	ons)			16
		,		•	
Grants, d	onations 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
	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	of lines 8, 12, and 16)			19
Uncompe	ensated care cost (see instructions for each line)				
Oncompe	chisated care cost (see histractions for each fine)	Uninsured	Insured	Total	
		Patients	Patients	(col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts (see instructions)		1		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
2.1					2.1
	Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay lim by Medicaid or other indigent care program?	it imposed on patients covered			24
-	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-	stavilimit (saa instructions)			25
	Time 24 is yes, enter the charges for patient days beyond the indigent care program's length-of- Charges for insured patients' liability (see instructions)	stay limit (see instructions)			25.01
	Bad debt amount (see instructions)				25.01
	Medicare reimbursable bad debts (see instructions)			+	27
	Medicare allowable bad debts (see instructions)			+	27.01
-	Non-Medicare bad debt amount (see instructions)				27.01
	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29
	Cost of mon-viculcare and non-reimbursable viculcare bad debt amounts (see instructions) Cost of uncompensated care (line 23, col. 3, plus line 29)				30
	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31
J1	Total amenioaisea and ancompensated care cost (line 1) plus line 30)			1	51

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.0,0	(001111)			1 014.1 01.10						
HOSPI	TAL-BASED FQHC IDENTIF	TICATION DATA					PROVIDER CCN:	PERIOD:	WORKSHEET S-11	
							GOL MONTENIT GOV	FROM:	PART I	
							COMPONENT CCN:	TO:		
PARTI	- HOSPITAL-BASED FOHC I	DENTIFICATION DATA								
TAKTI	1-1103111AE-BASED I QUE I	DENTIFICATION DATA				Type of control	Date	V/I	Date of	T
						(see instructions)	Decertified	Decertification	CHOW	
		1				2	3	4	5	1
1	Site Name:					_				1
2	Street:		P.O. Box:							2
3	City:	State:	ZIP Code:	County:	Designation - Enter "R	" for rural or "U" for url	oan:			3
4	Is this hospital-based FQHC p	art of an entity that owns, leas	es or controls multiple FQH	Cs? Enter "Y" for yes or "N" for no. If yes,						4
	enter the entity's information b	elow.								
5	Name of Entity:					-				5
6	Street:	P.O. Box:		HRSA Award Number:						6
7	City:	State:		ZIP Code:						7
						Y/N	Date Requested	Date Approved	Number of FQHCs	
Consoli	dated Cost Report					1	2	3	4	
8				oter 9, §30.8? Enter "Y" for yes or "N" for no						8
	If column 1 is yes, complete co	olumns 2 through 4, and line 9	beginning with line 9.01. I	f column 1 is no, leave line 9 blank. (see inst	structions)				+	
						CCN	CBSA	Date Requested	Date Approved	4
	Triange and the same	l				2	3	4	5	
	List of Consolidated Providers Site Name:	8:								9.01
	l-Based FQHC Operations					<u> </u>	1	2	+	9.01
		sis boomital based FOUC2. If		e sub-type of an organization, enter only the	annliachta almba		1	2	3	10
10	characters in column 2. (see in		you operate as more man on	e sub-type of an organization, enter only the	аррисавіе аірпа					10
- 11			the PHS Act during this cos	st reporting period? If this is a consolidated of	cost report did the hospital-base	d FOHC reported				11
11	1	0		period? Enter "Y" for yes or "N" for no. (c	1 / 1	a i Qiic reported				**
12				warded (see instructions). Enter the date of the						12
				grant subscript this line accordingly.	ane grant avvare in					
Medica	l Malpractice	avaid named in Column 31 11	Journeed more man one	grant successful and the decorating.						
		submit an initial deeming or a	nnual redeeming application	n for medical malpractice coverage under the	FTCA with HRSA? Enter "Y"	for				13
	yes or "N" for no in column 1.									
Interns	and Residents	* /	8				•	•		
		receive a THC development g	rant authorized under Part C	of Title VII of the PHS Act from HRSA?	Enter "Y" for					14
	yes or "N" for no in column 1.	If yes, enter in column 2, the	number of FTE residents tha	at your hospital-based FQHC trained and reco	eived funding through your					
	THC grant in this cost reportir	ng period and in column 3. ento	er the total number of visits	performed by residents funded by the THC g	grant in this cost reporting					
	nariod (see instructions)			. , , , , , , , , , , , , , , , , , , ,						1

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02-24			FORM CN	MS-2552-10				409	0 (Cont.)
HOSPITAL-BASED F	QHC IDENTIFICATION DATA					PROVIDER CCN: COMPONENT CCN: SUBCOMPONENT CCN	PERIOD: FROM TO	WORKSHEET S-11 PART II	
PART II - HOSPITAL-	BASED FQHC CONSOLIDATED COST REPORT PA	ARTICIPANT IDENTI	FICATION DATA			_			
				Date Certified	Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW	
	1			2	(see instructions)	4	5	6 6	
1 Site Name:								1	1
2 Street:	P.O. Box:								2
3 City:	State:	ZIP Code:	County:		Designation - Enter "R" f	or rural or "U" for urban:			3
Hospital-Based FQHC	Operations					1	2	3	
~ 1	organization is this hospital-based FQHC? If you operators in column 2. (see instructions)	te as more than one sub-	-type of an organization, enter or	nly the applicable					4
5 Did this hospi	tal-based FQHC receive a grant under §330 of the PHS	Act during this cost rep	orting period? Enter "Y" for yes	or "N" for no. (complete	e line 6)				5
1	e to line 5 is yes, indicate in column 1, the type of HRSA enter the grant award number in column 3. If you recei		,	ate of the grant award in					6
Medical Malpractice									
7 Did this hospi	tal-based FQHC submit an initial deeming or annual rec yes or "N" for no in column 1. If column 1 is yes, enter			nder the FTCA with HRS.	A?				7
Interns and Residents									
	tal-based FQHC receive a THC development grant auth	orized under Part C of	Fitle VII of the PHS Act from H	IRSA?					
	yes or "N" for no in column 1. If yes, enter in column 2				gh				٥
	nt in this cost reporting period and in column 3, enter th		, .		b				
, ,	nouting manied (see instructions)								

Rev. 22

4070 (Cont.)		I Oldivi Ci	VID-2332-10				02-2-
HOSPITAL-BASED FQHC IDENTIFICATION DA	TA			PROVIDER CCN: COMPONENT CC	PERIOD: FROM TO	WORKSHEET S-	11
PART III - HOSPITAL-BASED FQHC STATISTICA	AL 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							5
6 Total IOP Visits							6
7 Total FQHC Visits (sum of lines 2, 4, and 6)							7

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1 001 2 002 3 003 4 002 5 003 6 000 7 007 8 008 9 009 10 010 11 011	00100 00200 00300 00400 00500 00600 00700 00800 00900 01000	GENERAL SERVICE COST CENTERS Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping Dietary	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	FROMTOADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	1 2 3
1 001 2 002 3 003 4 002 5 003 6 000 7 007 8 008 9 009 10 010 11 011	00100 00200 00300 00400 00500 00600 00700 00800 00900 01000	(omit cents) GENERAL SERVICE COST CENTERS Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping	SALARIES 1			CATIONS	TRIAL BALANCE	ADJUSTMENTS	FOR ALLOCATION (col. 5 ± col. 6) 7	3
1 001 2 002 3 003 4 002 5 003 6 000 7 007 8 008 9 009 10 010 11 011	00100 00200 00300 00400 00500 00600 00700 00800 00900 01000	(omit cents) GENERAL SERVICE COST CENTERS Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping	SALARIES 1			CATIONS	TRIAL BALANCE		FOR ALLOCATION (col. 5 ± col. 6) 7	3
1 001 2 002 3 003 4 002 5 003 6 000 7 007 8 008 9 009 10 010 11 011	00100 00200 00300 00400 00500 00600 00700 00800 00900 01000	(omit cents) GENERAL SERVICE COST CENTERS Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping	SALARIES 1			CATIONS			(col. 5 ± col. 6) 7	3
2 002 3 003 4 004 5 005 6 000 7 007 8 008 9 009 10 011 11 011 12 012	00200 00300 00400 00500 00600 00700 00800 00900	GENERAL SERVICE COST CENTERS Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping	SALARIES 1		(col. 1 + col. 2) 3		(col. 3 ± col. 4) 5		7	3
2 002 3 003 4 004 5 005 6 000 7 007 8 008 9 009 10 011 11 011 12 012	00200 00300 00400 00500 00600 00700 00800 00900	Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping	1	2	3	4	5	6	1	3
2 002 3 003 4 004 5 005 6 000 7 007 8 008 9 009 10 011 11 011 12 012	00200 00300 00400 00500 00600 00700 00800 00900	Capital Related Costs-Buildings and Fixtures Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping							-()-	3
2 002 3 003 4 004 5 005 6 000 7 007 8 008 9 009 10 011 11 011 12 012	00200 00300 00400 00500 00600 00700 00800 00900	Capital Related Costs-Movable Equipment Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping							-()-	3
3 003 4 004 5 005 6 006 7 007 8 008 9 009 10 010 11 011	00300 00400 00500 00600 00700 00800 00900	Other Capital Related Costs Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping							-()-	3
4 002 5 003 6 006 7 007 8 008 9 009 10 010 11 011 12 012	00400 00500 00600 00700 00800 00900	Employee Benefits Department Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping							-0-	_
5 005 6 006 7 007 8 008 9 009 10 016 11 011 12 012	00500 00600 00700 00800 00900	Administrative and General Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping								
6 000 7 007 8 008 9 009 10 010 11 011 12 012	00600 00700 00800 00900	Maintenance and Repairs Operation of Plant Laundry and Linen Service Housekeeping								4
7 007 8 008 9 009 10 010 11 011 12 012	00700 00800 00900 01000	Operation of Plant Laundry and Linen Service Housekeeping								5
8 008 9 009 10 010 11 011 12 012	00800 00900 01000	Laundry and Linen Service Housekeeping								6
9 009 10 010 11 011 12 012	00900	Housekeeping								7
10 010 11 011 12 012	1000									8
11 011 12 012		Dietary								9
12 012	1100	Dictary								10
		Cafeteria								11
12 010	1200	Maintenance of Personnel								12
13 013	1300	Nursing Administration								13
14 014	1400	Central Services and Supply								14
15 015		Pharmacy								15
16 016	1600	Medical Records & Medical Records Library								16
17 017	1700	Social Service								17
18		Other General Service (specify)								18
19 019	1900	Nonphysician Anesthetists								19
20 020		Nursing Program								20
		Intern & Res. Service-Salary & Fringes (Approved)								21
		Intern & Res. Other Program Costs (Approved)								22
23		Paramedical Ed. Program (specify)	i .							23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30 030	3000	Adults and Pediatrics (General Routine Care)								30
		Intensive Care Unit			1				+	31
		Coronary Care Unit			1				+	32
		Burn Intensive Care Unit			1				+	33
		Surgical Intensive Care Unit			1				+	34
35		Other Special Care (specify)							 	35
		Subprovider - IPF							 	40
		Subprovider - IRF								41
42		Subprovider (specify)								42
		Nursery								43
		Skilled Nursing Facility								43
		Nursing Facility Nursing Facility								45
		Other Long Term Care							+	45

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

RECLA	SSIFICAT	ION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A	
	COS	T 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 ± col. 6)	
		OTHER REIMBURSABLE COST CENTERS	1	L	,	7	3	Ü	,	
94	09400	Home Program Dialysis								g
95	09500	Ambulance Services								9
96	09600	Durable Medical Equipment-Rented								
97	09700	Durable Medical Equipment-Sold								
98		Other Reimbursable (specify)								
99		Outpatient Rehabilitation Provider (specify)								
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								1
101	10100	Home Health Agency								1
102	10200	Opioid Treatment Program								1
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								1
106	10600	Heart Acquisition								1
107	10700	Liver Acquisition								1
108	10800	Lung Acquisition								1
109	10900	Pancreas Acquisition								1
110	11000	Intestinal Acquisition								1
111	11100	Islet Acquisition								1
112		Other Organ Acquisition (specify)								1
113	11300	Interest Expense							- 0 -	1
114	11400	Utilization Review-SNF							- 0 -	1
115	11500	Ambulatory Surgical Center (Distinct Part)								1
116	11600	Hospice								1
117		Other Special Purpose (specify)								1
118		SUBTOTALS (sum of lines 1 through 117)								1
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								1
191	19100	Research								1
192	19200	Physicians' Private Offices								1
193	19300	Nonpaid Workers								1
194		Other Nonreimbursable (specify)								1
200		TOTAL (sum of lines 118 through 199)				- 0 -				2

RECLAS	SSIFICATIONS							PROVIDER (CCN:	PERIOD: FROMTO	WORKSI	IEET A-6	
				INCR	EASES				DECR	EASES			
		CODE		WKST. A					WKST. A			WKST. A-7	1
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	COST	CENTER	LINE #	SALARY	OTHER	REF.	1
	•	1	2	3	4	5		6	7	8	9	10	1
1													1
2													2
3													3
4													4
5													5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
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16													16
17													17
18													18
19													19
20													20
21													21
22													22
23													23
24													24
25													25
26													26
27													27
28													28
29													29
30													30
31													31
32													32
33													33
34													34
35												T	35

500 Total reclassifications (sum of columns 4 and 5

must equal sum of columns 8 and 9)

500

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

RECON	CILIATION OF CAPITAL COSTS CENTERS		PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A-7, PARTS I, II & III				
PART I	- ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	ı		4 1 1/1		D: 1		F 11	
		Beginning	1	Acquisitions	T	Disposals and	Ending	Fully Depreciated	
	Description	Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
	Description	1	2	3	4	5	6	Assets 7	
1	Land			-					1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1 through 7)								8
9	Reconciling Items								9
10	Total (line 7 minus line 9)								10
PART I	I - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 A	ND 2							
					SUMMARY OF CAPIT	AL			
							Other Capital-	Total (1)	
					Insurance	Taxes	Related Costs	(sum of	
	Description	Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Total (sum of lines 1 and 2)								3
(1)	The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, line	es 1 and 2. Enter in each of	column the appropriate a	mounts including any d	lirectly assigned cost that	may have been included	in Worksheet A,		
	column 2, lines 1 and 2.								

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

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

			;	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.)

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

ADIUS	TMENTS TO EXPENSES	FORM CMS	PROVIDER O	CN.	PERIOD:	WORKSHEE		(Cont.
110000	THE TO EMPERODE		THO VIDENCE		FROM	,, orazonez		
					TO	=		
			1			_		
					EXPENSE CLASSIFIC	CATION ON		
	DESCRIPTION (1)				WORKSHEET A TO/FF		Wkst.	
	(-)	BASIS /			THE AMOUNT IS TO B		A-7	
		CODE (2)	AMOUNT		COST CENTER			
		1	2		3	4	5	
1	Investment income - buildings and fixtures (chapter 2)		_		gs and Fixtures	1	-	1
2	Investment income - movable equipment (chapter 2)				le Equipment	2		2
3	Investment income - other (chapter 2)							3
4	Trade, quantity, and time discounts (chapter 8)							
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)							7
8	Television and radio service (chapter 21)							8
9	Parking lot (chapter 21)							9
10	Provider-based physician adjustment	Worksheet A-8-2						10
11	Sale of scrap, waste, etc. (chapter 23)							11
12	Related organization transactions (chapter 10)	Worksheet A-8-1						12
13	Laundry and linen service							13
14	Cafeteria-employees and guests							14
15	Rental of quarters to employee and others							15
16	Sale of medical and surgical							16
	supplies to other than patients							
17	Sale of drugs to other than patients							17
18	Sale of medical records and abstracts							18
19	Nursing and allied health education (tuition,							19
	fees, books, etc.)							
20	Vending machines							20
21	Income from imposition of interest,							21
	finance or penalty charges (chapter 21)							
22	Interest expense on Medicare overpayments and							22
	borrowings to repay Medicare overpayments							
23	Adjustment for respiratory therapy							23
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respira	ntory 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)				tion Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildir	gs and Fixtures	1		26
27	Depreciation - movable equipment				le Equipment	2		27
28				Nonph	ysician Anesthetist	19		28
29	Physicians' assistant							29
30	Adjustment for occupational therapy costs							30
	in excess of limitation (chapter 14)	Worksheet A-8-3			ational Therapy	67		
30.99	Hospice (non-distinct) (see instructions)			Adults	and Pediatrics	30		30.99
31	Adjustment for speech pathology costs		I					31
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech	Pathology	68		
32								32
33	Other adjustments (specify) (3)							33
50	TOTAL (sum of lines 1 through 49)							50
	(Transfer to Worksheet A, column 6, line 200)							

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

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

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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

⁽³⁾ 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	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 colur	nn 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 Organizat	ion(s) and/or Home Offic	ce	
			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

PROVIDER-BASED PH	HYSICIANS ADJUSTMENTS		ORIVI CIVIS-2332			PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET A-8-2	2
Wkst. A	Cost Center/ Physician	Total	Professional	Provider	RCE	Physician/ Provider	Unadjusted	5 Percent of Unadjusted	1
Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	_
1	2	3	4	5	6	7	8	9	+
2									1
3									
4									
5									
6									
7									
8									
9									—
10									1
200 TOTAL									20
Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
10	11	12	13	14	15	16	17	18	
1									
2									
3		+							
5									
6					+				
7									
8		İ							
9									
10									1
11									1
200 TOTAL									20

99 (Cont.) FORM CMS-2552-10										
REASONABLE COST DETERMINATION FOR THERAPY FURNISHED BY OUTSIDE SUPPLIERS	Y SERVICES			PROVIDER CCN:	PERIOD: FROM	WORKSHEET A-8- PARTS I & II	3,			
Check applicable box: [] Occupational [] Phys	sical [] Respiratory [] Speech Pathology									
PART I - GENERAL INFORMATION	.									
1 Total number of weeks worked (excluding aides) (se	ee instructions)						1			
2 Line 1 multiplied by 15 hours per week							2			
Number of unduplicated days in which supervisor or	or therapist was on provider site (see instructions)						3			
	stant was on provider site but neither supervisor nor therapist was or	n provider site (see instructions)					4			
5 Number of unduplicated offsite visits - supervisors of	or therapists (see instructions)	•					5			
6 Number of unduplicated offsite visits - therapy assist	stants (include only visits made by therapy assistant and on which						6			
supervisor and/or therapist was not present during the	the visit(s)) (see instructions)									
7 Standard travel expense rate										
8 Optional travel expense rate per mile										
				_						
		Supervisors	Therapists	Assistants	Aides	Trainees	_			
·		1	2	3	4	5				
9 Total hours worked							9			
10 AHSEA (see instructions)	 						10			
11 Standard travel allowance (columns 1 and 2, one-hal	.lf of column 2,						11			
line 10; column 3, one-half of column 3, line 10)							- 10			
12 Number of travel hours (see instructions)							12			
13 Number of miles driven (see instructions)							13			
PART II - SALARY EQUIVALENCY COMPUTATION										
14 Supervisors (column 1, line 9 times column 1, line 1	10)						14			
15 Therapists (column 2, line 9 times column 2, line 10	-7					_	15			
16 Assistants (column 3, line 9 times column 3, line 10						_	16			
17 Subtotal allowance amount (sum of lines 14 and 15	,					_	17			
18 Aides (column 4, line 9 times column 4, line 10)	for respiratory alerapy of fines 14 To for all outers)						18			
19 Trainees (column 5, line 9 times column 9, line 10)							19			
20 Total allowance amount (sum of lines 17-19 for resp							20			
•					•	<u> </u>				
If the sum of columns 1 and 2 for respiratory therapy	y or columns 1 through 3 for physical therapy, speech pathology or c	occupational therapy, line 9, is greater than line	2, make no entries on lin	es 21 and 2, and enter of	on line 23					
the amount from line 20. Otherwise complete lines	21 through 23.									
21 Weighted average rate excluding aides and trainees	(line 17 divided by sum of columns 1 and 2, line 9 for respiratory th	herapy or columns 1 through 3, line 9 for all other	ers)				21			
22 Weighted allowance excluding aides and trainees (li	ine 2 times line 21)						22			
23 Total salary equivalency (see instructions)							23			

FORM CMS-2552-10 (03-2016)	(INSTRUCTIONS FOR	THIS FORM ARE PUBI	LISHED IN CMS PUB.	15-2, SECTIONS 4019)

Rev. 9

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)

45 Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)

46 Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)

44

45

46

2-10					03-16
		PROVIDER CCN:	PERIOD: FROM TO_	WORKSHEET A-8 PARTS V-VI	-3,
Therapists	Assistants	Aides	Trainees	Total	
1	2	3	4	5	
					47
					48
					49
					50 51 52 53 54 55
•	•	1		•	
					57
					58
					59
					60
					61
					62
	Therapists 1	Therapists Assistants	PROVIDER CCN: Therapists Assistants Aides	PROVIDER CCN: PERIOD: FROM TO	PROVIDER CCN:

64 Total cost of outside supplier services (from provider records)

65 Excess over limitation (line 64 minus line 63; if negative, enter zero)

64

65

COST A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST	CAP RELATE	ITAL D COSTS						
COS	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 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	U	ı	2	4	4A	3	0	/	
	Capital Related Costs-Buildings and Fixtures									
2	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									
	Housekeeping									
	Dietary									
	Cafeteria									
12										
	Nursing Administration									
	Central Services and Supply									
	Pharmacy									
16	Medical Records & Medical Records Library									
	Social Service									
18	Other General Service (specify)									
19	Nonphysician Anesthetists									
20	Nursing Program									
	Intern & Res. Service-Salary & Fringes (Approved)									
	Intern & Res. Other Program Costs (Approved)									
23	Paramedical Education 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)									
	Subprovider IPF									
41	Subprovider IRF									4
42										
	Nursery									
44	Skilled Nursing Facility									
45	Nursing Facility									
46	Other Long Term Care									4

COST AI	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST		ITAL D COSTS						
COST	CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	4	4A	5	6	7	_
	Operating Room									50
	Recovery Room	+					+			51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
56	Radioisotope									56
	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
										62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									82
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75 76
	Other Ancillary (specify)									77
	Allogeneic HSCT Acquisition 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 Service (specify)									93
	Partial Hospitalization Program									93.99

COST ALLOCATION - G	ENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART I	
		NET EXPENSES FOR COST	CAP RELATE							
COST CENTER DESC	RIPTIONS	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	
	JRSABLE COST CENTERS									4
94 Home Program I										94
95 Ambulance Servi										95
96 Durable Medical										96
97 Durable Medical										97
98 Other Reimbursa										98
	ilitation Provider (specify)									99
	ervice (not appvd. tchng. prgm.)									100
101 Home Health Ag										101
102 Opioid Treatmen										102
	OSE COST CENTERS									
105 Kidney Acquisiti	on									105
106 Heart Acquisition	1									106
107 Liver Acquisition	ı									107
108 Lung Acquisition	ı									108
109 Pancreas Acquisi	tion									109
110 Intestinal Acquis	ition									110
111 Islet Acquisition										111
112 Other Organ Acq	uisition (specify)									112
115 Ambulatory Surg	ical Center (Distinct Part)									115
116 Hospice										116
117 Other Special Pu	rpose (specify)									117
	um of lines 1 through 117)									118
	SABLE COST CENTERS									
190 Gift, Flower, Cof	fee Shop, & Canteen									190
191 Research										191
192 Physicians' Privat	te Offices									192
193 Nonpaid Worker	s									193
194 Other Nonreimbu	rsable (specify)									194
200 Cross Foot Adjus										200
201 Negative Cost Co	enters									201
202 TOTAL (sum lin										202

11 Cafeteria	COST ALLO	OCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	
GINERAL SIRVICE COST CENTERS 1 Capital Related Cost-Movable Equipment 4 Employee Benefits Department 5 Administrative and General 6 Mattenance and Repairs 7 Operation of Plant 8 Landry and Lineus Service 9 Housekeeping 11 Colateria 12 Mattenance of Personnel 13 Medical Service and Supply 14 Central Service and Supply 15 Plantace 16 Central Service and Supply 17 Social Service 18 Ober General Service (specify) 19 Noticeal Records & Medical Records Library 10 Notice Records & Medical Records Library 10 Noticeal Records & Medical Records Library 11 Social Service 12 Union Service (specify) 13 North Service (specify) 14 North Service (specify) 15 North Service (specify) 16 North Service (specify) 17 Social Service (specify) 18 Other General Service (specify) 19 North Service (specify) 10 North Service (specify) 10 North Service (specify) 11 Social Service (specify) 12 Hone Service Service (specify) 13 North Service (specify) 14 Hone Service Service (specify) 15 Social Service (specify) 16 North Service (specify) 17 Social Service (specify) 18 North Service (specify) 19 North Service (specify) 10 North Service (specify) 10 North Service (specify) 11 Hone Service (specify) 12 Hone Service Se	COST CE	INTER DESCRIPTIONS	& LINEN SERVICE	KEEPING		TENANCE OF PERSONNEL	ADMINIS- TRATION	SERVICES & SUPPLY		RECORDS & LIBRARY	SERVICE	
Capital Related Cost-Buildings and Fatures	GE	NERAL SERVICE COST CENTERS	Ü		10	 	13		10	10	• 1	
2 Capital Related Costs-Movable Equipment 4 Engines Barriells Department 5 Administrative and General 6												1
Employee Benefits Department												2
6 Maintenance and Repairs 7 Operation of Plant 8 Laundry and Linno Service 9 Housekeeping 10 Declary 11 Cafetron 12 Maintenance of Personnel 12 Maintenance of Personnel 13 Noving Administration 14 Central Services and Supply 15 Planmacy 16 Medical Records & Medical Records Library 17 Social Service 18 Other General Service (specify) 19 Noughlysician Ansethetists 10 Nourisp Program 10 Nourisp Program 11 Intent & Res. Other Program Costs (Approved) 12 Intent & Res. Other Program Costs (Approved) 13 Intents Res. Other Program Costs (Approved) 14 Intents Res. Other Program Costs (Approved) 15 Paramodical Education Program (specify) 16 Nourisp Program Costs (Approved) 17 Nourisp Program Costs (Approved) 18 Intents Res. Other Program Costs (Approved) 19 Nourisp Costs (Approved) 10 Nourisp Costs (Approved) 10 Nourisp Costs (Approved) 11 Intents Res. Other Program Costs (Approved) 12 Intents Res. Other Program Costs (Approved) 13 Intents Costs (Approved) 14 Supproduct (Specify) 15 Other Special Care Unit Unit 16 Supprovider (Specify) 17 Supprovider (Specify) 18 Supprovider (Specify) 18 Supprovider (Specify) 19 Supprovider (Specify) 10 Supprovider (Specify) 11 Supprovider (Specify) 12 Supprovider (Specify) 13 Supprovider (Specify) 14 Supprovider (Specify) 15 Supprovider (Specify) 16 Supprovider (Specify) 17 Supprovider (Specify) 18 Supprovider (Specify) 18 Supprovider (Specify) 18 Supprovider (Specify) 19 Supprovider (Specify) 10 Supprovider (Specify) 11 Supprovider (Specify) 12 Supprovider (Specify) 13 Supprovider (Specify) 14 Supprovider (Specify) 15 Supprovider (Specify) 16 Supprovider (Specify) 17 Supprovider (Specify) 18 Supprovider (Specify) 18 Supprovider (Specify) 19 Supprovider (Specify) 19 Supprovider (Specify) 10 Supprovider (Specify) 11 Supprovider (Specify) 12 Supprovider (Specify) 13 Supprovider (Specify) 14 Supprovider (Specify) 15 Supprovider (Specify) 16 Supprovider (Specify) 17 Supprovider (Specify) 18 S												4
7 Operation of Plant	5 Ad	Iministrative and General										5
S. Laundty and Linen Service	6 Ma	aintenance and Repairs										6
Housekeeping	7 Op	peration of Plant										7
10 Dietary	8 La	undry and Linen Service										8
11 Cafeteria	9 Ho	ousekeeping										9
12 Maintenance of Personnel	10 Di	etary										10
13 Nursing Administration												11
14 Central Services and Supply	12 Ma	aintenance of Personnel										12
15 Pharmacy												13
16 Medical Records & Medical Records Library												14
17 Social Service												15
18 Other General Service (specify)												16
19 Nonphysician Anesthetists 20 Nursing Program 20 Nursing Program 21 Intern & Res. Service-Salary & Fringes (Approved) 22 Intern & Res. Other Program Costs (Approved) 23 Paramedical Education Program (specify) 24 Paramedical Education Program (specify) 25 Paramedical Education Program (specify) 26 Paramedical Education Program (specify) 27 Paramedical Education Program (specify) 27 Paramedical Education Program (specify) 28 Paramedical Education Program (specify) 28 Paramedical Education Program (specify) 29 Paramedical Educat												17
20 Nursing Program												18
21 Intern & Res. Service-Salary & Fringes (Approved)		1 3										19
22 Intern & Res. Other Program Costs (Approved)												20
23 Paramedical Education Program (specify)												21
INPATIENT ROUTINE SERVICE COST CENTERS												22
30 Adults and Pediatrics (General Routine Care)												23
31 Intensive Care Unit												
32 Coronary Care Unit		`										30
33 Burn Intensive Care Unit 34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF 42 Subprovider (specify) 43 Nursery 44 Skilled Nursing Facility 45 Nursing Facility												31
34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify) 40 Subprovider IPF 41 Subprovider IRF 42 Subprovider (specify) 43 Nursery 44 Skilled Nursing Facility 45 Nursing Facility												33
35 Other Special Care Unit (specify)												34
40 Subprovider IPF 41 Subprovider (Specify) 42 Subprovider (Specify) 43 Nursery 44 Skilled Nursing Facility 45 Nursing Facility												35
41 Subprovider IRF			+			1		1				40
42 Subprovider (specify)												41
43 Nursery												42
44 Skilled Nursing Facility												43
45 Nursing Facility						 						44
												45
40 FORESTAND TERRITORIE		her Long Term Care						1				46

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	0	9	10	11	12	13	14	13	10	17	+
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
54	Radiology-Diagnostic											54
55	Radiology-Therapeutic											55
56	Radioisotope											56
57	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
	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
73	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program									1		93.99

COST A	LLOCATION - GENERAL SERVICE COSTS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	
COS	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS			10		.2	13		15	10	.,	_
94	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition									1		105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
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
	Research											191
	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
200	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	TOTAL (sum lines 118 through 201)											202

12-22 FORM CMS-2552-10 4090 (Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: PERIOD: WORKSHEET B,

12-22		rui	XW CW3-233	2-10					4090	(Cont.
COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROM TO_	WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS	10	17	20	Z1	LL	23	21	23	20	_
Capital Related Costs-Buildings and Fixtures										1
Capital Related Costs-Movable Equipment	=									
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										- 8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										1
12 Maintenance of Personnel										13
13 Nursing Administration										1.
14 Central Services and Supply										14
15 Pharmacy										1.
16 Medical Records & Medical Records Library										10
17 Social Service										17
18 Other General Service (specify)										13
19 Nonphysician Anesthetists										19
20 Nursing Program										20
21 Intern & Res. Service-Salary & Fringes (Approved)										2
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										2.
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										3
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										3.
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF 41 Subprovider IRF										40
41 Subprovider IRF 42 Subprovider (specify)	+	1						+		42
42 Subprovider (specify) 43 Nursery	+	+					 			4.
44 Skilled Nursing Facility										4.
45 Nursing Facility										4:
46 Other Long Term Care										4.
to Other Long Term Care	1	1	1	1			1	I .	1	نصل

4090 (rui	CWI CIVIS-233	Z-1U			T	T	T	12-22
COST A	LLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROMTO_	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	16	19	20	21	ZZ	23	24	23	20	
	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
	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

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

COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD: FROMTO	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	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
OTHER REIMBURSABLE COST CENTERS	10	17	20	21	22	23	27	23	20	
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							1			105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1 through 117)										118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118 through 201)										202

ALLOCA	ATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		ITAL D COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
-	GENERAL SERVICE COST CENTERS	U	1		ZA	4	3	0	,	_
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
	Employee Benefits Department						1			4
5	Administrative and General									5
6	Maintenance and Repairs								1	6
7	Operation of Plant									7
8	Laundry and Linen Service									8
9	Housekeeping									9
10	Dietary									10
										11
12	Maintenance of Personnel									12
										13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
										18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									4
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									36
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider (specify)									42
	Nursery									43
	Skilled Nursing Facility									44
	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		ITAL D COSTS						
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	U	1	2	ZA	4	3	6	/	_
	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
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
62										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 Drugs Charged to Patients									72 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									10
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
93	Other Outpatient Service (specify)									93
93.99	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	
OTVER BEHADARDA DA E GOGT GENATERS	0	1	2	2A	4	5	6	7	-
OTHER REIMBURSABLE COST CENTERS									4
94 Home Program Dialysis									94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold	+								98
98 Other Reimbursable (specify) 99 Outpatient Rehabilitation Provider (specify)									98
1 17									
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
101 Home Health Agency									10
102 Opioid Treatment Program									10.
SPECIAL PURPOSE COST CENTERS									400
105 Kidney Acquisition									105
106 Heart Acquisition									100
107 Liver Acquisition									10
108 Lung Acquisition									10
109 Pancreas Acquisition									10
110 Intestinal Acquisition									110
111 Islet Acquisition									11
112 Other Organ Acquisition (specify)									112
115 Ambulatory Surgical Center (Distinct Part)									11:
116 Hospice									113
117 Other Special Purpose (specify)									11'
118 SUBTOTALS (sum of lines 1 through 117)									118
NONREIMBURSABLE COST CENTERS									4
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									20
202 TOTAL (sum lines 118 through 201)									202

ALLOCATION OF CAPITAL-RELATED COSTS	_							PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 15	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	Ü		10	- 11	12	13	11	13	10	17	+
Capital Related Costs-Buildings and Fixtures											\top
Capital Related Costs-Movable Equipment	1										
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							1				
14 Central Services and Supply								1			
15 Pharmacy									1		
16 Medical Records & Medical Records Library										1	
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 Education 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 (specify)											
43 Nursery											
44 Skilled Nursing Facility											
45 Nursing Facility											
46 Other Long Term Care											

ALLOC	ATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART II	
								I		ТО	_	1
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	ANCILLARY SERVICE COST CENTERS	8	9	10	11	12	13	14	15	16	17	_
50	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
	Electrocardiology											69
	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
78	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												92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

ALLOCATION OF CAPITAL-RELATED COSTS				T GTEVT GTV				PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET B, PART II	(cont.
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 17	
OTHER REIMBURSABLE COST CENTERS	8	9	10	11	12	13	14	15	16	1/	
94 Home Program Dialysis											0/
95 Ambulance Services	-							.	+	_	94
96 Durable Medical Equipment-Rented	-							.	+	_	96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)	+							 	1	+	98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
100 Intern-Resident Service (not appvd. tcnng. prgm.) 101 Home Health Agency											100
102 Opioid Treatment Program	-							.	+	_	10
SPECIAL PURPOSE COST CENTERS											10.
105 Kidney Acquisition											105
106 Heart Acquisition	-							.	+	_	100
107 Liver Acquisition											10
107 Liver Acquisition 108 Lung Acquisition	-							.	+	_	10
109 Pancreas Acquisition											10
110 Intestinal Acquisition											110
111 Islet Acquisition											11
112 Other Organ Acquisition (specify)											111
115 Ambulatory Surgical Center (Distinct Part)											11:
116 Hospice											11
117 Other Special Purpose (specify)											11
118 SUBTOTALS (sum of lines 1 through 117)											11
NONREIMBURSABLE COST CENTERS											111
190 Gift, Flower, Coffee Shop, & Canteen											19
191 Research	+										19
192 Physicians' Private Offices											192
193 Nonpaid Workers	-										193
194 Other Nonreimbursable (specify)	-										19
200 Cross Foot Adjustments											20
201 Negative Cost Centers											20
202 TOTAL (sum lines 118 through 201)										+	20

ALLOC	ATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART II	
									ТО		
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	
	GENERAL SERVICE COST CENTERS	18	19	20	21	22	23	24	25	20	
	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
- 5	Administrative and General										5
- 6	Maintenance and Repairs										6
7	Operation of Plant										7
- 8	Laundry and Linen Service										8
9	Housekeeping										9
	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
	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	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)										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 21	INTERNS & RESIDENTS PROGRAM COSTS	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	2.3	20	-
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
	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
	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program										93.99

ALLOCA	TION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	_
	OTHER REIMBURSABLE COST CENTERS										0.4
	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										
	SPECIAL PURPOSE COST CENTERS										
	Kidney Acquisition										105
106	Heart Acquisition										106
	Liver Acquisition										107
	Lung Acquisition										108
	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										113
117	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
-	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118 through 201)										202

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

COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM		
				•	•		ТО		
			LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		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
	Laboratory								60
	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63									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
	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
77	Allogeneic HSCT Acquisition								77
78	CAR T-Cell Immunotherapy								78
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
	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-		1
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COS	T CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	1
	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
112	Other Organ Acquisition (specify)								112
	Ambulatory Surgical Center (Distinct Part)								115
	Hospice								116
									117
118	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
									194
	Cross foot adjustments								200
201	Negative cost centers								201
									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
									206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207

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

12-22				<u> </u>	UVI CIVIS-233	02-10					4090	(Cont.)
COST AI	LOCATION - STATISTICAL BASIS	_							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	
										TO 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	
	ANCILLARY SERVICE COST CENTERS											
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
57	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
	Speech Pathology											68
69	Electrocardiology											69
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
76	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				Î			1				91
	Observation Beds											92
	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)	_
	OTHER REMAINING A DUE COOT OF VITERS	8	9	10	11	12	13	14	15	16	17	—
	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.)				1						1	100
	Home Health Agency											100
	Opioid Treatment Program											101
	SPECIAL PURPOSE COST CENTERS											102
	Kidney Acquisition											105
	Heart Acquisition											105
	Liver Acquisition											100
107	Lung Acquisition											107
108	Pancreas Acquisition											108
	Intestinal Acquisition											110
	Islet Acquisition											111
	Other Organ Acquisition (specify)											111
												115
115	Ambulatory Surgical Center (Distinct Part)											116
	Hospice											116
	Other Special Purpose (specify)											
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											100
	Gift, Flower, Coffee Shop, & Canteen											190
191												191
	Physicians' Private Offices											192 193
	Nonpaid Workers											
	Other Nonreimbursable (specify)											194
	Cross foot adjustments											200
201	Negative cost centers											201
	Cost to be allocated (per Worksheet B, Part I)											202
203	Unit cost multiplier (Worksheet B, Part I)											203
	Cost to be allocated (per Worksheet B, Part II)											204
	Unit cost multiplier (Worksheet B, Part II)											205
	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		
									ТО		
			NON-		INTERNS &	RESIDENTS	PARA-		INTERN &		1
		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	1
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
- 8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)										18
	Nonphysician Anesthetists										19
20	Nursing Program										20
	Intern & Res. Service-Salary & Fringes (Approved)										21
	Intern & Res. Other Program Costs (Approved)										22
	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
	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
	Subprovider (specify)										42
	Nursery										43
	Skilled Nursing Facility										44
	Nursing Facility										45
46	Other Long Term Care										46

COST ALLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
								FROM		
								TO		
		NON-		INTERNS &	RESIDENTS	PARA-		INTERN &		
	OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
	GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
	(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)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93
93.99 Partial Hospitalization Program										93.99
~	-	-		-		-				

COST A	LLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM	WORKSHEET B-1	
									TO		
		I	NON-		INTEDNS &	RESIDENTS	PARA-		INTERN &		$\overline{}$
		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		
COST	CENTER DESCRIPTIONS	(SPECIFY)	(ASGND TIME)	TIME)	TIME)	TIME)	TIME)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	(ASGND TIME)	20	21	22	23	24	25	26	-
	OTHER REIMBURSABLE COST CENTERS	10	17	20	21	LL	23	27	23	20	
	Home Program Dialysis										94
	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
	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
	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											191
	Physicians' Private Offices										192
											193
	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)										202
203	Unit cost multiplier (Worksheet B, Part I)										203
204											204
205											205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)										206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										207

ST	TEPDOWN ADJUSTMENTS	PROV	IDER CCN:	PERIO FROM TO			WORKSHEET B-2	
T			· · · · · · · · · · · · · · · · · · ·			HEET		
- [DESCRIPTION			COD		LINE NO.	AMOUNT	_
_[1			2		3	4	l
1	Adjustment for EPO costs in Renal Dialysis cost center			1		74		
	Adjustment for EPO costs in Home Program Dialysis cost center			1		94		
	Adjustment for ARANESP costs in Renal Dialysis cost center			1		74		
	Adjustment for ARANESP costs in Home Program Dialysis cost center			1		94		
5	Adjustment for ESA costs in Renal Dialysis cost center (see instructions)			1		74		1
	Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)			1	-+	94		+
	Adjustment for ESA costs in Home Frogram Diarysis cost center (see instructions)			1	-+	94		
7					-			
8								_
9								
0								
1								
2								1
3								1
4				1				+
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5				1				—
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2								
3								
4								
5								1
6								+
				-	-			+
7					_			-
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6								
7								T
				1	T t			1
8								

COMPU	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET O	3
COST	CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I,, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Dis- allowance	Total Costs	Inpatient	Charges Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	10	11	
	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 (specify)	_											35
	Subprovider IPF	+ +							-				40
	Subprovider IFF Subprovider IRF												40
													41
	Subprovider (Specify)												42
	Nursery												43
	Skilled Nursing Facility												
	Nursing Facility												45 46
	Other Long Term Care												46
	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
	Laboratory												60
	PBP Clinical Laboratory Services-Prgm. Only												61
	Whole Blood & Packed Red Blood Cells												62
	Blood Storing, Processing, & Trans.												63
	Intravenous Therapy												64
65	Respiratory Therapy												65
	Physical Therapy												66
67	Occupational Therapy												67
68	Speech Pathology		_										68

COMPU	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET (PART I	С
		1			Costs			Charges		10			т —
COST	CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I,, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	†
69	Electrocardiology	•		, i			v	,	Ü		- 10		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												
88	Rural Health Clinic (RHC)												88
	Federally Qualified Health Center (FQHC)												89
90													90
	Emergency												91
92	Observation Beds (see instructions)												92
	Other Outpatient Service (specify)												93
	Partial Hospitalization Program												93.99
	OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis												94
	Ambulance Services												95
	Durable Medical Equipment-Rented												96
	Durable Medical Equipment-Sold	1											97
	Other Reimbursable (specify)												98
	Outpatient Rehabilitation Provider (specify)	1											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
	Liver Acquisition												107
108													108
109													109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)												200
201	Less Observation Beds												201
202	Total (see instructions)												202

12 22			1 OTOM CIVIS 2332 10			1070 (COIIt.
CALCULATION OF OUTPATIE	ENT SERVICE COST T	. <mark>O</mark>		PROVIDER CCN:	PERIOD:	WORKSHEET C,
CHARGE RATIOS NET OF REL	DUCTIONS FOR MED	ICAID ONLY			FROM	PART II
					ТО	_
Check applicable box:	[] Title V	[] Title XIX				

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

4070 (Cont.)			1 OKWI CWI5-2532-10			12-22
CALCULATION OF OUTPATI	ENT SERVICE COST	TO		PROVIDER CCN:	PERIOD:	WORKSHEET C.
CHARGE RATIOS NET OF RE	DUCTIONS FOR MEI	DICAID ONLY			FROM	PART II (CONT.)
					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 4	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)	
	OUTPATIENT SERVICE COST CENTERS	•	2	J			Ü	,	Ü	_
88	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
91	Emergency									91
92	Observation Beds (see instructions)									92
93	Other Outpatient Service (specify)									93
	Partial Hospitalization Program									93.99
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	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
105	Kidney Acquisition									105
106	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
	Subtotal (sum of lines 50 through 199)									200
	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

44

45

200

Skilled Nursing Facility

Total (lines 30 through 199)

Nursing Facility

44

200

⁽A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CARITAL COSTS						PROVIDER CCN: PERIOD: WORKSHEET D				
SERVIC	SERVICE CAPITAL COSTS						FROM			
						COMPONENT CCN:	то	_		
Check		[] Title V	[] Hospita	[] Subprovider ((Other)	[] PPS				
applicabl	le.	Title XVIII, Part A	[] IPF	[] PARHM Demonstration		[] TEFRA				
boxes:		Title XIX	[] IRF	[] []	iionou uu on	[] 121101				
			· ` `	Capital						
			Related Cost	Total Charges	Ratio of Cost	Inpatient				
				(from Wkst. B	(from Wkst. C,	to Charges	Program	Capital Costs		
				Part II, col. 26)	Pt .I, col. 8)	(col .1 ÷ col. 2)	Charges	(col. 3 x col. 4)		
(A)	Cost Center Description			1	2	3	4	5		
	ANCIL	LARY SERVICE COST CEN	TERS							
50	1 0								50	
51	, , , , , , , , , , , , , , , , , , ,								51	
52	,								52	
53	22								53	
54									54	
55	82								55	
56									56	
57									57	
58									58	
59									60	
60									60	
61									61	
62	Whole Blood & Packed Red Blood Cells								62	
63									63	
64	17								64	
65									65	
66									66	
67	12								67	
68	1 67								68	
69									69	
70	1 0 1 7								70	
71									71	
72									72	
73									73	
74	,								74	
75									75	
76	3 (1 3/								76 77	
77 78	<u> </u>								78	
			UTEDC						/8	
- 00	-	ATIENT SERVICE COST CET	NIERS						00	
88 89							 	+	88 89	
90	Federally Qualified Health Center (FQHC) Clinic								90	
91	Emergency								90	
92	Observation Beds								92	
93							 		93	
93.99		Hospitalization Program	-				 		93.99	
73.79		R REIMBURSABLE COST C	ENTERS						23.39	
94			LIVIENO						94	
95	Home Program Dialysis Ambulance Services								95	
96									96	
96									96	
98									98	
									200	

⁽A) Worksheet A line numbers

		F INPATIENT ROUTINE SS-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	nonstration		[] 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 De		1A	1	2A	2	3	4	5	6	7	8	9	<u> </u>
30	Adults & Pedi													30
31	Intensive Care	Unit												31
	Coronary Care													32
33	Burn Intensive	e Care Unit												33
34	Surgical Intens	sive Care Unit												34
35	Other Special	Care Unit (specify)												35
40	Subprovider II	PF												40
41	Subprovider II	RF												41
42	Subprovider ((Other)												42
43	Nursery													43
44	Skilled Nursin	g Facility												44
45	Nursing Facili	ity												45
200	Total (sum of	lines 30 through 199)												200

⁽A) Worksheet A line numbers

	ONMENT OF INPATIENT/OUTPA OTHER PASS-THROUGH COST							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET D, PART IV	
Check	[] Title V	[] Hospital	[] SNF		[] PARHM Demon		[] PPS	COMPONENT CCN:	10		
applicable boxes:	[] Title XVIII, Part A [] Title XIX	[] IPF [] IRF [] Subprovider (Other)	[] NF [] ICF/IID [] Swing-Bed S	NF	[] PARHM CAH S	wing Bed-SNF	[] TEFRA [] Other				
			Non Physician Anesthetist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
	NCILLARY SERVICE COST CEN	NTERS									
	Operating Room										50
	Recovery Room										51
	abor room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	6 6 7										58
											59
	60 Laboratory 61 PBP Clinical Laboratory ServPrgm. Only										60
	Vhole Blood & Packed Red Blood (61 62
	Blood Storing, Processing, & Transfi										
	ntravenous Therapy	using									63
	Respiratory Therapy								.		64 65
	Physical Therapy										66
	Occupational Therapy								.		67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged To Patien	te									71
	mplantable Devices Charged to Pati										72
	Drugs Charged to Patients	ono									73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	UTPATIENT SERVICE COST CE	NTERS									<u></u>
	Rural Health Clinic (RHC)										88
	Gederally Qualified Health Center (F	OHC)				†			1		89
	Clinic	,									90
	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)										93
	Partial Hospitalization Program								1		93.99

Ambulance Services

96 Durable Medical Equipment-Rented

97 Durable Medical Equipment-Sold

98 Other Reimbursable (specify)
200 Total (sum of lines 50 through 199)

95

95

96

97 98

⁽A) Worksheet A line numbers

	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY OTHER PASS THROUGH COSTS						PROVIDER CCN: PERIOD: FROM PAR		
Check applicable boxes:	[] Title XVIII, Part A	SNF NF ICF/IID Swing-Bed SNF		[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF				·	
		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	
AN	NCILLARY SERVICE COST CENTERS								
50 O	perating Room								50
51 R	ecovery Room								51
52 D	elivery Room and Labor Room								52
53 A	nesthesiology								53
	adiology-Diagnostic								54
55 Ra	adiology-Therapeutic								55
56 Ra	adioisotope								56
	omputed Tomography (CT) Scan								57
	Iagnetic Resonance Imaging (MRI)								58
	ardiac Catheterization								59
	aboratory								60
	BP Clinical Laboratory ServPrgm. Only								61
	/hole Blood & Packed Red Blood Cells								62
	lood Storing, Processing, & Transfusing								63
	stravenous Therapy								64
	espiratory Therapy								65
	hysical Therapy								66
	ccupational Therapy								67
	peech Pathology							<u> </u>	68
	lectrocardiology								69
	lectroencephalography							 	70
	Iedical Supplies Charged To Patients							+	71
	nplantable Devices Charged to Patients								72
	rugs Charged to Patients enal Dialysis					-		 	73 74
	· · · · · · · · · · · · · · · · · · ·								
	SC (Non-Distinct Part)					+		+	75
	ther Ancillary (specify) llogeneic HSCT Acquisition		!			+	 	+	76 77
	AR T-Cell Acquisition							+	78
	UTPATIENT SERVICE COST CENTERS								/6
	ural Health Clinic (RHC)	_							88
	ederally Qualified Health Center (FQHC)		1			+		+	89
	linic							+	90
	mergency							+	91
	bservation Beds					1		+	92
	ther Outpatient Service (specify)					1		+	93
	ential Hamitalization Program		†					+	02.00

(col. 5 ÷ col. 7)

(col. 6 ÷ col. 7)

Charges

10

(col. 8 x col. 10)

11

Charges

12

(col. 9 x col. 12)

13

94

95

96 97

98

200

Part I, col. 8)

(A) Worksheet A line numbers

94 Home Program Dialysis

Ambulance Services

Cost Center Description

96 Durable Medical Equipment-Rented

200 Total (sum of lines 50 through 199)

Durable Medical Equipment-Sold 98 Other Reimbursable (specify)

OTHER REIMBURSABLE COST CENTERS

(A)

95

4090 (Cont.) FORM CMS-2						2-10					07-23
	TIONMENT OF MEDICAL AND OTH	HER				PROVIDER CCN:		PERIO		WORKSHEET D	
HEALTI	H SERVICES COSTS					COMPONENT CC	.N.	FROM _		PART V	
						com onzari co			-		
Check	[] Title V - O/P	[] Hospital		[] Subprovider	(Other)	[] Swing-Bed SN			RHM Demonstration		
applicabl		[] IPF		[] SNF		[] Swing-Bed NF		[] PA	RHM CAH Swing-	Bed SNF	
boxes:	[] Title XIX - O/P	[] IRF		[] NF		[] ICF/IID					
PART V	- APPORTIONMENT OF MEDICAL	AND OTHER	HEALTH SERV	ICES COSTS							
					Program Charges				Program Cost		
			Cost		Cost	Cost			Cost	Cost	1
			to		Reimbursed	Reimbursed			Reimbursed	Reimbursed	
			Charge	PPS	Services	Services Not	PP		Services	Services Not	
			Ratio from	Reimbursed	Subject to	Subject to	Serv		Subject to	Subject to	
			Wkst. C, Pt. I, col. 9	Services	Ded. & Coins.	Ded. & Coins.	(se		Ded. & Coins.	Ded. & Coins.	
(A)	Cost Center Description		1	(see inst.)	(see inst.)	(see inst.)	(see in		(see inst.)	(see inst.)	
(A)	ANCILLARY SERVICE COST CENT	TERS	1	2	3	7			0	,	
50	Operating Room										50
51	Recovery Room										51
52	Labor & Delivery Room										52
	Anesthesiology										53
54	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58 59	Magnetic Resonance Imaging (MRI) Cardiac Catheterization					 					58 59
	Laboratory										60
61	PBP Clinical Laboratory ServPrgm. 0	Only				_					61
62	Whole Blood & Packed Red Blood Ce										62
	Blood Storing, Processing, & Transfus										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
68	Speech Pathology										68
	Electrocardiology										69 70
	Electroencephalography Medical Supplies Charged To Patients										71
72	Implantable Devices Charged to Patier										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
77	Allogeneic HSCT Acquisition										77
78	CAR T-Cell Immunotherapy	TEDC									78
88	OUTPATIENT SERVICE COST CEN Rural Health Clinic (RHC)	TEKS									88
89	Federally Qualified Health Center (FQ	HC)									89
90	Clinic	,									90
91	Emergency										91
92	Observation Bed										92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program										93.99
	OTHER REIMBURSABLE COST CE	ENTERS									
	Home Program Dialysis	-									94
	Ambulance Durable Medical Equipment-Rented					-					95 96
	Durable Medical Equipment-Rented Durable Medical Equipment-Sold				 	+				-	96
	Other Reimbursable Cost Center					 					98
	Subtotal (see instructions)					 					200
	Less PBP Clinic Lab. Services-Program	m									201
	Only Charges										
202	Net Charges (line 200 - line 201)										202

12-27		I OIGNI C	NIO-2332-10) UCUT	Cont.
COMPU	COMPUTATION OF INPATIENT			PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERA	TING COST				FROM	PART I	
				COMPONENT CCN:	ТО		
Check	[] Title V - I/P [] Ho	spital [] NF		•	[] PPS		
applicab	le [] Title XVIII, Part A [] IPI	[] ICF/IID			[] TEFRA		
boxes:	[] Title XIX - I/P	F [] PARHM De	emonstration		[] Other		
	[] Sui	oprovider (other)					
	[] SN	F					
PART I	- ALL PROVIDER COMPONENTS				•		
	INPATIENT DAYS						
1	Inpatient days (including private room days and sw	ing-bed days, excluding newborn)					1
2	Inpatient days (including private room days, exclud-	ing swing-bed and newborn days)					2
3	Private room days (excluding swing-bed and obser		oom days, do not comple	ete this line.			3
4	Semi-private room days (excluding swing-bed and						4
5	Total swing-bed SNF type inpatient days (including		of the cost reporting per	riod			5
6	Total swing-bed SNF type inpatient days (including	private room days) after December 31 of	the cost reporting period	l (if			6
	calendar year, enter 0 on this line)			`			
7	Total swing-bed NF type inpatient days (including	private room days) through December 31	of the cost reporting perio	od			7
8	Total swing-bed NF type inpatient days (including	private room days) after December 31 of the	he cost reporting period ((if			8
	calendar year, enter 0 on this line)						
9	Total inpatient days including private room days ap	plicable to the Program (excluding swing-	bed and newborn days)	(see instructions)			9
10	Swing-bed SNF type inpatient days applicable to ti	le XVIII only (including private room day	s) through December 31	of the			10
	cost reporting period (see instructions).		, ,				
11	Swing-bed SNF type inpatient days applicable to ti	le XVIII only (including private room day	s) after December 31 of	the			11
	cost reporting period (if calendar year, enter 0 on t						
12	Swing-bed NF type inpatient days applicable to title	es V or XIX only (including private room	days) through December	31 of			12
	the cost reporting period.		-				
13	Swing-bed NF type inpatient days applicable to title	es V or XIX only (including private room	days) after December 31	of the			13
	cost reporting period (if calendar year, enter 0 on the	is line)	•				
14	Medically necessary private room days applicable t						14
15	Total nursery days (title V or XIX only)						15
16	Nursery days (title V or XIX only)						16
	SWING BED ADJUSTMENT						
17	Medicare rate for swing-bed SNF services applicab	le to services through December 31 of the	cost reporting period				17
18	Medicare rate for swing-bed SNF services applicab	le to services after December 31 of the co	st reporting period				18
19	Medicaid rate for swing-bed NF services applicable	to services through December 31 of the c	cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable	to services after December 31 of the cost	reporting period				20
21	Total general inpatient routine service cost (see ins	ructions)					21
22	Swing-bed cost applicable to SNF type services thr	ough December 31 of the cost reporting p	period (line 5 x line 17)				22
23	Swing-bed cost applicable to SNF type services aft	er December 31 of the cost reporting period	od (line 6 x line 18)				23
24	Swing-bed cost applicable to NF type services thro	ugh December 31 of the cost reporting pe	riod (line 7 x line 19)				24
25	Swing-bed cost applicable to NF type services after	December 31 of the cost reporting period	(line 8 x line 20)				25
26	Total swing-bed cost (see instructions)						26
27	General inpatient routine service cost net of swing-	bed cost (line 21 minus line 26)					27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMEN						
28	General inpatient routine service charges (excludin	g swing-bed and observation bed charges)					28
29	Private room charges (excluding swing-bed charge						29
30	Semi-private room charges (excluding swing-bed of						30
31	General inpatient routine service cost/charge ratio (31
32	Average private room per diem charge (line 29 ÷ li						32
33	Average semi-private room per diem charge (line 3						33
34	Average per diem private room charge differential						34
35	Average per diem private room cost differential (lin						35
36	Private room cost differential adjustment (line 3 x l	·					36
37	General inpatient routine service cost net of swing-	bed cost and private room cost differential	(line 27 minus line 36)			I	37

		F INPATIENT				PROVIDER CC		WORKSHEET D-1,		
OPERAL	[] Title XVIII, Part A [] IPF					COMPONENT O	FROM CCN: TO	PART II		
Check			[] Hospital	[] PARH!	M Demonstration		PPS			
applicable	;						TEFRA			
boxes:		[] Title XIX - I/P	[] IRF			[]	Other			
DADTH	HOCDITA	I AND CURREDOWNERS ONLY	[] Subprovider (oth	er)						
		L AND SUBPROVIDERS ONLY I INPATIENT OPERATING COST I	REFORE							
		OUGH COST ADJUSTMENTS	BEFORE					1		
		eneral inpatient routine service cost po	er diem (see instructions)					1	38	
		eneral inpatient routine service cost (li							39	
	<u> </u>	necessary private room cost applicable		x line 35)					40	
		am general inpatient routine service of		,					41	
						Average				
				Total	Total	Per Diem	Program	Program Cost		
				Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2	2) Days	(col. 3 x col. 4)		
				1	2	3	4	5		
		le V & XIX only)							42	
		are Type Inpatient								
	Iospital Ur								- 12	
	Intensive C								43	
	Coronary C					+			44	
		sive Care Unit tensive Care Unit				1			46	
		ial Care Unit (specify)							47	
7/	Other Spec	iai care Omi (speerly)						1		
48	Program in	patient ancillary service cost (Worksh	eet D-3, column 3, line 2	200)				•	48	
		patient cellular therapy acquisition co							48.01	
		am inpatient costs (sum of lines 41 th							49	
F	ASS-THR	OUGH COST ADJUSTMENTS								
50	Pass throug	th costs applicable to Program inpatie	nt routine services (from	Worksheet D, sum of Par	rts I and III)				50	
		th costs applicable to Program inpatie		n Worksheet D, sum of P	arts II and IV)				51	
		ram excludable cost (sum of lines 50 a							52	
53	Total Progr	am inpatient operating cost excluding	capital related, nonphys	ician anesthetist, and me	dical education costs (li	ine 49 minus line 52	2)		53	
7	CADCET A	MOUNT AND LIMIT COMBUTAT	TON							
	Program di	MOUNT AND LIMIT COMPUTAT	ION						54	
		unt per discharge							55	
		adjustment amount per discharge							55.01	
		t amount per discharge (contractor use	e only)						55.02	
	_	amount paid as an interim payment							55.03	
		ount ((line 54 x sum of lines 55, 55.01	, and 55.02) plus line 55	.03)					56	
		between adjusted inpatient operating							57	
		ment (see instructions)							58	
59	Trended co	sts (lesser of line 53 ÷ line 54, or line	55 from the cost reporti	ng period ending 1996, u	pdated and compounded	d by the market bask	cet)		59	
		osts (lesser of line 53 ÷ line 54, or line							60	
		s improvement bonus payment (if line		•					61	
		which operating costs (line 53) are les	ss than expected costs (lin	nes 54 x 60), or 1 % of the	e target amount (line 56), otherwise enter ze	ero. (see instructions)			
		nent (see instructions)							62	
63	Allowable	Inpatient cost plus incentive payment	(see instructions)						63	
	DDOCD 43	INDATIENT DOUTINE OWNER D	ED COST							
		I INPATIENT ROUTINE SWING B		Pelina annet mamanetima mania d	(and instructions)				61	
	Medicare s (title XVIII	wing-bed SNF inpatient routine costs	unough December 31 01	the cost reporting period	(see instructions)			1	64	
		wing-bed SNF inpatient routine costs	ofter December 21 of the	a aget reporting period (c	aa instructions)				65	
	(title XVIII		and Determoer 31 01 mm	cost reporting period (s	ee manuchons)				03	
	`	care swing-bed SNF inpatient routine	costs (line 64 plus line 6	(5) (title XVIII only: for C	CAH, see instructions)				66	
		XIX swing-bed NF inpatient routine c						1	67	
									68	
69	Total title V	or XIX swing-bed NF inpatient rout	ine costs (line 67 + line 6	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						

01-22				FORM CMS-255	2-10		4090 ((Cont.)
COMPU	JTATION OF	INPATIENT			PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERA	TING COST				COMPONENT CCN:	FROM	PARTS III & IV	
					COMPONENT CCN:	то		
Check		[] Title V - I/P	[] Hospital	[] SN		[] PPS	•	
applicab boxes:	ole	[] Title XVIII, Part A [] Title XIX - I/P	[] IPF [] IRF	[] NF [] ICI		[] TEFRA [] Other		
DOXCS.		[] Title XIX - I/I	[] Subprovide		TAID	[] Other		
PART I	II - SNF, NF,	AND ICF/IID ONLY						
70	SNF / NF / I	CF/IID routine service cost (line	: 37)					70
71	4.11 . 1	41	1' (1' 70 -	1' 2)				7.1
71		neral inpatient routine service co		- ime 2)				71
72	Fiogramiiou	tine service cost (line 9 x line 71)					72
73	Medically no	ecessary private room cost applic	able to Program (line	e 14 x line 35)				73
74	Total Progra	m general inpatient routine servi	ice costs (line 72 + lin	ne 73)				74
75	Capital-relat	ed cost allocated to inpatient rou	tine service costs (fro	om Worksheet B, Part II, c	olumn 26, line 45)			75
76	Per diem cap	pital-related costs (line 75 ÷ line	2)					76
77	Program cap	oital-related costs (line 9 x line 7	5)					77
78	8 Inpatient routine service cost (line 74 minus line 77)							
79	Aggregate cl		79					
80	Total Progra	m routine service costs for comp			80			
81	Inpatient rou	ntine service cost per diem limita	tion					81
82	Inpatient rou	ntine service cost limitation (line	9 x line 81)					82
83	Reasonable	inpatient routine service costs (s	ee instructions)					83
84	Program inp	atient ancillary services (see ins	tructions)					84
85	Utilization re	eview - physician compensation	(see instructions)					85
86	Total Progra	m inpatient operating costs (sum	of lines 83 through	85)				86
PART I	V - COMPUT	ATION OF OBSERVATION B	ED PASS-THROUG	GH COST				
87	Total observ	ration bed days (see instructions))					87
88	Adjusted ger	neral inpatient routine cost per d	iem (line 27 ÷ line 2)					88
89	Observation	bed cost (line 87 x line 88) (see	instructions)					89
	COMPUTAT	TION OF OBSERVATION BEI	PASS THROUGH	COST				
				Routine		Total Observation	Observation Bed Pass-Through Cost	
				Cost	column 1 ÷	Bed Cost	(col. 3 x col. 4)	
				(from line 21)	column 2	(from line 89)	(see instructions)	
	 			2	3	4	5	
90	Capital-relat	ed cost						90
91	Nursing Pro	gram cost						91
92	Allied Heal	th cost						92
93	All other Me	edical Education						93

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APPORTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2.
			,
SERVICES RENDERED BY		FROM	PARTS I-III
DER TIPES RETURNED BY		110111	
INTERNS AND RESIDENTS		TO	
INTERNS AND RESIDENTS		10	

	I - NOT IN APPROVED TEACHING PROGRAM	Percent of	Expense	Total Inpatient Days
	Cost Centers	Assigned Time	Allocation	All Patients
		1	2	3
1	Total cost of services rendered	100.00		
	Hospital Inpatient Routine Services:			
2	Adults & pediatrics (general routine care)			
3	Intensive care unit			
4	Coronary care unit			
5	Burn Intensive Care Unit			
6	Surgical Intensive Care Unit			
7	Other Special Care (specify)			
8				
9	8 -)			
10	1			
11	<u>.</u>			
12				
13	U ,			
14	U J			
15				
16	Ų į			
17			_	
18			_	
19			 	
20	Subtotal (sum of lines 9 through 19)			T + 1.01
				Total Charges (from Wkst. C, Pt. I, col. 8, lines 88
	Hospital Outpatient Services:			through 93)
21				
22				
23				
24	<u> </u>			
25				
26	1 1 2			
27	<u> </u>			
28		100.00		
KII	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPA	Expenses Allocated	1	1
	Hagnital Innations Posting Services	to cost centers on Wkst. B, Pt. I cols. 21 and 22	Swing Bed Amount 2	Net Cost (col. 1 plus col. 2)
29	Hospital Inpatient Routine Services:	1	2	3
30	8			
31	- C			
32	· ·			
33				
34				
35				
36				
37	Subtotal (sum of lines 29, and 32 through 36)			
	IRF - Inpatient routine service		+	
38			+	
39		•	-	
39 40	Subprovider (Other)- Inpatient routine service			
39 40 41	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility			
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	RTS I AND II ARE USED)		
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	RTS I AND II ARE USED)	Not In Approved	Teaching Program Amount
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	RTS I AND II ARE USED)		
39 40 41 42 RT I	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA	RTS I AND II ARE USED)	(from Part I)	Amount
39 40 41 42 RT I	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA	RTS I AND II ARE USED)	(from Part I)	Amount
39 40 41 42 RT I	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA Hospital Inpatient	RTS I AND II ARE USED)	(from Part I) 1 col. 9, line 9	Amount
39 40 41 42 RT I 43 44 45	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA Hospital Inpatient Outpatient	RTS I AND II ARE USED)	(from Part I) 1 col. 9, line 9	Amount
39 40 41 42 RT I 43 44 45	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	RTS I AND II ARE USED)	(from Part I) 1 col. 9, line 9 col. 9, line 27	Amount
39 40 41 42 RT I 43 44 45 46	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PA Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service	RTS I AND II ARE USED)	(from Part I) 1 col. 9, line 9 col. 9, line 27 col. 9, line 10	Amount

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

PART I	- NOT IN APPROVED	TEACHING PROGRAM	M					
	Average Cost		th Care Program Inpatient	t Days	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
1								1
2								2
3								3
4								4
5								5
7								6 7
- 8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
			es V and XIX Outpatient		Title	es V and XIX Outpatient	and	
	Ratio of Cost		Fitle XVIII Part B Charge			Title XVIII Part B Cost		
	to Charges	Title	Title XVIII	Title	Title	Title XVIII	Title	
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX	
21								21
22								22
23								23
24								24 25
26								26
27								27
28								28
	- IN AN APPROVED	TEACHING PROGRAM	I (TITLE XVIII, PART E	B INPATIENT ROUTIN	E COSTS ONLY)			20
			l` í	Expenses	, in the second			
	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)				
	4	5	6	7				
29								29
30								30
31								31
32								32
33								33
34								34 35
36								36
37								37
38								38
39								39
40								40
41								41
42								42
PART II	I - SUMMARY FOR T	TLE XVIII (TO BE CO	MPLETED ONLY IF BO	OTH PARTS I AND II	ARE USED)			
	In Approved To	eaching Program		XVIII Costs				
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				
	3	4	5	6				
43	line 37							43
44								44
45			line 22					45
	line 38	ĺ	line 22					46
46								
47	line 39		line 22					47
			line 22 line 22 line 22					47 48 49

INPATI	ENT ANCILLARY SERVICE	PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST A	PPORTIONMENT	GOL MONTHY GOV	FROM	-	
		COMPONENT CCN:	ТО		
Check	[] Title V [] Hospital [] SNF [] ICF/IID	<u>I</u>	[] PPS	<u>I</u>	
applicab		monstration	[] TEFRA		
boxes:		AH Swing-Bed SNF	[] Other		
	[] Subprovider (Other) [] Swing-Bed NF	-			
		Ratio of Cost	Inpatient	Inpatient Program Costs	;
(4)	COST CENTER DESCRIPTION	to Charges	Program Charges	(col. 1 x col. 2)	ł
(A)	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	
30	Adults and Pediatrics (General Routine Care)				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify) Nursery				42
43	ANCILLARY SERVICE COST CENTERS				43
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 Magnetic Resonance Imaging (MRI)				57 58
59	Cardiac Catheterization				59
60	Laboratory				60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy				64
65	Respiratory Therapy				65
66	Physical Therapy				66
67	Occupational Therapy Speech Pathology				67
69	Electrocardiology				68 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) Allogeneic HSCT Acquisition	-	-		76 77
78	CAR T-Cell Immunotherapy	1			78
- 70	OUTPATIENT SERVICE COST CENTERS	<u>I</u>	1	1	7.0
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
93.99	Partial Hospitalization Program OTHER REIMBURSABLE COST CENTERS				93.99
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50 through 94 and 96 through 98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net charges (line 200 minus line 201)		I .		202

(A) Worksheet A line numbers

04-20			I OIGNI V	CIVID-2332-10	<u>'</u>		4070 (C0	111.
COMPUTATION	OF ORGAN ACQUIS	SITION COSTS AND	CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR A TRANSPL	ANT HOSPITAL WI	TH A MEDICARE-CE	ERTIFIED			FROM	PART I	
TRANSPLANT PR	ROGRAM				OPO CCN:	TO		
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET				
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE					

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

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

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED	PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-4, PART II	
TRANSPLANT PROGRAM	OPO CCN:	ТО		
Check [] HEART [] LIVER [] PANCREAS [] ISLET				
applicable box: [] KIDNEY [] LUNG [] INTESTINE				
PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE A ANCILLARY SERVICE COSTS)	AND			
	Average Cost		Organ	

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

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

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

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75.04

76

77 78

79

79.01

80 81

82

83

84

40			

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.

75.04

76

78

79

80

81

82

83

84

79.01

Organs transplanted, Other (see instructions)

Kidneys sold to MRTC with an agreement

Organs sent outside the U.S. (no revenue received)

Unusable/Discarded organs (see instructions)

Organs sold to MRTC without an agreement or VA hospitals

Organs sold to other hospitals

Organs sold outside the U.S

Organs used for research

Total (see instructions)

Organs sold to transplant hospitals

Organs sold to OPOs

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1000	(Cont.)	1 Oldin Cinib 23	J2 10					05 25
APPOR	RTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET D-5, PART I	
Check a	applicable box: [] Hospital Staff [] Medical Staff							
	- REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIOD	S ENDING REFORE ILINE 30) 2014					
Line	Specialty	Total	Professional	RCE	Physician/ Professional	Unadjusted	5 Percent of Unadjusted	
No.	Description/Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	ı
1	2	3	4	5	6	7	8	ı
1	General Practitioner Family Practice		·		v	,	Ü	1
2	Internal Medicine							2
3								2
4	Pediatrics							
5	Obstetrics-Gynecology							5
6	Radiology							6
7	Psychiatry							7
8	Anesthesiology							8
	Pathology							9
	All Other							10
	Total							11
		•	•	•	•	•	•	
		Cost of		Cost of			Adjust Cost	
		Membership	Professional	Physician	Professional		of Physician's	ı
Line	Specialty	& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	ı
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	l
9	10	11	12	13	14	15	16	1
1	General Practitioner Family Practice							1
2	Internal Medicine							2
	Surgery							3
4	Pediatrics							4
5	Obstetrics-Gynecology							5
6	Radiology							6
7	Psychiatry							7
8	Anesthesiology							8
9	Pathology							9
10	All Other							10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)							11

			Medical School	Total	
		Hospital Staff	Faculty	$(\operatorname{col} 1 + \operatorname{col} 2)$	
		1	2	3	
1	Adjusted Cost of Physician's Direct Medical and Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days				2
3	Average Per Diem (line 1 ÷ line 2)				3
	WELL THE GLIDE DO GOLLANDEN (DVDG LDVED LVG				
4	HEALTH CARE PROGRAM REIMBURSABLE DAYS Title V - Inpatient	<u> </u>			1 4
- 4					5
3	Title V - Outpatient				
6	Title XVIII - Part A				6
7	Title XVIII - Part B				7
8	Title XIX - Inpatient				8
9	Title XIX - Outpatient				9
10					10
11	Inpatient and Outpatient Liver Acquisition				11
12					12
13					13
14					14
15					15
16	Inpatient and Outpatient Islet Acquisition				16
17	Other Organ Acquisition				17
10	HEALTH CARE PROGRAM REIMBURSABLE COST	<u> </u>			10
18					18
19					19
20					20
21	Title XVIII - Part B (line 3 x line 7)				21
22	Title XIX - Inpatient (line 3 x line 8)				22
23					23
24					24
25					25
26					26
27					27
28					28
29	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)				29
29					
30	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)				30

Transfer the amounts in column 3 as follows:

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

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

Line 21 to Worksheet E, Part B

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

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

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

APPOR	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART IV
Check	[] Hospital	l		
applical				
box:	[] IRF			
PART I	V - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPIT	AL FOR COST REPORTING	PERIODS ENDIN	G ON OR AFTER JUNE 30, 2014
1	Adjusted cost of physicians' direct medical and surgical services			1
2	Total inpatient days and outpatient visit days			2
3	Average per diem (line 1 ÷ line 2)			3
	HEALTH CARE PROGRAM REIMBURSABLE DAYS			
4	Title V - Inpatient			4
5	Title V - Outpatient			5
6				6
7	Title XVIII - Part B			7
8	Title XIX - Inpatient			8
9	Title XIX - Outpatient			9
10	Inpatient and outpatient kidney acquisition			10
11	Inpatient and outpatient liver acquisition			11
12	Inpatient and outpatient heart acquisition			12
13	Inpatient and outpatient lung acquisition			13
14	Inpatient and outpatient pancreas acquisition			14
15				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			
	Title V - Inpatient (line 3 x line 4)			18
19	1 (' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '			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				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	Y 2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			31
	Inpatient allogeneic HSCT acquisition (line 3 x line 17.01) Outpatient allogeneic HSCT acquisition (line 3 x line 17.02)			31.01
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

MPUTATION OF CELLULAR THEF	RAPY ACQUISITION	COSTS			PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET D-6, PARTS I & II	
RT I - INPATIENT ROUTINE AND A	NCILLARY SERVIC	ES CEL	LULAR THERAPY ACQU	JISITION COSTS	-			
	Routine Services		Ì	Inpatient				
	Acquisition		Per Diem Costs	Acquisition	Acquisition Costs			
npatient Routine Services	Charges		(see instructions)	Days	(col. 2 x col. 3)			
Acquisition Costs	1	D-1	2	3	4	1		
1 Adults and Pediatrics	1	38	2	3	7			-
2 Intensive Care		43						-
3 Coronary Care		44						-
4 Burn Intensive Care Unit		45						-
5 Surgical Intensive Care Unit		46						+
		46						_
6 Other Special Care (specify)		4/						+
7 Total (sum of lines 1 through 6)								
				*		T	T 6	
			D 1 00 1	Inpatient	Outpatient	Inpatient	Outpatient	1
			Ratio of Cost	Ancillary Services	Ancillary Services	Ancillary Services	Ancillary Services	
			to Charges	Acquisition	Acquisition	Acquisition	Acquisition	
			from Wkst. C, Pt. I, col. 9)	Charges	Charges	Cost	Cost	_
Ancillary Services Acquisition Costs		C	1	2	3	4	5	
8 Operating Room		50						
9 Recovery Room		51						
10 Labor Room & Delivery Room		52						
11 Anesthesiology		53						
12 Radiology-Diagnostic		54						
13 Radiology-Therapeutic		55						
14 Radioisotope		56						T
15 Computed Tomography (CT) Sca	n	57						╅
16 Magnetic Resonance Imaging (M		58						+
17 Cardiac Catheterization)	59						╅
18 Laboratory		60						╅
19 PBP Clinical Laboratory Services	-Program Only	61						+
20 Whole Blood & Packed Red Bloo		62						+
21 Blood Storage, Processing, & Tra		63						+
22 IV Therapy	listusing	64						╁
23 Electrocardiology		69						+
24 Medical Supplies Charged to Pati	anta	71						+
25 Drugs Charged to Patients	CHIS	73	+		+	+		+
<u> </u>		75	1		+	+		+
		76				 		+
27 Other Ancillary (specify)28 Clinic		90				+		+
		90						+
30 Total (sum of lines 8 through 28)						1		
RT II - INTERNS AND RESIDENTS	NOT IN AN APPROV	ED TEA			-			
			Average Cost Per Day	Inpatient	Inpatient Part B			1
nterns and Residents Not in Approved			(from Wkst. D-2, Pt. I, col. 4)	Acquisition Days	Acquisition Costs (col. 1 x col. 2)			

			Average Cost Per Day		Inpatient Part B		
			(from Wkst. D-2,	Acquisition	Acquisition Costs		
Inter	ns and Residents Not in Approved Teaching		Pt. I, col. 4)	Days	(col. 1 x col. 2)		
Program 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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CALCU	ILATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTL	EMENT	COMPONENT CCN:	FROM TO	PART A	
		COMPONENT CCN.	10		
	pplicable box: [] Hospital [] PARHM Demonstration		-		
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1	1
-	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.02
	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see institution)	ructions)			1.03
	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see in				1.04
2	Outlier payments for discharges (see instructions)				2
$\overline{}$	Outlier reconciliation amount				2.01
	Outlier payment for discharges for Model 4 BPC1 (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)				2.02
	Outlier payments for discharges occurring prior to October 1 (see instructions)				2.03
	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)				4
	Indirect Medical Education Adjustment Calculation for Hospitals			1	
	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/3	1/1996 (see instructions)			5 01
	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in	accordance with 42 CER	413 70(e)		5.01
	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 20.		(+15.77(c)		6.26
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)	,			7
7.01	ACA $\S5503$ reduction amount to the IME cap as specified under 42 CFR $\$12.105(f)(1)(iv)(B)(2)$. If the cost report states a specified under $\$2000000000000000000000000000000000000$	traddles July 1, 2011, see	instructions.		7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with	n a rural track for Medicar	e GME affiliated		7.02
	programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				0
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	accordance			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddi	les July 1 2011 see instru	ections		8.01
	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of AC		ettoris:		8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				8.21
8.28	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)				8.28
9	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minu	s/minus line 8,			9
10	plus lines 8.01 through 8.28 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records				10
	FTE count for residents in dental and podiatric programs				11
	Current year allowable FTE (see instructions)				12
13	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
	Adjustment for residents in initial years of the program (see instructions) Adjustment for residents displaced by program or hospital closure				16 17
	Adjusted rolling average FTE count				18
	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
	Enter the lesser of lines 19 or 20 (see instructions)				21
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)				22.01
22.01	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA				22.01
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).				23
	IME FTE resident count over cap (see instructions)				24
	If 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
	IME payments adjustment factor (see instructions)				27 28
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)				28.01
	Total IME payment (sum of lines 22 and 28)				29
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30
$\overline{}$	Percentage of Medicaid patient days to total patient days (see instructions) Sum of lines 30 and 31				31
$\overline{}$	Allowable disproportionate share percentage (see instructions)				33
	Disproportionate share adjustment (see instructions)				34
	Uncompensated Care Payment Adjustment		Prior to October 1	On or after October 1	
35	Total uncompensated care amount (see instructions)				35
	Factor 3 (see instructions)				35.01
	Hospital UCP, including supplemental UCP (see instructions) Program of the beginning IUCP including supplemental UCP (see instructions)				35.02 35.03
	Pro rata share of the hospital UCP, including supplemental UCP (see instructions) Pro rata share of the MDH's UCP, including supplemental UCP (see instructions)				35.03
	Pro rata share of the SCH's UCP, including supplemental UCP (see instructions)				35.05
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)				36

12-24	1 OKWI CWIS-2552-10			4090 (Colli.)
CALCULATION OF REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT			FROM	PART A (Cont.)
		COMPONENT CCN:	TO	

SEIIL	EMEN!	COMPONENT CCN:	TO	PART A (Cont.)	
	applicable box: [] Hospital [] PARHM Demonstration				
PART A	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
41	Total ESRD Medicare discharges (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)				47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)				49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)				50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).				52
53	Nursing and allied health managed care payment				53
	Special add-on payments for new technologies				54
	Islet isolation add-on payment				54.01
55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)			1	55
	Cellular therapy acquisition cost (see instructions)			1	55.01
	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35)				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
	Total (sum of amounts on lines 49 through 58)				59
	Primary payer payments			-	60
61				-	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
70.76	Essential medicines payment adjustment amount (see instructions)			-	70.76
70.87	Demonstration payment adjustment amount before sequestration			-	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			+	70.88
70.89				-	_
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			+	70.89 70.90
70.90	HSP bonus payment HPP adjustment amount (see instructions)			+	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			+	70.91
	Bundled Model 1 discount amount (see instructions)			+	
70.93	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)			+	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)			+	70.97
, ,,,,,	HAC adjustment amount (see instructions)			+	70.99
71					71
71.01	Sequestration adjustment (see instructions)				71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
71.03	Sequestration adjustment-PARHM pass-throughs				71.03
72	Interim payments				72
72.01	Interim payments-PARHM				72.01
73	Tentative settlement (for contractor use only)	<u> </u>			73
	Tentative settlement-PARHM (for contractor use only)		·		73.01
73.01					
73.01 74	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)				74
	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73) Balance due provider/program-PARHM (see instructions)				74 74.01

	ULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTL	EMENT		FROM	PART A	
		COMPONENT CCN:	то		
Check	applicable box: [] Hospital [] PARHM Demonstration				
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)				101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)				103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for year	es or "N" for no.			200
	Cost Reimbursement				
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201
202	Medicare discharges (see instructions)				202
203	Case-mix adjustment factor (see instructions)				203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration pe	eriod)			
204	Medicare target amount				204
205	Case-mix adjusted target amount (line 203 times line 204)				205
206	Medicare inpatient routine cost cap (line 202 times line 205)				206
	Adjustment to Medicare Part A Inpatient Reimbursement				
207	Program reimbursement under the §410A Demonstration (see instructions)				207
208	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208
209	Adjustment to Medicare IPPS payments (see instructions)				209
210	Reserved for future use				210
211	Total adjustment to Medicare IPPS payments (see instructions)				211
	Comparison of PPS versus Cost Reimbursement				
212	Total adjustment to Medicare Part A IPPS payments (from line 211)				212
213	Low-volume adjustment (see instructions)				213
218	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213	3) (see instructions)			218

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	JLATION OF		OVIDER CCN:	PERIOD:	WORKSHEET E, PART B	02-24
KEIMBU	URSEMENT SETTLEMENT	CON	MPONENT CCN:	FROM TO	PARI B	
Check	[] Hospital [] Subprovider (Other)					
applicable box:	ole [] IPF [] SNF [] PARHM Demonstration					
	3 - MEDICAL AND OTHER HEALTH SERVICES					
	Medical and other services (see instructions)					1
3	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments					3
4	Outlier payment (see instructions)					4
4.01	1 2 \					4.01
5	Enter the hospital specific payment to cost ratio (see instructions)					5
- 6	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6					7
8						8
9	Ancillary service other pass through costs including REH direct graduate medical education of	costs from Wkst.	D, Pt. IV, col. 13,	line 200		9
						10
	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	e basis				15
16	1 1 7	arge				16
- 17	basis had such payment been made in accordance with 42 CFR §413.13(e)					17
17	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)					17 18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11)	(see instructions)				19
	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18)	(see instructions)				20
21	Lesser of cost or charges (see instructions) Interns and residents (see instructions)					21
	Cost of physicians' services in a teaching hospital (see instructions)					22
	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9)					24
- 25	COMPUTATION OF REIMBURSEMENT SETTLEMENT					2.5
25	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]	(see instructions)			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)					28
	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)					28.50
	Subtotal (sum of lines 27, 28, 28.50, and 29)					30
						31
32	Subtotal (line 30 minus line 31)					32
33	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)				33
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)					34
35	Adjusted reimbursable bad debts (see instructions)					35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)					36
37	Subtotal (see instructions) 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)					40.01
40.02	Demonstration payment adjustment amount after sequestration 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)					42 01
42.01	Tentative settlement-PARHM (for contractors use only) Balance due provider/program (see instructions)					42.01
43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)					43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapt	oter 1, §115.2	-	-		44

93 94

93 Time Value of Money (see instructions)
94 Total (sum of lines 91 and 93)

Rev. 21 40-587

	SIS OF PAYMENTS TO PRO RVICES RENDERED	OVIDERS					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET E-1, PART I	,
Check applicab box:	[] Hospital le [] IPF [] IRF	[] Subprovider (Other) [] SNF [] Swing-Bed SNF	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF						-	
-						In	patient			
							Part A		Part B	
					ļ	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	escription					1	2	3	4	
	Total interim payments paid									1
2		individual bills, either submitted or to be								2
		ost reporting period. If none, write "NON	VE" or enter a zero	In . n . i	- 01					2.01
3	List separately each retroactive			Program to Provider	.01					3.01
	lump sum adjustment amoun				.02					3.02
	on subsequent revision of the				.03					3.03
	interim rate for the cost repor				.04				+	3.04
	Also show date of each paym			n 1 . n	.05					3.05
	If none, write "NONE" or en	ter a zero. (1)		Provider to Program	.50				+	3.50
					.51					3.51
									+	3.52
					.53				+	3.53
	C-1-4-4-1 (£1: 2 01 - 3	2.40			.99					3.54 3.99
4	,	3.49 minus sum of lines 3.50-3.98)			.99					3.99
4	(transfer to Wkst. E or Wkst.									4
	and column as appropriate)	E-3, line								
	and column as appropriate)									
- 5	List separately each tentative	settlement		Program to Provider	.01				$\overline{}$	5.01
5	payment after desk review. A			r rogram to r rovider	.02				+	5.02
	date of each payment.	iiso silow			.03				+	5.03
	If none, write "NONE" or en	ter a zero (1)		Provider to Program	.50				+	5.50
	ir none, with trotte or en	101 11 2010. (1)		Trovider to Trogram	.51				+	5.51
					.52				+	5.52
-	Subtotal (sum of lines 5.01-5	.49 minus sum of lines 5.50 -5.98)			.99					5.99
- 6	Determined net settlement an			Program to Provider	.01					6.01
_	due) based on the cost report			Provider to Program	.02				1	6.02
7	Total Medicare program liab			. 8	•					7
- 8	Name of Contractor					Contractor Number		NPR Date (Month/D	ay/Year)	8
									,	

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

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

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS PROVIDER CCN: FROM COMPONENT CCN: [] Swing-Bed SNF applicable [] Title V [] Swing-Bed NF	4090 (Cont.)			F	ORM CMS-2552-10				07-23
COMPONENT CON To Part	CALCU	LATION OF RE		ENT			PROVIDER CCN:			
Check Tale VI Swing-Bed SNF applicable Tale XXI PARTM CAH Swing-Bed SNF	SETTLE	EMENT - SWIN	G BEDS				COMPONENT CON-			
applicables [] The KVII							COMPONENT CCN:	10		
applicables [] The KVII	Check	[] Titl	e V	ſ	1 Swing-Bed SNF					
COMPUTATION OF NET COST OF COVERED SERVICES 1 Inpatient routine services - swing bed-NF (see instructions) 1 Inpatient routine services - swing bed-NF (see instructions) 2 Inpatient routine services - swing bed-NF (see instructions) 3 Ancillary services (from Wast D. 2, od. 3, line 2005, for Patr A; and sum of Wast. D, Pt. V, col. 6, and 7, line 202, for Patr B), (for CAII and swing-bed pass-through, see instructions) 3 Nursing and alled health popurerh-PARIEI (see instructions) 4 Per diem cost for interns and residents not in approved teaching program (see instructions) 5 Program and alled health popurerh-PARIEI (see instructions) 6 Interns and residents not in approved teaching program (see instructions) 7 Program days 6 Interns and residents not in approved teaching program (see instructions) 8 Substati (sum of lines 1 through 3 plass lines 6 and 7) 9 Primary perspagaments (see instructions) 10 Substati (line 8 minus line 9) 11 Deductible billed to program patients (exclude amounts applicable to physician professional services) 11 Deductible billed to program patients (exclude amounts applicable to physician professional services) 11 Substati (line 10 minus line 1) 12 Substati (line 10 minus line 1) 13 Consumante billed to program patients (from provider records) (exclude coinstrurance for physician professional services) 14 Strive of Part It costs (line 12 x 80%) 15 Substati (line 10 minus line 1) 16 Other adjustments (speciely) (line instructions) 16 Other adjustments (speciely) (line instructions) 17 Allowable had debts (exc instructions) 18 Substation (line instructions) 19 Application of the contractions payment adjustment (see instructions) 19 Application of the contraction payment adjustment (see instructions) 10 Other adjustments (speciely) (line instructions) 11 Allowable had debts for dual edigible beneficiaries (see instructions) 11 Allowable had debts for dual edigible beneficiaries (see instructions) 11 Application and payments and payments and payments and payments				_						
COMPUTATION OF NET COST OF COVERED SERVICES 1 Inpatient routine services - swing bed-SNF (see instructions) 2 Inpatient routine services - swing bed-SNF (see instructions) 3 Ancillary services (from Wisk 2D, 3cd. 3, Ine 20), for Part A; and sum of Wisk 1D, Pt. V, cols. 6 and 7, line 202, for Part B), GFO CAH and swing-bed pass-through, see instructions) 3 Noving and allich leading purposer PARHIM (see instructions) 4 Per diem cost for interns and residents not in approved teaching program (see instructions) 5 Program crises - post-sine continues of the co	boxes:	[] Titl	e XIX	[] PARHM CAH Swing-Bed SNF					
COMPUTATION OF NET COST OF COVERED SERVICES 1 Inpatient routine services - swing bed-SNF (see instructions) 2 Inpatient routine services - swing bed-SNF (see instructions) 3 Ancillary services (from Wisk 2D, 3cd. 3, Ine 20), for Part A; and sum of Wisk 1D, Pt. V, cols. 6 and 7, line 202, for Part B), GFO CAH and swing-bed pass-through, see instructions) 3 Noving and allich leading purposer PARHIM (see instructions) 4 Per diem cost for interns and residents not in approved teaching program (see instructions) 5 Program crises - post-sine continues of the co										
Inpatient routine services - swing bed-SNF (see instructions) 2 Inpatient routine services - swing bed-SNF (see instructions) 2 2 Inpatient routine services - swing bed-SNF (see instructions) 2 3 Ancillary services (from Wst. D-3, col. 3, line 200, for Part A; and sum of Wist. D. Pt. V, col. 6 and 7, line 200, for Part B) (for CAR June 200, for Part A; and sum of Wist. D. Pt. V, col. 6 and 7, line 200, for Part B) (for CAR June 200, for Part A; and sum of Wist. D. Pt. V, col. 6 and 7, line 200, for Part B) (for CAR June 200, for Part A; and sum of Wist. D. Pt. V, col. 7 Villization review - physician compensation - SNF optional method only 5 Program days 5 Prog		COMBLITATIO	N OF NET C	ОСТ	OF COVERED SERVICES			PART A	PART B	-
2 Inpatient routine services - swing bed-NF (see instructions) 2 3 Ancillary services (from Web, D. 3, ed. 3), inc (20), for Part A, and sum of Wisst, D. Pt. V, ed. 6, and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) 3.01	1							1	2	1
Accillancy services (from Wiss D-3, col. 3, line 200, for Part A; and sum of Wisst. D. Pt. V. col. 6 and A. Line 200, for Part B) (for CAH and swip-led prassythough, see instructions) 3.01 Nursing and allied health payment-PARHM (see instructions) 4. Per diem con for interns and residents not in approved teaching program (see instructions) 5. Pergam days: 6. Interns and residents not in approved teaching program (see instructions) 7. Utilization review - physician compensation - SNP optional method only 8. Subtoal (sum of lines I through 3 plas lines o and 7) 8. Subtoal (sum of lines I through 3 plas lines o and 7) 8. Subtoal (sum of lines I through 3 plas lines o and 7) 10. Subtoal (line 8 minus line 9) 11. Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12. Subtoal (line 8 minus line 1) 13. Consurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 13. Subtoal (line 10 minus line 11) 14. Silvis of Part B costs (line 12 x 80%) 15. Subtoal (see instructions) 16. Other adjustments (specify) (see instructions) 17. Allowable cise instructions) 18. Subtoal (see instructions) 18. Subtoal (see instructions) 19. Allowable bad debts (see instructions) 19. Allowable bad debts (see instructions) 19. Allowable bad debts for dual eligible beneficiaries (see instructions) 19. Interim payments 20. Sequestration adjustment (see instructions) 19. Interim payments 21. Tentative settlement (for contractor use only) 22. Balance due provide/programs/ administration minus lines 19.01, 19.02, 19.25, 20, and 21) 23. Subtoal (see instructions) 24. Interim payments 25. Subtoal (see instructions) 26. Interim payments 27. Interim payments 28. Subtoal (see instructions) 28. Tentative settlement (for contractor use only) 29. Tentative settlement (for contractor use only) 20. Interim payments 21. Tentative settlement (for contractor use only) 22. Interim payments 23. Minus for the current		•		_	`					2
3.01 Nursing and allied health payment-PARIEM (see instructions) 3.01	3			_		f Wkst. D, Pt. V,				3
4 Per diem cost for interns and residents not in approved teaching program (see instructions) 5 Peogram days 6 Interns and residents not in approved teaching program (see instructions) 7 Utilization review, Physician compression - SNP optional method only 7 Utilization review, Physician compression - SNP optional method only 8 Subtotal (sum or lines 1 through 3 plus lines 6 and 7) 9 Primary payer payments (see instructions) 10 Subtotal (time 8 mins line 9) 11 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 11 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 11 Deductibles billed to program patients (from provider records) (exclude coinsurance for physician professional services) 11 Subtotal (fine 10 minus line 11) 12 Subtotal (fine 10 minus line 11) 13 Subtotal (see instructions) 14 Store 12 R to sets (fine 12 x 80%) 14 Store 14 R to sets (fine 12 x 80%) 15 Subtotal (see instructions) 16 Other adjustments (specify) (see instructions) 16 Other adjustments (specify) (see instructions) 16 Other adjustments (specify) (see instructions) 16 Other adjustments (specify) (see instructions) 16 Demonstration payment adjustment (see instructions) 17 Allowable bad debtes (see instructions) 18 Allowable bad debtes (see instructions) 19 Demonstration payment adjustment (see instructions) 19 Demonstration payment adjustment (see instructions) 19 Total (see instructions) 19 Demonstration payment adjustment (see instructions) 19 Demonstration payment adjustment amount before sequestration 19 Demonstration payment adjustment amount before sequestration 19 Demonstration payment adjustment (see instructions) 19 Total (see instructions) 19 Total (see instructions) 19 Total (see instructions) 19 Total (see instructions) 19 Demonstration payment seed amounts (see instructions) 19 Demonstration payment seed amounts (see instructions) 19 Demonstration payment seed amounts (see instructions) 19 Demonstration payment adjustment amo		cols. 6 and 7, li	ne 202, for Pa	rt B)	(For CAH and swing-bed pass-through,	, see instructions)				
S. Program days					`					3.01
Interns and residents not in approved teaching program (see instructions)			or interns and	reside	ents not in approved teaching program (see instructions)				4
Title Utilization review - physician compensation - SNF optional method only S Subtotal (sum of lines 1 through 3 plus lines 6 and 7) S Subtotal (sum of lines) Through 3 plus lines 6 and 7) 9		_	1		16 11 (1 6 7)					5
8 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9 Primary payer payments (see instructions) 19 Subtotal (line 8 minsi line 9) 10 Subtotal (line 8 minsi line 9) 11 Deductible (line 1 minsi line 9) 11 Deductible (line 1 minsi line 9) 11 Deductible (line 1 minsi line 9) 11 Deductible (line 1 minsi line 9) 11 Deductible (line 1 minsi line 9) 11 Demonstration payment adjustment (see instructions) 11 Demonstration payment adjustment (see instructi				_						7
9 Primary payer payments (see instructions) 10 10 10 10 10 10 10 1										8
10										
12 Subtotal (line 10 minus line 1) 12 13 13 15 15 15 15 15 15	10				,					10
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14 80% of Part B costs (line 12 x 80%)										
15 Subtotal (see instructions) 15				_		oinsurance for physician professi	onal services)			
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16.55 Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions) 16.55 16.99 Demonstration payment adjustment amount before sequestration 16.99 17 Allowable bad debts (see instructions) 17.01 18 Allowable bad debts (see instructions) 17.01 18 Allowable bad debts (see instructions) 18 19 Total (see instructions) 19 19.01 Sequestration adjustment (see instructions) 19 19.02 Demonstration payment adjustment amount after sequestration 19.02 19.03 Sequestration adjustment (see instructions) 19.02 19.03 Sequestration payment adjustment amount after sequestration 19.02 19.03 Sequestration in payment adjustment amount after sequestration 19.02 19.03 Sequestration for non-claims based amounts (see instructions) 19.03 19.25 Sequestration for non-claims based amounts (see instructions) 19.25 20 Interim payments 20 20 Interim payments 20 21 Tentative settlement (for contractor use only) 21 22 Balance due provider/program (fine 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 23 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200 201 Interim bursament 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 201 202 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 202 203 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 202 204 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 202 205 Medicare swing-bed SNF inpatient routine instructions) 203 206 Computation of Demonstration Target Amount Limitation (N/A in first year of the current		_		_	· · · · · · · · · · · · · · · · · · ·					
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17.01 Adjusted reimbursable bad debts (see instructions) 17.01	16.99	Demonstration	payment adju	stmen	t amount before sequestration		•			16.99
Allowable bad debts for dual eligible beneficiaries (see instructions) 19 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Demonstration payment adjustment amount after sequestration 19.03 Sequestration adjustment-PARHM pass-throughs 19.03 Sequestration adjustment-PARHM pass-throughs 19.03 Interim payments 20 Interim payments 20 Interim payments 21 Tentative settlement (for contractor use only) 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22 Balance due provider/program-PARHM (see instructions) 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 24 Sequestration for non-claims based amounts (see instructions) 25 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 26 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 27 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 28 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 29 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 20 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 20 Cost Reimbursement 20 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 20 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 20 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 20 Medicare swing-bed	17	Allowable bad	debts (see ins	tructi	ons)					17
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202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 202 203 Total (sum of lines 201 and 202) 203 204 Medicare swing-bed SNF discharges (see instructions) 204 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 205 Medicare swing-bed SNF target amount 205	201					D. H. F CC (6:4. 20200)	. 1))	T		201
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Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 205 Medicare swing-bed SNF target amount 206					es (see instructions)					
205 Medicare swing-bed SNF target amount 205	201					r of the current 5-year demonstra	ation period)	1		201
206 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)	205									205
	206	Medicare swing	g-bed SNF inp	atien	routine cost cap (line 205 times line 20)4)				206

207 Program reimbursement under the §410A Demonstration (see instructions)

209 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)

210 Reserved for future use

208 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)

Comparison of PS versus Cost Reimbursement

215 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)

208

209

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

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

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

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	JLATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART II	
		COMPONENT CC	1: TO		
Check	[] Hospital		1		
applicab					
box:					
DADTI	I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IP	DDC DDC			
raki i	1 - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IF	7 773			
1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments	s)			1
2	Net IPF PPS Outlier payment				2
	Net IPF PPS ECT payment				3
4	- L				4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were contact would not be counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a temporary contact without a day of the counted without a day of the co	1 71 0 1	*		4.01
5	that would not be counted without a temporary cap adjustment under 42 CFR §412.424(New teaching program adjustment (see instructions)	(d)(1)(III)(F)(1) of (2) (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth	neriod			6
Ü	of a "new teaching program" (see instructions)	i period			0
7	Current year unweighted I&R FTE count for residents within the new program growth p	period			7
	of a "new teaching program" (see instructions)				
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)				8
9	Average daily census (see instructions)				9
10					10
11					11
12	, , , , ,				12
13					13
14	6 1				14
15					15
16					16
17 18	- /1 / 1 /				17 18
19	Subtotal (line 16 less line 17). Deductibles				19
20	Subtotal (line 18 minus line 19)				20
21	Coinsurance				21
22	Subtotal (line 20 minus line 21)				22
23					23
24	• /				24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)				25
26	Subtotal (sum of lines 22 and 24)				26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)				27
28	Other pass through costs (see instructions)				28
29	Outlier payments reconciliation				29
30					30
30.50					30.50
30.99	Demonstration payment adjustment amount before sequestration				30.99
31	Total amount payable to the provider (see instructions)				31
31.01	Sequestration adjustment (see instructions)				31.01 31.02
31.02	Demonstration payment adjustment amount after sequestration Interim payments				31.02
33	Tentative settlement (for contractor use only)				33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32, and 33)				34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	, chapter 1, §115.2			35
	, , , , , , , , , , , , , , , , , , , ,				
	TO BE COMPLETED BY CONTRACTOR Opinional partition amount from Worldshoot E. 2. Part H. ling 2. (see instructions)			<u> </u>	50

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,
		COMPONENT CCN:	FROM TO	PART III
		COMPONENT CEN.	10	
Check	[] Hospital	•		
applicab	le [] Subprovider IRF			
box:				
PARTI	II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF	PPS		
1711(11	. CAECOLATION OF MEDICARE REMIDERS EMENT OF DER IN			
1	Net Federal PPS payment (see instructions)			1
2	7			2
3	Inpatient Rehabilitation LIP payments (see instructions)			3
5	Outlier payments Unweighted intern and resident FTE count in the most recent cost reporting period ending	~		5
3	on or prior to November 15, 2004 (see instructions)	g		3
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were dis	splaced by program or hospital		5.01
	closure, that would not be counted without a temporary cap adjustment under 42 CFR §41			
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	period		7
	of a "new teaching program" (see instructions)			
8	Current year unweighted I&R FTE count for residents within the new program growth per of a "new teaching program" (see instructions)	riod		8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	*			10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)			13
14				14
15				15
17	Cost of physicians' services in a teaching hospital (see instructions) Subtotal (see instructions)			16 17
18	\			18
19	71 7 1 7			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 26	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)			25
27	Subtotal (sum of lines 23 and 25)			27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
31.99	Demonstration payment adjustment amount before sequestration			31.99
32 32.01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			32 32.01
32.01	Demonstration payment adjustment amount after sequestration			32.01
33	Interim payments			33
34				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, cl	hapter 1, §115.2		36
	TO BE COMPLETED BY CONTRACTOR			
	TO BE COMPLETED BY CONTRACTOR			1

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

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

TO BE COMPLETED BY CONTRACTOR

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

Check [] PARTM Demonstration	CALCU	LATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET E-3, PART V	
1 Inputient services 2 Nursing and allied health managed care payment (see instructions) 3 Organ sequisition 3 Organ sequisition 4 Substatal (aum of lines 1 through 3.01) 5 Primary payer payments 6 Total coot (see instructions) 7 Primary payer payments 7 Primary payer payments 8 Organ Part A Total coot (see instructions) 8 Primary payer payments 9 Primary payer payment	applicab		•			
2 Nursing and allied health managed care payment (see instructions) 3.01 Cellular therapy acquisition oct (see instructions) 4 Subtotal (sum of lines 1 through 3.01) 5 Primary payer payments 6 Total cost (see instructions) 6 Total cost (see instructions) 7 OMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 7 Routine service charges 8 Ancillary service charges 9 Organ acquisition charges, net of revenue 10 Total caseonable charges 11 Aggregate amount actually collected from patients liable for payment for services on a charge basis 12 Amounts that would have been realized 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 on a charge basis 14 Amounts that would have been realized from patients liable for payment for services on a charge basis 15 Amounts that would have been realized from patients liable for payment for services on a charge basis and such payment been mande in accordance with 42 CFR \$413.3(c) 13 Ratio of line 11 to line 12 (not to exceed 1.000000) 14 Total customany charges (see instructions) 15 Excess of customany charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16 Excess of reasonable cost over customany charges (complete only if line 6 exceeds line 14) (see instructions) 17 Cost of physicians' services in a teaching hospital (see instructions) 18 Direct graduate medical education payments 19 Cost of covered services (sum of lines 6 and 17) 20 Deductibles (exclude professional component) 21 Excess reasonable cost (from line 16) 22 Subtotal (line 19 minus lines 20 and 21) 23 Coinsurance 24 Subtotal (line 19 minus lines 23) 25 Allowable bad debts (see instructions) 26 Other adjustments (specify) (see instructions) 27 Allowable bad debts (see instructions) 28 Subtotal (see instructions) 29 Demonstration adjustment amount before sequestration 30 Subtotal (see instructions) 30 Demonstration adjustment amount after sequestration 31 Interim payments PARHM	PART V	- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICE	CES - COST REIMBURSE	MENT		
2 Nursing and allied health managed care payment (see instructions) 3.01 Cellular therapy acquisition oct (see instructions) 4 Subtotal (sum of lines 1 through 3.01) 5 Primary payer payments 6 Total cost (see instructions) 6 Total cost (see instructions) 7 OMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 7 Routine service charges 8 Ancillary service charges 9 Organ acquisition charges, net of revenue 10 Total caseonable charges 11 Aggregate amount actually collected from patients liable for payment for services on a charge basis 12 Amounts that would have been realized 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 on a charge basis 14 Amounts that would have been realized from patients liable for payment for services on a charge basis 15 Amounts that would have been realized from patients liable for payment for services on a charge basis and such payment been mande in accordance with 42 CFR \$413.3(c) 13 Ratio of line 11 to line 12 (not to exceed 1.000000) 14 Total customany charges (see instructions) 15 Excess of customany charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16 Excess of reasonable cost over customany charges (complete only if line 6 exceeds line 14) (see instructions) 17 Cost of physicians' services in a teaching hospital (see instructions) 18 Direct graduate medical education payments 19 Cost of covered services (sum of lines 6 and 17) 20 Deductibles (exclude professional component) 21 Excess reasonable cost (from line 16) 22 Subtotal (line 19 minus lines 20 and 21) 23 Coinsurance 24 Subtotal (line 19 minus lines 23) 25 Allowable bad debts (see instructions) 26 Other adjustments (specify) (see instructions) 27 Allowable bad debts (see instructions) 28 Subtotal (see instructions) 29 Demonstration adjustment amount before sequestration 30 Subtotal (see instructions) 30 Demonstration adjustment amount after sequestration 31 Interim payments PARHM	1	Inpatient services				1
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COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 7 Routine service charges 9 Organ acquisition charges, net of revenue 10 Total reasonable charges Customary charges 11 Aggregate amount actually collected from patients liable for payment for services on a charge basis 12 Amounts that would have been realized from patients liable for payment for services on a charge basis and of incentification of i	4	Subtotal (sum of lines 1 through 3.01)				4
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21 Excess reasonable cost (from line 16) 22 Subtotal (line 19 minus lines 20 and 21) 23 Coinsurance 24 Subtotal (line 22 minus line 23) 25 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26 Adjusted reimbursable bad debts (see instructions) 27 Allowable bad debts for dual eligible beneficiaries (see instructions) 28 Subtotal (sum of lines 24 and 25 or 26) 29 Other adjustments (specify) (see instructions) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 31 Interim payments 31.01 Interim payments-PARHM	19	Cost of covered services (sum of lines 6 and 17)				19
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27 Allowable bad debts for dual eligible beneficiaries (see instructions) 28 Subtotal (sum of lines 24 and 25 or 26) 29 Other adjustments (specify) (see instructions) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 31.01 Interim payments 31.01 Interim payments-PARHM						25
28 Subtotal (sum of lines 24 and 25 or 26) 29 Other adjustments (specify) (see instructions) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment -PARHM 31 Interim payments 31.01 Interim payments-PARHM						26
29 Other adjustments (specify) (see instructions) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment Agiustment amount after sequestration 31.01 Interim payments 31.01 Interim payments-PARHM						27 28
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30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31 Interim payments 31.01 Interim payments-PARHM					- 7	30.01
30.03 Sequestration adjustment-PARHM 31 Interim payments 31.01 Interim payments-PARHM						30.02
31 Interim payments 31.01 Interim payments-PARHM						30.03
31.01 Interim payments-PARHM						31
					3	31.01
	32					32
32.01 Tentative settlement-PARHM (for contractor use only)	32.01				3	32.01
33 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	33					33
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)	33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01	.)		3	33.01
34 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §	115.2			34

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

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

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

12-24			I OKWI CI	VIS-2332-10			4090 (Cont.)
CALCULATIO	N OF REIMBURSEME	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

	COMPUTATION OF NET COST OF COVERED SERVICES	Inpatient Title V or Title XIX	Outpatient Title V or Title XIX	
1	Inpatient hospital/SNF/NF services	Title XIX	THE AIA	1
- 1	Medical and other services			2
2	Organ acquisition (certified transplant programs only)			3
3	Subtotal (sum of lines 1, 2 and 3)			4
				5
	Inpatient primary payer payments Outpatient primary payer payments			6
	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			/
	Reasonable Charges			
	į	1		8
- 8	Routine service charges			9
10	Ancillary service charges			
10	6 1 67			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8 through 11)			12
	CUSTOMARY CHARGES			
13				13
14	Amounts that would have been realized from patients liable for payment for services			14
	on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15				15
16	, ,			16
17	Excess of customary charges over reasonable cost (complete only if line 16			17
	exceeds line 4) (see instructions)			
18	======================================			18
19	Interns and residents (see instructions)			19
20				20
21	Cost of covered services (enter the lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22				22
23	1.2			23
	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (title V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	·		
30	Excess of reasonable cost (from line 18)	·		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37				37
38	Subtotal (line $36 \pm line 37$)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40				40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)		1	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

4090 ((Cont.) FORM	I CMS-2552-10				12-24
DIRECT	Γ GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
	O OUTPATIENT DIRECT MEDICAL			FROM		
	ATION COSTS			ТО		
Check	[] Title V [] Hospital		[] CAH-Based IPF	10		
applicab		Demonstration	[] CAH-Based IRF			
box:	[] Title XIX					
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for	cost reporting periods en	ding on or before December	31, 1996		1
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)					1.01
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79	(e) (see instructions)				2
2.26	Rural track program FTE cap limitation adjustment after the cap-building w	indow closed under §127	of the CAA 2021 (see instru	ictions)		2.26
3	Amount of reduction to Direct GME cap under §422 of MMA	U	,	/		3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42	2 CFR 8413 79 (m) (see	instructions		 	3.01
5.01	for cost reporting periods straddling 7/1/2011)	2 C1 K 9+13.77 (III). (See	msu detions			3.01
2.02		() C 1 (1	:a 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	CME		2.02
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation			re GME		3.02
	affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (Augu					+
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic pr	ograms due to a Medicard	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 re	eporting periods straddlin	g 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructio	ns for cost reporting perio	ods straddling 7/1/2011)			4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §12	26 of the CAA 2021 (see	instructions)			4.21
4.28	The amount of increase if the hospital was awarded FTE cap slots under §4					4.28
5	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2			lue or minue		5
3	line 4, plus lines 4.01 through 4.28	,	, _F 145 of 1111145 line 5.02, p	21 11111111	I	1
	71	. d			 	
6	Unweighted resident FTE count for allopathic and osteopathic programs for	me current year from you	ii records (see instructions)		1	6
7	Enter the lesser of line 5 or line 6		T 2: 0	0.1	m . 1	7
			Primary Care	Other	Total	4
			1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program	n for				8
	the current year					
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line	8 times				9
	the result of line 5 divided by the amount on line 6. For cost reporting perio	ds beginning				
	on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see					
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
						10.01
11	Total weighted FTE count					
12	Total weighted resident FTE count for the prior cost reporting year (see inst					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 closu	ire				16.01
17	Adjusted rolling average FTE count					17
18	Per resident amount					18
18.01	Per resident amount Per resident amount under §131 of the CAA 2021			 		18.01
	v v					
19	Approved amount for resident costs	1	42.6412.70(.)(4)	I .	1	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident	cap slots received under	42 §413.79(c)(4)		_	20
21	Direct GME FTE unweighted resident count over cap (see instructions)					21
22	Allowable additional direct GME FTE resident count (see instructions)				1	22
23	Enter the locality adjustment national average per resident amount (see instr	ructions)				23
24	Multiply line 22 time line 23					24
25	Total direct GME amount (sum of lines 19 and 24)					25
	,	Inpatient Part A	Managed Care	Managed Care	Total	Т
		r	Prior to 1/1	On or after 1/1		1
	COMPUTATION OF PROGRAM PATIENT LOAD	1	2	2.01	3	1
26	Inpatient days (see instructions)	1		2.01	J	26
			+	 		
27	Total inpatient days (see instructions)			1		27
28	Ratio of inpatient days to total inpatient days			 		28
29	Program direct GME amount			ļ		29
29.01	Percent reduction for MA DGME			<u> </u>		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 RA	ATE - TITLE XVIII ONL	Y (NURSING PROGRAM A	AND		
	PARAMEDICAL EDUCATION COSTS)		•			
32	·	ol 20 and 23 lines 74 and	194)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of		,		†	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	111100 / T and 74 J				34
					+	_
	Medicare outpatient ESRD charges (see instructions)	\			 	35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35))			Ī	36

49 50

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

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T 0/0	(Cont.)	J2-10			07-23
OUTLI	ER RECONCILIATION AT TENTATIVE SETTLEMENT	PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-5	
			ТО		
	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

PAYN	REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD				RM APPROVED B NO. 0938-1473	
(42 U	(SC 1395g).			EXF	PIRES 11-30-2027	
PAYME	ENT ADJUSTMENT FOR ESTABLISHING AND MAINTAINING ACCESS TO	PROVIDER CCN:	PERIOD:	WC	PRKSHEET E-90	
A BUF	FER STOCK OF ESSENTIAL MEDICINES		FROM:			
			<i>TO</i> :			
PART	I - ADDITIONAL RESOURCE COST OF ESSENTIAL MEDICINES					
1	COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - I	DIRECTLY INCURRED				1
2	COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - (CONTRACT				2
3	TOTAL COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDIC	INES				3
PART	II - CALCULATION OF MEDICARE PAYMENT ADJUSTMENT FOR ESSENTIAL ME	DICINES				
1	MEDICARE ROUTINE/ANCILLARY COST					1
2	MEDICARE ACQUISITION COST					2
3	COST OF PHYSICIANS' SERVICES IN A TEACHING HOSPITAL					3
4	TOTAL MEDICARE REASONABLE COST					4
5	TOTAL FACILITY COST					5
6	MEDICARE PERCENTAGE					6
7	ESSENTIAL MEDICINES PAYMENT ADJUSTMENT					7

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-XXXX. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED TO BE 1.00 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING DATA RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S), OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850. PLEASE DO NOT SEND APPLICATIONS, CLAIMS, PAYMENTS, MEDICAL RECORDS, OR ANY DOCUMENTS CONTAINING SENSITIVE INFORMATION TO THE PRA REPORTS CLEARANCE OFFICE. PLEASE NOTE THAT ANY CORRESPONDENCE NOT PERTAINING TO THE INFORMATION COLLECTION BURDEN APPROVED UNDER THE ASSOCIATED OMB CONTROL NUMBER LISTED ON THIS FORM WILL NOT BE REVIEWED, FORWARDED, OR RETAINED. IF YOU HAVE QUESTIONS OR CONCERNS REGARDING WHERE TO SUBMIT YOUR DOCUMENTS, PLEASE CONTACT 1-800-MEDICARE.

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40-599.3 Rev. 23

	S REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)) MENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PEI					FORM APPROVED OMB NO. 0938-1425 EXPIRES 02-28-2025	
					Innaran		
	ENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED			PROVIDER CCN:	PERIOD:	WORKSHEET E-95	
SURGI	CAL N95 RESPIRATORS				FROM TO		
					10	<u>. </u>	
PART	I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAY	MENT ADJUSTMENT	ELIGIBILITY AND	DATA			
	Bombotte (Moon Milke VEB Bokelerin 1997 Messi Marioka 1111		EBIOIDIBITITION		DOMESTIC	NON-DOMESTIC	
					RESPIRATORS	RESPIRATORS	
					1	2	1
1	Did the hospital or hospital healthcare complex purchase domestic (column 1) "N" for no in each column. If "Y" for either column, complete line 2.	or non-domestic (colun	nn 2) respirators? Ente	er "Y" for yes or			1
				RESPIRATORS		C RESPIRATORS	
			TOTAL	NUMBER	TOTAL	NUMBER	
			COST	PURCHASED	COST	PURCHASED	4
	Enter the total cost of domestic respirators purchased in column 1 and the num	1 6. 1	1	2	3	4	2
2	respirators purchased in column 2.	iber of domestic					2
	Enter the total cost of non-domestic respirators purchased in column 3 and the	number of					
	non-domestic respirators purchased in column 4.	number of					
	non domestic respirators parenased in cotalini 1.				L		
PART	II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-A	APPROVED SURGICA	L N95 RESPIRATOR	RS			
				DOMESTIC	NON-DOMESTIC	COST	
				RESPIRATORS	RESPIRATORS	DIFFERENTIAL	
				1	2	3	
	Total cost of NIOSH-approved surgical N95 respirators purchased						1
	Number of NIOSH-approved surgical N95 respirators purchased						2
	Average cost per respirator						3
	Hospital-specific unit cost differential for domestic respirators						4
5	Total cost differential for domestic respirators						5
D. D. D. D.	W. G. G. G. W. L. THON OF D. VII. CO. W. C. VII. L. D. W. C. W. T. VII. D. D. D. C. C. T. C. VII.	arr i bbb or indication	CYCLY MAS DECRYD	mon a			
PART	III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIC	SH-APPROVED SUR	GICAL N95 RESPIRA	IPF	IRF		1
		HOSPITAL	HOSPITAL	SUBPROVIDER	SUBPROVIDER		
		PART A	PART B	PART B	PART B	TOTAL	
		1 AK1 A	2	3	4	5	1
	Medicare routine/ancillary costs	1		3	7	J	1
1.01	Medicare acquisition costs						1.01
1.02	Cost of physicians' services in a teaching hospital						1.02
1.15	Total Medicare reasonable costs						1.15
2	Total facility costs						2
3	ž						3
4	Domestic NIOSH-approved surgical N95 respirators payment adjustment						4

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FORM CMS-2552-10 (12-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4039)

4090 (Cont.)	FORM CMS-255	2-10			12-24
BALANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type			FROM		
accounting records, complete the General Fund column only)			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		_			
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-25:	52-10		4090) (Cont.)
BALAN	ICE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you a	are nonproprietary and do not maintain fund-type			FROM	(CONT.)	
account	ing records, complete the General Fund column only)			ТО		
			Specific			
	Liabilities and Fund	General	Purpose	Endowment	Plant	
	Balances	Fund	Fund	Fund	Fund	
	(Omit cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable					37
38	Salaries, wages, and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					4(
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of					4:
	lines 37 thru 44)					
	ONG TERM LIABILITIES					
	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of					50
	lines 46 thru 49)					
51	Total liabilities (sum of lines 45 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund					54
	balance - restricted					
55	Donor created - endowment fund					55
	balance - unrestricted					
56	Governing body created - endowment					56
	fund balance					
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant					58
	improvement, replacement, and expansion					
59	Total fund balances (sum of lines 52 thru 58)					59
60	Total liabilities and fund balances (sum of					60
	lines 51 and 59)					

1090 (Cont.)		10	THIS 2332	10					10 1
STATEMENT OF CHANGES IN FUND BALANCES						PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET G-1	
	GENERA	L FUND	SPECIFIC PUI	RPOSE FUND	ENDOWN	MENT FUND	PLAN	IT FUND	
	1	2	3	4	5	6	7	8	1
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)									
19 Fund balance at end of period per balance									
sheet (line 11 minus line 18)									

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

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	Т
	REVENUE CENTER	1	2	3	-
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital				\neg
2	Subprovider IPF				+
3	Subprovider IRF				+
4					+
5					+
6					+
7	Skilled nursing facility				+
8	· ·				+
	Other long term care				+
					+
10	Total general inpatient care services (sum of lines 1 through 9)				ㅗ
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11					_
12	· ·				4
13					4
14					_
15					
16	71 1 1				
	of lines 11-15)				
17	Total inpatient routine care services (sum of lines 10 and 16)				
18	Ancillary services				
19					
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)				T
28	Total patient revenues (sum of lines 17 through 27) (transfer column 3 to				
	Worksheet G-3, line 1)				
	-, ,	•			
T II	I - OPERATING EXPENSES				
			1	2	7
29	Operating expenses (per Wkst. A, column 3, line 200)				
30					
31					
32					
33					_
34					-
35					-
36	Total additions (sum of lines 30 through 35)				_
37	Deduct (specify)				+
38	Deduce (specify)				-
39			 		-
40			 		-
_			-		-
41					
42	Total deductions (sum of lines 37 through 41)				

1090 (Cont.) FORM	I CMS-2552-10			01-2
	IENT OF REVENUES PENSES	PROVIDER CCN:	PERIOD: FROM	WORKSHEET G-3	
			ТО		
	Description				
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)				
	Less contractual allowances and discounts on patients' accounts				
	Net patient revenues (line 1 minus line 2)				
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)				
5	Net income from service to patients (line 3 minus line 4)				
	OTHER INCOME				
	OTHER INCOME				
6	Contributions, donations, bequests, etc.				
7	Income from investments				
8	Revenues from telephone and other miscellaneous communication services				
9	Revenue from television and radio service				
10	Purchase discounts				
11	Rebates and refunds of expenses				
12	Parking lot receipts				
13	Revenue from laundry and linen service				
14	Revenue from meals sold to employees and guests				
15	Revenue from rental of living quarters				
16	Revenue from sale of medical and surgical supplies to other than patients				
17	Revenue from sale of drugs to other than patients				
18	Revenue from sale of medical records and abstracts				
19	Tuition (fees, sale of textbooks, uniforms, etc.)				
20	Revenue from gifts, flowers, coffee shops, and canteen				
21	Rental of vending machines				
22	Rental of hospital space				
23	Governmental appropriations				
	Other (specify)				
	COVID-19 PHE Funding				2
	Total other income (sum of lines 6-24)				
	Total (line 5 plus line 25)		<u> </u>		
	Other expenses (specify)				
	Total other expenses (sum of line 27 and subscripts)				
29	Net income (or loss) for the period (line 26 minus line 28)				

	YSIS OF HOSPITAL-BASED HEALTH AGENCY COSTS							PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	Wo	ORKSHEET H	
	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENT		
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related-Bldgs. and Fixtures											1
2	Capital Related-Movable Equipment											2
3	Plant Operation & Maintenance											3
4	Transportation (see instructions)											4
5	Administrative and General											5
	HHA REIMBURSABLE SERVICES											
- 6	Skilled Nursing Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech Pathology											9
10	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
	Drugs											13
14												14
	HHA NONREIMBURSABLE SERVICES											
1.5	Home Dialysis Aide Services											15
	Respiratory Therapy											16
	Private Duty Nursing											17
	Clinic			+	<u> </u>			†			+	18
19		1						†			+	19
	Day Care Program							 				20
	Home Delivered Meals Program											21
	Homemaker Service	1		+	+			+			+	22
	All Others	1		+	+			+			+	23
	Total (sum of lines 1 through 23)			 				+				23

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

4090 (Cont.)		FO.	KM CMS-2552-1	10						11-16
COST ALLOCATION - HHA GENERAL SERVICE COST							ER CCN:	PERIOD: FROM	WORKSHEET H-1 PART I	
						ННА СС	'N:	то		
	NET EXPENSES FOR COST		ITAL							
	ALLOCATION (from Wkst. H, col. 10)	RELATE BLDGS. & FIXTURES	D COSTS MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRAN PORTA		SUBTOTA (cols. 0-4		TOTAL	
	0	1	2	3	4 FORTA	HON	(cois. 0-4 4a	5	(cois. 4a + 3)	-
GENERAL SERVICE COST CENTERS	0	1	2	3	7		74	,	0	_
Capital Related-Bldgs. and Fixtures										1
2 Capital Related-Movable Equipment										2
3 Plant Operation & Maintenance										3
4 Transportation (see instructions)										4
5 Administrative and General										5
HHA REIMBURSABLE SERVICES										
6 Skilled Nursing Care										6
7 Physical Therapy										7
8 Occupational Therapy										8
9 Speech Pathology										9
10 Medical Social Services										10
11 Home Health Aide										11
12 Supplies (see instructions)										12
13 Drugs										13
14 DME										14
HHA NONREIMBURSABLE SERVICES										
15 Home Dialysis Aide Services										15
16 Respiratory Therapy										16
17 Private Duty Nursing										17
18 Clinic										18
19 Health Promotion Activities										19
20 Day Care Program										20
21 Home Delivered Meals Program										21
22 Homemaker Service										22
23 All Others										23
24 Totals (sum of lines 1 through 23)										24

COST ALLOCATION - HHA STATISTICAL BASIS					PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-1, PART II	•
			DOTAL DOTAL DOTAL 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	L	,	4	Ja	,	
Capital Related-Bldgs. and Fixtures								
2 Capital Related-Movable Equipment								1
3 Plant Operation & Maintenance								
4 Transportation (see instructions)								
5 Administrative and General								
HHA REIMBURSABLE SERVICES								
6 Skilled Nursing Care								
7 Physical Therapy								1
8 Occupational Therapy								
9 Speech Pathology								
10 Medical Social Services								10
11 Home Health Aide								1
12 Supplies (see instructions)								12
13 Drugs								1.
14 DME								14
HHA NONREIMBURSABLE SERVICES								
15 Home Dialysis Aide Services								1:
16 Respiratory Therapy								10
17 Private Duty Nursing								1
18 Clinic	_							13
19 Health Promotion Activities								19
20 Day Care Program								20
21 Home Delivered Meals Program								2
22 Homemaker Service								22
23 All Others								2:
24 Total (sum of lines 1-23)								24
25 Cost To Be Allocated (per Worksheet H-1, Part I)								2
26 Unit Cost Multiplier								2

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	ATION OF GENERAL SERVICE TO HHA COST CENTERS								PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	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	
		line	0	1	2	4	4A	5	6	7	8	
1	Administrative and General	5										1
2	Skilled Nursing Care	6										2
3	Physical Therapy	7										3
4	Occupational Therapy	8										4
5	Speech Pathology	9										5
6	Medical Social Services	10										6
7	Home Health Aide	11										7
8	Supplies	12										8
9	Drugs	13										9
10	DME	14										10
11	Home Dialysis Aide Services	15										11
12	Respiratory Therapy	16										12
13	Private Duty Nursing	17										13
14	Clinic	18										14
15	Health Promotion Activities	19										15
16	Day Care Program	20										16
17	Home Delivered Meals Program	21										17
18	Homemaker Service	22										18
19	All Others	23										19
20	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1, line 20, minus column 26, line 1, rounde											21

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

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

	ATION OF GENERAL SERVICE TO HHA COST CENTERS									PROVIDER CCN: HHA CCN:	PERIOD: FROMTO	WORKSHEET H-2, PART I (CONT.)	
	HHA COST CENTER (omit cents)	HOUSE KEEPING 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
	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
	Clinic												14
15	Health Promotion Activities												15
	Day Care Program												16
17	Home Delivered Meals Program												17
18	Homemaker Service												18
19	All Others												19
20	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1, di line 20, minus column 26, line 1, rounded												21

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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		01011 01115 2332			PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-2, PART II	(Cont.)
STATISTICAL BASIS					HHA CCN:	то	_	
	CA	APITAL					1	Т
	RELA	TED 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	
1 Administrative and General								
2 Skilled Nursing Care								1
3 Physical Therapy								
4 Occupational Therapy								
5 Speech Pathology								
6 Medical Social Services								
7 Home Health Aide								
8 Supplies								
9 Drugs								
10 DME								1
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								1
17 Home Delivered Meals Program								1'
18 Homemaker Service								13
19 All Others								19
20 Totals (sum of lines 1-19)								20
21 Total cost to be allocated								2
22 Unit Cost Multiplier								2:

ALDICATION OF GENERAL SERVICE COSTS TO HA COST CENTERS FROM_ PART II (CONT.)	77 13
HHA COST CENTER SERVICE KEEPING DIETARY CAFETERIA PERSONNEL TRATION SUPPLY PHARMACY LIBRARY LIBRARY (MEALS (MEALS (MEALS (NUMBER (NUMBE	
Administrative and General	
2 Skilled Nursing Care	
3 Physical Therapy	2
4 Occupational Therapy Speech Pathology Speech Path	2
5 Speech Pathology	3
6 Medical Social Services	4
7 Home Health Aide	3
8 Supplies 9 Drugs 10 DME 11 Home Dialysis Aide Services 12 Respiratory Therapy 13 Private Duty Nursing	6
9 Drugs	/
10 DME	8
11 Home Dialysis Aide Services	10
12 Respiratory Therapy 13 Private Duty Nursing	11
13 Private Duty Nursing	12
	13
14 Clinic	14
15 Health Promotion Activities	15
16 Day Care Program	16
17 Home Delivered Meals Program	17
17 Home Derivered Weats Frogram 18 Homemaker Service	18
19 All Others	19
20 Totals (sum of lines 1-19)	20
20 Total cost to be allocated	21
21 Vait Cost Multiplier	22

ALLOCATION OF GENERAL SERVICE		2332	10		PROVIDER CCN:	PERIOD:	WORKSHEET H-2,	(Cont.)
COSTS TO HHA COST CENTERS STATISTICAL BASIS					HHA CCN:	FROM TO	PART II (CONT.)	
			NON-				PARA-	Τ
			PHYSICIAN			& RESIDENTS	MEDICAL	
	SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
HHA COST CENTER	SERVICE	GENERAL	THETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	
	(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
	SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	_
	17	18	19	20	21	22	23	
1 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

4090 (Cont.)					FORM	I CMS-	2552-1	0						01-22
APPORTIONMENT OF PATIENT SERV	ICE COST	ΓS						P	ROVIDER CO	N:	PERIOD:		WORKSHE	ET H-3,
											FROM		Parts I & II	
								H	HA CCN:		ТО			
Check applicable box:	[] Title	V [] Titl	e XVIII	[] Title	2 XIX									
PART I - COMPUTATION OF THE AGGREGA	ATE PROGR	AM COST												
Cost Per Visit Computation								Program Vi				of Services		
	_			Total					rt B			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 Visits		
				Par	rt B	
				Not Subject to	Subject to	
				Deductibles &	Deductibles &	
	Patient Services	CBSA NO. (1)	Part A	Coinsurance	Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care					8
9	Physical Therapy					9
10	Occupational Therapy					10
11	Speech Pathology					11
12	Medical Social Services					12
13	Home Health Aide					13
14	Total (sum of lines 8 through 13)					14

Supplies and Drugs Cost							Program (Covered Charg	ges	Cost of S	ervices		
Computations								Par	rt B		Pa	rt B]
		Facility	Shared					Not Subject			Not Subject		
	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	
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

						(-	
CALCULATION OF HHA	REIMBURSEMENT			PROVIDER CCN:	PERIOD:	WORKSHEET H-4,	•
SETTLEMENT					FROM	Parts I & II	
				HHA CCN:	TO		
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX				

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

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

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4090	(Cont.)	FORM	CMS-	2552-10				12-22
BASED	YSIS OF PAYMENTS TO HOSPITAL- O HHAS FOR SERVICES				PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-5	
RENDI	ERED TO PROGRAM BENEFICIARIES				HHA CCN:	ТО		
				P	art A		Part B	
	Description			mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills eith to be submitted to the intermediary for services cost reporting period. If none, write "NONE" or	rendered in the						2
3	List separately each retroactive lump sum	Program	.01					3.01
	adjustment amount based on subsequent revision		.02					3.02
	of the interim rate for the cost reporting period. Also show date of each payment. If none, write	Provider	.03					3.03
	"NONE" or enter a zero.(1)		.05					3.04
	THORIE OF CINCI & ZOTON(1)	Provider	.50					3.50
		to	.51					3.51
		Program	.52					3.52
			.53					3.53
	Subtotal (sum of lines 3.01-3.49 minus sum		.54					3.54
	of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3 (transfer to Wkst. H-4, Part II, column as appropriate to the state of th							4
	TO BE COMPLETED BY INTERMEDIARY							
5	List separately each tentative settlement paymen	-	.01					5.01
	after desk review. Also show date of each payment. If none, write "NONE" or enter	to Provider	.02			+		5.02
	a zero. (1)	Provider	.50					5.50
	4 25161 (1)	to	.51					5.51
		Program	.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	(see instructions) Name of Contractor Contractor Number				NPR Date: Month, Da	ay, Year		8

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

ANALY	SIS OF RENAL I	DIALYSIS DEPARTMENT COSTS			PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET I-1	
Check a	pplicable box:	Renal Dialysis Department	[] Home Program Dia	lvsis	<u>l</u>	10		
		1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		TOTAL			FTEs per	
				COSTS	BASIS	STATISTICS	2080 Hours	
				1	2	3	4	
1	Registered Nurse	es			Hours of Service			1
2	Licensed Practic	al Nurses			Hours of Service			2
3	Nurses Aides				Hours of Service			3
4	Technicians				Hours of Service			4
5	Social Workers				Hours of Service			5
6	Dieticians				Hours of Service			6
7	Physicians				Accumulated Cost			7
8	Non-patient Care	Salary			Accumulated Cost			8
9	Subtotal (sum of	lines 1-8)						9
10	Employee Benef	its			Salary			10
11	Capital Related (Costs-Bldgs. & Fixtures			Square Feet			11
12	Capital Related (Costs-Mov. Equip.			Percentage of Time			12
13	Machine Costs &	Repairs			Percentage of Time			13
14	Supplies	•			Requisitions			14
14.01	Pediatric 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 (Costs-Bldgs. & Fixtures			Square Feet			18
19	Capital Related (Costs-Mov. Equip.			Percentage of Time			19
20	Employee Benef	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	& Supplies			Requisitions			24
25	Pharmacy				Requisitions			25
26	Other Allocated	Costs			Accumulated Cost			26
27	Subtotal (sum of	lines 17-26)*						27
28	Laboratory (see i	nstructions)			Charges			28
29	Respiratory Ther	apy (see instructions)			Charges			29
30	Other (see instru	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.

ALLOCATION OF RENAL DEPARTMENT CO	OSTS TO TREAT	MENT MODALIT	ΓΙES	101	dvi Civis-233	2-10				PROVIDER CCN:	PERIOD: FROMTO	WORKSHEET I-2	12-24
Check applicable box: [] Renal Dialys	is Department	[] Home Progra	am Dialysis							II.			
OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPIT. RELATE	AL AND ED COSTS EQUIPMENT 2	DIRECT	PATIENT SALARY OTHER 4	EMPLOYEE BENEFITS DEPARTMENT 5	DRUGS 6	MEDICAL SUPPLIES	PEDIATRIC MEDICAL SUPPLIES 7.01	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (sum of cols. 1-8)	OVERHEAD 10	TOTAL (col. 9 + col. 10)	
Total Renal Department Costs	1	2	3	4	3	0	/	7.01	0	9	10	11	1
MAINTENANCE													1
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
4.02 Hemodialysis-AKI													4.02
5 Intermittent Peritoneal													5
5.01 IPD-Pediatric													5.01
5.02 IPD-AKI													5.02
6 CAPD													6
6.01 CAPD-Pediatric													6.01
6.02 CAPD-AKI													6.02
7 CCPD													7
7.01 CCPD-Pediatric													7.01
7.02 CCPD-AKI													7.02
HOME													
8 Hemodialysis													8
8.01 Hemodialysis-Pediatric													8.01
8.02 Hemodialysis-AKI													8.02
9 Intermittent Peritoneal													9
9.01 IPD-Pediatric													9.01
9.02 IPD-AKI													9.02
10 CAPD													10
10.01 CAPD-Pediatric													10.01
10.02 CAPD-AKI													10.02
11 CCPD													11
11.01 CCPD-Pediatric													11.01
11.02 CCPD-AKI													11.02
OTHER BILLABLE SERVICES													4
12 Inpatient Dialysis	 			 						ļ	+	1	12
13 Method II Home Patient													13
14 ESAs (included in Renal Department) 15 ARANESP (see instructions)													14 15
16 Other				-								+	16 17
17 Total (sum of lines 2 through 16) 18 Medical Educational Program Costs													
10 Iviedical Educational Program Costs													18
19 Total Renal Costs (line 17 plus line 18)													19

	AND INDIRECT	Γ RENAL DIALYSIS COST AL	LOCATION -								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-3	
Check ap	oplicable box:	[] Renal Dialysis Departmen	t []Home	Program Dialysis										
				AL AND ED COSTS EQUIPMENT		PATIENT SALARY	EMPLOYEE BENEFITS		MEDICAL	PEDIATRIC MEDICAL	ROUTINE ANCILLARY		OVERHEAD	
	COMPOSITE PA	AYMENT SERVICES	(SQUARE FEET)	(% OF TIME)	RNs (HOURS)	OTHERS (HOURS)	DEPARTMENT (SALARY) 5	DRUGS (REQUIST.)	SUPPLIES (REQUIST.)	SUPPLIES (REQUIST.) 7.01	SERVICES (CHARGES) 8	SUB- TOTAL 9	(ACCUM. COST) 10	_
1	Total Renal Depa	artment Costs	•				,	Ů	,	7.01	Ů	,	- 10	1
	MAINTENANC													
2	Hemodialysis						1							2
	AKI-Hemodialys	sis					1							2.01
2.02	Hemodialysis-Pe	diatric												2.02
3	Intermittent Perit	oneal												3
3.01	AKI- Intermitten	t Peritoneal												3.01
3.02	IPD-Pediatric													3.02
	TRAINING													
4	Hemodialysis													4
4.01	Hemodialysis-Pe	diatric												4.01
	Hemodialysis-Al-													4.02
	Intermittent Perit	oneal												5
	IPD-Pediatric													5.01
	IPD-AKI													5.02
	CAPD													6
	CAPD-Pediatric													6.01
	CAPD-AKI													6.02
	CCPD						ļ							7
	CCPD-Pediatric						ļ							7.01
7.02	CCPD-AKI													7.02
	HOME													_
	Hemodialysis													8
	Hemodialysis-Pe													8.01
	Hemodialysis-Al												_	8.02
	Intermittent Perit	ioneal											_	9
	IPD-Pediatric													9.01
	IPD-AKI CAPD						-							9.02 10
	CAPD-Pediatric			+			 						_	10.01
10.01	CAPD-Fediatric			+			 	-	1				_	10.01
	CCPD CCPD						+							10.02
	CCPD-Pediatric						+							11.01
	CCPD-AKI													11.01
11.02	OTHER BILLAI	DI E SEDVICES												11.02
12	Inpatient Dialysis													12
	Method II Home			 			+							13
	ESAs	1 auont												14
	ARANESP (see	instructions)												15
	Other	,												16
	Total Statistical I	Basis		 		İ	1	i	1					17
		dier (line 1 ÷ line 17)		i i										18

	TATION OF AVERAGE COST PER TREATMENT TPATIENT RENAL DIALYSIS									PROVIDER O	CCN:	PERIOD: FROM TO		WORKSHEET	Г І-4
Check ar	pplicable box: Renal Dialysis Department	[] Home Program	m Dialysis							II.		- II		L	
Chook up	produce com	Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments 4.01	Number of Program Treatments 4.02	Total Program Expenses (see instructions)	Total Program Payment 6	Total Program Payment 6.01	Total Program Payment 6.02	Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01) 7.01	Average Payment Rate (col. 6.02 ÷ col. 4.02) 7.02	
1	Maintenance - Hemodialysis														1
1.01	Maintenance - AKI Hemodialysis														1.01
2	Maintenance - Peritoneal Dialysis														2
2.01	Maintenance - AKI Peritoneal Dialysis														2.01
3	Training - Hemodialysis														3
3.01	Training - AKI Hemodialysis														3.01
4	Training - Peritoneal Dialysis														4
4.01	Training - AKI Peritoneal Dialysis														4.01
5	Training - CAPD														5
5.01	Training - AKI CAPD														5.01
6	Training - CCPD														6
6.01	Training - AKI CCPD														6.01
7	Home Program - Hemodialysis														7
7.01	Home Program - AKI Hemodialysis														7.01
8	Home Program - Peritoneal Dialysis														8
8.01	Home Program - AKI Peritoneal Dialysis														8.01
9	Home Program - CAPD	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
9.01	Home Program - AKI CAPD														9.01
10	Home Program - CCPD														10
10.01	Home Program - AKI CCPD														10.01
	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instructions)														11
	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)														12

12-22	FORM C	JMS-2552-10		4090 (Cont.)		
	JLATION OF REIMBURSABLE EBTS - TITLE XVIII - PART B	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-5		
	Description					
1	Total expenses related to care of program beneficiaries (see instructions)				1	
			1	2	1	
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 de	ebt recoveries for			5.01	
	services rendered on or after 1/1/2011 but before 1/1/2012					
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad de	ebt recoveries for			5.02	
	services rendered on or after 1/1/2012 but before 1/1/2013					
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad de	ebt recoveries for			5.03	
	services rendered on or after 1/1/2013 but before 1/1/2014					
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for				5.04	
	services rendered on or after 1/1/2014					

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

5.05

9

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

Allowable bad debts (sum of lines 5 through line 5.04)
Adjusted reimbursable bad debts (see instructions)

9 Program payment (see instructions)

Allowable bad debts for dual eligible beneficiaries (see instructions)

Unrecovered from Medicare (Part B) patients (see instructions)

Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)

11 Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)

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.0,0	(001111)			-	014.1 01.10 2001						
								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	TERS					<u> </u>	
		NET EXPENSES FOR COST ALLOCATION (see instru.)	CAPITAL RELATED COSTS BLDGS. & MOVABLE		EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	
1	ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS PART I - ALLOCATION OF GENERAL SERVICE COST COMPONENT COST CENTER (omit cents) 1 Administrative and General 2 Skilled Nursing Care 3 Physical Therapy 4 Occupational Therapy 5 Speech Pathology 6 Medical Social Services 7 Respiratory Therapy 8 Psychiatric/Psychological Services 9 Individual Therapy 10 Group Therapy 11 Individualized Activity Therapies 12 Family Counseling 13 Diagnostic Services 14 Approved Patient Training & Education 15 Prosthetic and Orthotic Devices 16 Drugs and Biologicals 17 Medical Supplies 18 Medical Appliances 19 Durable Medical Equipment-Rented 20 Durable Medical Equipment-Sold	Ů	•	-	·			· ·	,		1
											2
3											3
											4
											5
											6
7											7
											8
											9
		+		-							10
		+		-							11
		+		-							12
											13
											14
											15
		+		-							16
											17
											18 19
		+					!				
	All Others	+					!				20
										-	21
	Totals (sum of lines 1-21)(1)										22

⁽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	552-10					4090 (Cont.
ALLOCATION OF GENERAL SERVICE COS COMMUNITY MENTAL HEALTH CENTERS									PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART I (CONT.)	
PART I - ALLOCATION OF GENERAL SERV	VICE COSTS TO CO	MMUNITY MEN	TAL HEALTH CE	ENTER COST CE	NTERS				<u>l</u>			
COMPONENT 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												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	n											14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)(1)												22

23 Unit Cost Multiplier (see instructions)

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

7070 (Cont.)			1	OKWI CIVIS-233.	2-10					01-22
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS)						PROVIDER CCN:	PERIOD: FROM_	WORKSHEET J-1, PART I	
							COMPONENT CCN:	то	-	
PART I - ALLOCATION OF GENERAL SERVICE O	COSTS TO COMMUNIT	Y MENTAL HEALTH	CENTER COST CEN	TERS			1	<u>I</u>		
				PARA-		INTERN & RESIDENT		ALLOCATED		
COMPONENT COST CENTER		INTERNS &	RESIDENTS	MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
	PROGRAM	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	
	20	21	22	23	24	25	26	27	28	1
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)(1)										22
23 Unit Cost Multiplier (see instructions)										23

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

09-13				F	ORM CMS-2552-	·10				4090 (Cont.)
	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS									WORKSHEET J-1, PART II	
								COMI ONLIVI CCIV.	10	-	
DADTI	I - ALLOCATION OF GENERAL SERVICE C	MMOO OT 2T20	INITY MENTAL HEAL	TH CENTED COST CE	NITEDS STATISTICAL	DACIC				1	
IAKII	I - ALEOCATION OF GENERAL SERVICE C	OBIS TO COMMIC		TTAL	NILKS - STATISTICAL	DASIS	1	1	I		
				ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	i
			BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN	i
	CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	SERVICE	i
	(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	i
	,		FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	i
		0	1	2	4	4A	5	6	7	8	i
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6											6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)										22
	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

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4090	(Cont.)				FOR	CM CM3-233	02-10						09-1
	CATION OF GENERAL SERVICE COSTS TO									PROVIDER CCN:	PERIOD:	WORKSHEET J-1,	
COMM	UNITY MENTAL HEALTH CENTERS										FROM	PART II (CONT.)	
										COMPONENT CCN:	ТО	_	
DADE	A ALLOCATION OF CENERAL CERVICE C	OCTO TO COLO	G DUTTY A GENT	AL HEALTH CE	VITED COST SEN	TED C CTATICT	TO A DAGIG						
PARI	I - ALLOCATION OF GENERAL SERVICE C	OSTS TO COMM	IUNITY MENTA	AL HEALTH CE	1	11EKS - STATIST	ICAL BASIS	1	1	T	T .	YOY	
					MAIN-							NON-	
					TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
		HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
	CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
	(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
		SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
	9	10	11	12	13	14	15	16	17	18	19		
1	Administrative and General												
2	Skilled Nursing Care												
3	Physical Therapy												
4	Occupational Therapy												1
5	Speech Pathology												Î
6	Medical Social Services												
7	Respiratory Therapy												
8	Psychiatric/Psychological Services												
9	Individual Therapy												
10	Group Therapy												1
11	Individualized Activity Therapies												1
12	Family Counseling												1
13	Diagnostic Services												1
14	Approved Patient Training & Education												1
15	Prosthetic and Orthotic Devices												1
16	Drugs and Biologicals												1
17	Medical Supplies												1
18	Medical Appliances												1
19													1
20	Durable Medical Equipment-Sold												2
21	All Others												2
22	Totals (sum of lines 1-21)												2
23	Total Cost to be Allocated			1								1	2

24 Unit Cost Multiplier (see instructions)

							COMI ONENT CCN.	10		
PART II - ALLOCATION OF GENERAL SERVICE	CE COSTS TO COMMUNITY	MENTAL HEALTH C	ENTER COST CENTE	RS - STATISTICAL BA	SIS					
CORF COST CENTER (omit cents)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & SALARY & FRINGES (ASSIGNED TIME)	RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)						
1 Administrative and General	20	21	22	23	24	25	26	27	28	
2 Skilled Nursing Care										1 2
3 Physical Therapy										3
										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										7
7 Respiratory Therapy										
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.)				10	JIMI CIVIS-2332-	10					01-22
COMPUTATION OF COMM	UNITY MENTAL HEAL	TH CENTER PROV	IDER COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET J-2,	
									FROM	PART I	
								COMPONENT CCN:	TO	_	
PART I - APPORTIONMENT	OF CMHC COST CENT	TERS									
		(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
1 Administrative and G	eneral]
2 Skilled Nursing Care											2
3 Physical Therapy											3
4 Occupational Therap	у										4
5 Speech Pathology											4
6 Medical Social Service	ces										(
7 Respiratory Therapy											
8 Psychiatric/Psycholog	gical Services										8
9 Individual Therapy											9
10 Group Therapy											10
11 Individualized Activit	ty Therapy										11
12 Family Counseling											12
13 Diagnostic Services											13
14 Approved Patient Tra	ining & Education										14
15 Prosthetic and Orthot	ic Devices										15
16 Drugs and Biological	S										16
17 Medical Supplies											17
18 Medical Appliances											18
19 All Others (1)											19
20 Totals (sum of lines 1	through19)										20

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

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

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

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

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

4090 (Cont.		FORM CMS-2552-10						
CALCULATIO	N OF REIMBURSEMENT SETTLEMENT COMMUNITY	PROVIDER CCN:	PERIOD:	WORKSHEET J-3				
MENTAL HEA	LTH CENTER PROVIDER SERVICES		FROM					
		COMPONENT CCN	: TO					
Check	[] Title V							
applicable	[] Title VIII							
box:	[] Title XIX							
				PROGRAM				
				COST				
1 Cost of	f component services (from Wkst. J-2, Pt. II, line 29)				1			
2 PPS pa	syments received excluding outliers				2			

		PROGRAM COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 29)	0001	1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary paver payments		4
5	Total reasonable cost (see instructions)		5
6	Total charges for program services		6
	CUSTOMARY CHARGES		
7	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge		8
	basis had such payment been made in accordance with 42 CFR 413.13(e)		8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
10	Total customary charges (see instructions)		10
11	Excess of customary charges over reasonable cost (see instructions)		11
12	Excess of reasonable cost over customary charges (see instructions)		12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
13	Total reasonable cost (from line 5)		13
14	Part B deductible billed to program patients		14
	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Allowable bad debts (from provider records) (see instructions)		21
22	Adjusted reimbursable bad debts (see instructions)		22
23	Allowable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		25.50
25.99	Demonstration payment adjustment amount before sequestration		25.99
26	Total cost (see instructions)		26
26.01	Sequestration adjustment (see instructions)		26.01
26.02	Demonstration payment adjustment amount after sequestration		26.02
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		29
30	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)		30

11-10		FORM CMS-2	332-10			4090	(Cont.)
	PAYMENTS TO HOSPITAL-BASED COMM		PROVIDER	. CCN:	PERIOD:	WORKSHEET J-4	
CENTER FOR S	SERVICES RENDERED TO PROGRAM BEI	NEFICIARIES	COMPONE	NT CCN.	FROM	-	
			COMPONE	NI CCN.	ТО	_	
Check			ı			ı	
applicable	[] Title XVIII						
boxes:	1						
					P	art B	
DES	SCRIPTION				1	2	
					mm/dd/yyyy	Amount	
	nterim payments paid to providers						1
	payments payable on individual bills, either						2
	ted or to be submitted to the intermediary, for						
	s rendered in the cost reporting periods. If						
	vrite "NONE", or enter zero.		1				
	parately each retroactive			.01			3.01
	um adjustment amount		Program	.02			3.02
	on subsequent revision of		to	.03			3.03
	erim rate for the		Provider	.04			3.04
	porting period. Also show						3.05
	each payment. , write "NONE",		Provider	.50			3.50 3.51
	r zero (1).		to	.52			3.51
or enter	zelo (1).		Program	.53			3.53
			Tiogram	.54			3.54
Subtots	al (sum of lines 3.01-3.49			.54			3.34
	sum of lines 3.50-3.98)			.99			3.99
	nterim payments (sum of lines 1, 2, and 3.99)			.,,,			4
	er to Worksheet J-3, line 27)						
(transit	a to Workshoet U.S. Into 27)						
TO BE	COMPLETED BY INTERMEDIARY						
	parately each tentative		Program	.01			5.01
	ent payment after desk review.		to	.02			5.02
Also sh	now date of each payment.		Provider	.03			5.03
If none	, write "NONE,"		Provider	.50			5.50
or enter	r zero (1).		to	.51			5.51
			Program	.52			5.52
	al (sum of lines 5.01-5.49 minus		·				
	lines 5.50-5.98)			.99			5.99
	nine net settlement amount		Program				
	e due) based on the cost		to				
report ((see instructions). (1)		Provider	.01			6.01
			Provider				
			to				
			Program	.02			6.02
	Medicare liability						7
	structions)			NIDE 1	2 + 04 + 12 - 11	`	
8 Name o	of Contractor	Contractor Number		NPR I	Date (Month, Day, Year	")	8
I		I		1			1

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

	SIS OF HOSPITAL-BASED EE COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD: WORKSHEE FROM I: TO									
COS	T CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER 5	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	<u> </u>	0	/	8	,	10	_
1	Capital Related Costs-Bldg and Fixt.											1
	Capital Related Costs-Movable Equip.											2
	Plant Operation and Maintenance											3
	Transportation - Staff											4
5	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
10	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
	Physical Therapy											12
	Occupational Therapy											13
	Speech/ Language Pathology											14
	Medical Social Services											15
16	Spiritual Counseling											16
17	Dietary Counseling											17
18	Counseling - Other											18
	Home Health Aide and Homemaker											19
20	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						İ	İ				25
	Durable Medical Equipment/Oxygen							i				26
	Patient Transportation		1				1	1	1			27
28	Imaging Services											28
	Labs and Diagnostics											29
	Medical Supplies											30
	Outpatient Services (including E/R Dept.)											31
	Radiation Therapy											32
	Chemotherapy											33
	Other											34
	HOSPICE NONREIMBURSABLE SERVICE											
35	Bereavement Program Costs											35
	Volunteer Program Costs											36
	Fundraising											37
38	Other Program Costs											38
39	Total (sum of lines 1 thru 38)											39

11-10			Г	JKWI CIVIS-2332	2-10					(Cont.
HOSPICE COMPENSATION ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-1	
SALARIES AND WAGES							l . 	FROM	_	
							COMPONENT CCN:	ТО	_	
			MEDICAL							
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
GENERAL SERVICE COST CENTERS										
Capital Related Costs-Bldg and Fixt.										1
 Capital Related Costs-Movable Equip. 										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff										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									1	15
16 Spiritual Counseling									1	16
17 Dietary Counseling									1	17
18 Counseling - Other									1	18
19 Home Health Aide and Homemaker									1	19
20 HH Aide & Homemaker - Cont. Home Care									1	20
21 Other									1	21
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									1	27
28 Imaging Services									†	28
29 Labs and Diagnostics									†	29
30 Medical Supplies								Ì	1	30
31 Outpatient Services (including E/R Dept.)									1	31
32 Radiation Therapy									1	32
33 Chemotherapy									 	33
34 Other	†			1	i			1	 	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
27 15th (Sum of fines I that 50)		1		1				1		

⁽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	-	
			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										
Capital Related Costs-Bldg and Fixt.										
2 Capital Related Costs-Movable Equip.										
3 Plant Operation and Maintenance							_		_	
4 Transportation - Staff							_		_	
5 Volunteer Service Coordination							_		_	
6 Administrative and General										
INPATIENT CARE SERVICE										
7 Inpatient - General Care									+	
8 Inpatient - Respite Care VISITING SERVICES										-
										_
9 Physician Services										١.,
10 Nursing Care										1
11 Nursing Care-Continuous Home Care										1
12 Physical Therapy									 	1
13 Occupational Therapy 14 Speech/ Language Pathology									 	1
									 	1
										1
, č										1
										1
19 Home Health Aide and Homemaker 20 HH Aide & Homemaker - Cont. Home Care					<u> </u>				+	2
21 Other	+								4	2
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy							+			2
23 Analgesics										2
24 Sedatives / Hypnotics										2
25 Other - Specify										2
26 Durable Medical Equipment/Oxygen										2
27 Patient Transportation										2
28 Imaging Services					 				+	2
29 Labs and Diagnostics					 				+	2
30 Medical Supplies									+	3
31 Outpatient Services (including E/R Dept.)									+	3
32 Radiation Therapy										3
33 Chemotherapy									†	3
34 Other										3
HOSPICE NONREIMBURSABLE SERVICE										T
35 Bereavement Program Costs										3
36 Volunteer Program Costs									1	3
37 Fundraising									†	3
38 Other Program Costs									1	3
39 Total (sum of lines 1 thru 38)									1	3

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

HOSPICE COMPENSATION ANALYSIS			1.0	JKWI CIVIS-2332	-10		PROVIDER CCN:	PERIOD:	WORKSHEET K-3	(Cont
CONTRACTED SERVICES/PURCHASED SERVICES							PROVIDER CCN:	FROM	WORKSHEET K-3	
CONTRACTED SERVICES/I ORCHASED SERVICES							COMPONENT CCN:		-	
							COMPONENT CCN.	10	-	
			MEDICAL							1
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	1
GENERAL SERVICE COST CENTERS										
 Capital Related Costs-Bldg and Fixt. 										
 Capital Related Costs-Movable Equip. 										
3 Plant Operation and Maintenance										
4 Transportation - Staff										
5 Volunteer Service Coordination										
6 Administrative and General										
INPATIENT CARE SERVICE										
7 Inpatient - General Care										
8 Inpatient - Respite Care										
VISITING SERVICES										
9 Physician Services										
10 Nursing Care										1
11 Nursing Care-Continuous Home Care										1
12 Physical Therapy										1:
13 Occupational Therapy										1.
14 Speech/ Language Pathology										1.
15 Medical Social Services										1.
16 Spiritual Counseling										1
17 Dietary Counseling										1
18 Counseling - Other										1
19 Home Health Aide and Homemaker										1
20 HH Aide & Homemaker - Cont. Home Care										2
21 Other										2
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy										2
23 Analgesics										2
24 Sedatives / Hypnotics										2
25 Other - Specify										2
26 Durable Medical Equipment/Oxygen										2
27 Patient Transportation										2
28 Imaging Services										2
29 Labs and Diagnostics										2
30 Medical Supplies										3
31 Outpatient Services (including E/R Dept.)										3
32 Radiation Therapy	_		ļ	.	.		_	.		3.
33 Chemotherapy										3.
34 Other										3.
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										3.
36 Volunteer Program Costs									 	3
37 Fundraising							_			3
38 Other Program Costs										3
39 Total (sum of lines 1 thru 38)				I						3

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

	ALLOCATION - HOSPICE GENERAL SERVICE	COST			3. Lan 2002			PROVIDER CCN: COMPONENT CCN:	PERIOD: FROMTO	WORKSHEET K-4, PART I	0, 10
COS	T 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	I	2	3	4	5	5A	6	7	
1											1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4											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						1				9
10	Nursing Care										10
11	<u> </u>										11
12	Physical Therapy										12
	Occupational Therapy										13
14											14
15											15
16											16
	Dietary Counseling										17
18											18
19											19
20											20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy						1				22
	Analgesics										23
24											24
25				1		1		1			25
26	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services										28
	Labs and Diagnostics										29
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy										32
	Chemotherapy										33
	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
	Volunteer Program Costs										36
37											37
38	S	•									38
39	Total (sum of lines 1 thru 38)										39

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

4090 (Cont.) FORM CMS-2552-10									09-				
	CATION OF GENERAL SERVICE S TO HOSPICE COST CENTERS							PROVIDER CCN: COMPONENT CCN:	FROM PART I				
PART I	- ALLOCATION OF GENERAL SERVICE COST	TS TO HOSPICE	COST CENTERS										
I	HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7, line	HOSPICE TRIAL BALANCE (1) 0		OTTAL ED COSTS MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT 7			
1	Administrative and General	6											
2	Inpatient - General Care	7											
3	Inpatient - Respite Care	8									1		
4	Physician Services	9											
- 5	Nursing Care	10											
6	Nursing Care-Continuous Home Care	11											
7	Physical Therapy	12											
8	Occupational Therapy	13											
9	Speech/ Language Pathology	14											
10	Medical Social Services	15									1		
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									1		
17	Drugs, Biological and Infusion Therapy	22									1		
18	Analgesics	23									1		
19	Sedatives / Hypnotics	24									1		
20	Other - Specify	25									2		
21	Durable Medical Equipment/Oxygen	26									2		
22	Patient Transportation	27									2		
23	Imaging Services	28									2		
24	Labs and Diagnostics	29									2.		
25	Medical Supplies	30									2		
26	Outpatient Services (including E/R Dept.)	31									2		
27	Radiation Therapy	32									2		
28	Chemotherapy	33									2		
29	Other	34									2		
30	Bereavement Program Costs	35									3		

31 Volunteer Program Costs

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

35 Unit Cost Multiplier (see instructions)

33 Other Program Costs

32 Fundraising

36

37

38

31

32

34

35

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

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

10-12				FO]	RM CMS-255	52-10					4090	(Cont.
ALLOC	CATION OF GENERAL SERVICE								PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
COSTS	TO HOSPICE COST CENTERS									FROM	PART I (Cont.)	
									COMPONENT CCN:	TO	_	
PART I	- ALLOCATION OF GENERAL SERVICE COSTS	TO HOSPICE COST	CENTERS	_			_	_	-			
	HOSPICE COST CENTER	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
	(omit cents)	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	4
	T	8	9	10	11	12	13	14	15	16	17	
1	Administrative and General									<u> </u>	_	+
	Inpatient - General Care									ļ	4	+
	Inpatient - Respite Care									ļ	4	+
	Physician Services									ļ	4	+
_	Nursing Care									ļ	4	+
	Nursing Care-Continuous Home Care									ļ	4	+
	Physical Therapy									ļ	4	
	Occupational Therapy									ļ	4	+
	Speech/ Language Pathology									<u> </u>		
	Medical Social Services									<u> </u>		1
	Spiritual Counseling									<u> </u>		1
	Dietary Counseling									<u> </u>		1:
	Counseling - Other									<u> </u>		1.
	Home Health Aide and Homemaker									<u> </u>		1-
	HH Aide & Homemaker - Cont. Home Care									<u> </u>		1:
	Other									<u> </u>		1
	Drugs, Biological and Infusion Therapy									<u> </u>		1
	Analgesics									<u> </u>	_	1
	Sedatives / Hypnotics									<u> </u>		1
	Other - Specify									<u> </u>	_	2
	Durable Medical Equipment/Oxygen									<u> </u>		2
	Patient Transportation									<u> </u>		
	Imaging Services									<u> </u>		2.
	Labs and Diagnostics									<u> </u>	_	2.
	Medical Supplies									<u> </u>		2
	Outpatient Services (including E/R Dept.)	1								↓	4	2
	Radiation Therapy	1			ļ							2
	Chemotherapy	1								↓	4	2
	Other									 	+	_
_	Bereavement Program Costs									 	+	3
	Volunteer Program Costs									 	+	3
32	Fundraising		1		1	1	1			1	1	32

33 Other Program Costs

34 Totals (sum of lines 1-33) (2) 35 Unit Cost Multiplier (see instructions)

33 34

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

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

	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS									PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART I (Cont.)	
PARTI	- ALLOCATION OF GENERAL SERVICE COS	TS TO HOSPICI	F COST CENTER	28							l.		
	HOSPICE COST CENTER (omit cents)	OTHER GENERAL SERVICE '8	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL 20	INTERNS & SALARY & FRINGES 21	RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (cols. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUST. 25	SUBTOTAL (cols. 24 ± 25) 26	ALLOCATED HOSPICE A&G (see Part II) 27	TOTAL HOSPICE COSTS (cols. 26 ± 27) 28	
	Administrative and General	Ü	.,	20			25		20	20	21	20	1
	Inpatient - General Care												2
	Inpatient - Respite Care												3
	Physician Services											1	4
5	Nursing Care												5
6	Nursing Care-Continuous Home Care												6
	Physical Therapy												7
	Occupational Therapy												8
9	Speech/ Language Pathology												9
	Medical Social Services												10
11	Spiritual Counseling												11
12	Dietary Counseling												12
13	Counseling - Other												13
	Home Health Aide and Homemaker												14
15	HH Aide & Homemaker - Cont. Home Care												15
	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
	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
29	Other												29
	Bereavement Program Costs												30
	Volunteer Program Costs												31
	Fundraising												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.

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

	ATION OF GENERAL SERVICE COSTS TO E COST CENTERS STATISTICAL BASIS							PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART II	
PART II	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE (COST CENTERS -	STATISTICAL BA	SIS			•			_	
	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.) 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
	Spiritual Counseling									†	11
	Dietary Counseling									†	12
	Counseling - Other									†	13
	Home Health Aide and Homemaker									†	14
	HH Aide & Homemaker - Cont. Home Care									†	15
	Other									†	16
	Drugs, Biological and Infusion Therapy										17
	Analgesics										18
	Sedatives / Hypnotics										19
	Other - Specify										20
	Durable Medical Equipment/Oxygen									†	21
	Patient Transportation									†	22
	Imaging Services									†	23
	Labs and Diagnostics									†	24
	Medical Supplies									†	25
	Outpatient Services (including E/R Dept.)									†	26
	Radiation Therapy									†	27
	Chemotherapy									†	28
	Other									†	29
	Bereavement Program Costs									 	30
	Volunteer Program Costs									 	31
	Fundraising									 	32
	Other Program Costs									 	33
	Totals (sum of lines 1-33) (2)									+	34
	Total cost to be allocated									+	35
33	Total cost to be allocated									 	33

	ATION OF GENERAL SERVICE COSTS TO					PROVIDER CCN:	PERIOD:	WORKSHEET K-5,	
HOSPIC	CE COST CENTERS STATISTICAL BASIS						FROM	PART II	
						COMPONENT CCN:	то		
DIDEL	A ANA OCUTION OF CENTER AS CENTRAL CONTO TO MOCROE COST CENTERS. CENTERS AS DESIGNATION OF COST.			1					
PARTI	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		1	NON	1	1		n.n.	1
				NON-		DITTEDNIC O	DEGIDENTE	PARA-	
				PHYSICIAN			RESIDENTS	MEDICAL	
	VICENCE COST OF VICEN	SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
	HOSPICE COST CENTER	SERVICE	GENERAL	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	
		(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
		SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	4
	Administrative and General	17	18	19	20	21	22	23	-
	Administrative and General Inpatient - General Care								2
	Inpatient - General Care Inpatient - Respite Care								3
	Physician Services								3
	Nursing Care								5
	Nursing Care-Continuous Home Care								7
	Physical Therapy								_
	Occupational Therapy								8
	Speech/ Language Pathology Medical Social Services								
									10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biological and Infusion Therapy								17
	Analgesics								18
	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (including E/R Dept.)								26
	Radiation Therapy								27
	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1-33) (2)								34
	Total cost to be allocated								35
36	Unit Cost Multiplier (see instructions)								36

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4090 ((Cont.)	FORM CMS-2552-10				10-12
APPOR	TIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART III	
PART I	II - COMPUTATION OF TOTAL HOSPICE SHARED COST	rs .				
	COST CENTER	Wkst. C, Part I, col. 9, line	Cost to Charge Ratio I	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
	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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07-23	Γ	OKW CW3-2332-10			4090 (Cont.)
CALCU	LATION OF HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD: FROM_	WORKSHEET K-6	<u>_</u>
			COMPONENT CCN:	то		
			J			
	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	<u> </u>
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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T070	(Cont.)	I OIUVI	CIVID-2332-10				07-23
CALCU	ULATION OF CAPITAL PAYMENT			PROVIDER CCN:	PERIOD:	WORKSHEET L	
					FROM		
				COMPONENT CCN:	то		
Check	[] Title V	[] Hamital	[] PPS				
applicabl		[] Hospital [] PARHM Demonstration	Cost Meth	no.d			
boxes:	Title XIX	[] FARHM Demonstration	[] Cost Meti	iou			
	I - FULLY PROSPECTIVE METHOD						
1711(11	CAPITAL FEDERAL AMOUNT						
1	Capital DRG other than outlier						1
1.01	4	outlier					1.01
2							2
2.01	Model 4 BPCI Capital DRG outlier pays	ments					2.01
	Total inpatient days divided by number of		nstructions)				3
4		• • • • • • • • • • • • • • • • • • • •					4
- 5	Indirect medical education percentage (see instructions)					5
6	Indirect medical education adjustment ((see instructions)					6
7	Percentage of SSI recipient patient days	to Medicare Part A patient days (Worksho	eet E, Part A line 30)	(see instructions)			7
8	Percentage of Medicaid patient days to t	total days (see instructions)					8
9	Sum of lines 7 and 8						9
10	Allowable disproportionate share percen	ntage (see instructions)					10
11	Disproportionate share adjustment (see	instructions)					11
12	Total prospective capital payments (see	instructions)					12
PART I	II - PAYMENT UNDER REASONABLE	COST					
1	Program inpatient routine capital cost (s	see instructions)					1
2	Program inpatient ancillary capital cost	(see instructions)					2
3	Total inpatient program capital cost (line	e 1 plus line 2)					3
4	Capital cost payment factor (see instruc	tions)					4
_	Total inpatient program capital cost (line	•					5
PART I	III - COMPUTATION OF EXCEPTION F						
1	Program inpatient capital costs (see inst	•					1
	Program inpatient capital costs for extra						2
	Net program inpatient capital costs (line	<u> </u>					3
	Applicable exception percentage (see in						4
	Capital cost for comparison to payments						5
	Percentage adjustment for extraordinary	`	2 1: 0				6
		t level for extraordinary circumstances (lin	ne 2 x line 6)				7 8
9							9
10		mum payment level to capital payments (li	ina & lace lina (I)				10
11			ille 8 less lille 9)				11
	(from prior year Worksheet L, Part III,						- 11
12	Net comparison of capital minimum pay	· ·	us line 11)				12
	Current year exception payment (if line		· ·				13
14			~ <i>,</i>				14
14	for the following period (if line 12 is neg						14
15							15
16		* * * * · · · · · · · · · · · · · · · ·					16
	Current year exception offset amount (s	1 /					17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY 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	
GENERAL SERVICE COST CENTERS	0	1	2	ZA	4	3	6	/	
1 Capital Related Costs-Buildings and Fixtures									T
2 Capital Related Costs-Movable Equipment				1					
4 Employee Benefits Department						1			
5 Administrative and General							1		
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		TTAL 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	0	I	2	ZA	4	3	ь	/	_
	Operating Room									50
	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy Occupational Therapy									67
	Speech Pathology					+		+		68
	Electrocardiology									69
	Electrocardiology									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
77	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
	Other Outpatient (specify)									93
93.99	Partial Hospitalization Program									93.99

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		ITAL D COSTS						
(Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	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									
	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
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									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
	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

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES	_						1	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	
ANCILLARY SERVICE COST CENTERS	8	9	10	11	12	13	14	13	16	17	+-
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 Service-Program Only											61
62 Whole Blood & Packed Red Blood Cells											62
63 Blood Storing, Processing, & Trans.											63
64 Intravenous Therapy											64
65 Respiratory Therapy											65
66 Physical Therapy											66
67 Occupational Therapy											67
68 Speech Pathology											68
69 Electrocardiology											69
70 Electroencephalography											70
71 Medical Supplies Charged to Patients											71
72 Implantable Devices Charged to Patients											72
73 Drugs Charged to Patients											73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)	_										75
76 Other Ancillary (specify)			ļ		ļ						76
77 Allogeneic HSCT Acquisition			ļ		ļ						77
78 CAR T-Cell Immunotherapy											78
OUTPATIENT SERVICE COST CENTERS											00
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)									1		89 90
90 Clinic	+		-		-		-	 	+		
91 Emergency 92 Observation Beds									_		91
92 Observation Beds 93 Other Outpatient (specify)											92 93
									1		93.99
93.99 Partial Hospitalization Program											93.99

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

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

	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART I (Cont.)	
LAIKA	SKDINAKT CIKCOMSTANCES								TO TO	TAKTT(Cont.)	
		1	1		1	ı	1		INTERN &		
					INTERNS &	INTERNS &	PARA-		RESIDENT		
		OTHER			RESIDENTS	RESIDENTS					
		OTHER	NONDHWALAN	NUMBERIC			MEDICAL		COST & POST		
(Cost Center Descriptions	GENERAL	NONPHYSICIAN	NURSING	SALARY AND	PROGRAM	EDUCATION		STEPDOWN		
		SERVICE	ANESTHETISTS	PROGRAM	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	ADJUSTMENTS	TOTAL	4
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	_
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catheterization										59
	Laboratory										60
	PBP Clinical Laboratory Service-Program Only										61
	Whole Blood & Packed Red Blood Cells										62
	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	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
	Clinic										90
91	Emergency										91
	Observation Beds										92
93	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 (Cont.)	`
	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	OTHER REIMBURSABLE COST CENTERS										
	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
108	Lung Acquisition										108
109	Pancreas Acquisition										109
	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	Total (sum of line 118 and lines 190 through 201)										202
	Total Statistical Basis										203
	Unit Cost Multiplier										204

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4090 ((Cont.)	FC	DRM CMS-2552		12-22				
COMPU	UTATION OF PROGRAM INPATIENT ROUTINE SERVICE					PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
	AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						FROM	PART II	
							ТО	-	
Check	[] Title V							_1	
applicable									
box:	Title XIX								
DOX.	Thic AIA	Capital Cost		Reduced			Т	T	
		for Extraordinary		Capital Cost					
								T (1 + T)	
		Circumstances	a : p :	for Extraordinary	m . 1	n n		Inpatient Program	
	G (G) B (1)	(from Wkst. L-1,	Swing Bed	Circumstances	Total	Per Diem	Inpatient	Capital Cost	
	Cost Center Description	Part I, col. 26)	Adjustment	(col. 1 - col. 2)	Patient Days	(col. 3 ÷ col. 4)	Program Days	(col. 5 x col. 6)	
(A)		l	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE						A		
	COST CENTERS								
20	Little a Dativity (G. L. L. David G. A.)								20
30	Adults & Pediatrics (General Routine Care)						_	-	30
2.1	The state of the s								2.1
31	Intensive Care Unit						_	-	31
22	Commence Com Hait								32
32	Coronary Care Unit						+	+	32
22	Burn Intensive Care Unit								33
- 33	Built intensive Care Unit							+	33
2.4	Surgical Intensive Care Unit								34
- 34	Surgical intensive Care Onit							+	34
25	Other Special Care Unit (specify)								35
33	Other Special Care Othic (specify)						+	+	33
40	Subprovider IPF								40
40	Subprovider if F						+	+	40
41	Subprovider IRF								41
41	Subprovider IKF						+	+	41
42	Subprovider (Other)								42
72	Duopioriusi (Ollisi)						+	+	72
43	Nursery								43
- 73	- Trainery						+	+	13
200	Total (sum of lines 30-199)						A .		200

⁽A) Worksheet A line numbers

02 2 .					1 01011 01110 2002	10				1070	(Com.
		F PROGRAM INPATIENT ANCILLA						PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
CAPITAL	L COSTS F	FOR EXTRAORDINARY CIRCUMST	TANCES						FROM	PART III	
								COMPONENT CCN:	ТО	-	
er 1		C1 77 2-1	1	itle V							
Check		[] Hospital		itle V itle XVIII, Part A							
applicable				itle XIX							
boxes:				itle XIX		Conital Contifor	T	T	1	т —	_
						Capital Cost for Extraordinary				D	
						Circumstances	Total Charges	Ratio of Cost		Program Extraordinary	
	C4 C4	r Description				(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
	Cost Center	Description				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)						1	2	(coi. 1 ÷ coi. 2)	A Frogram Charges	(coi. 5 x coi. 4)	-
	ANCILLAR	RY SERVICE COST CENTERS				1		,	4		-
	Operating I										50
	Recovery R										51
52	Labor Rooi	m and Delivery Room									52
53	Anesthesio	ology									53
54	Radiology-	-Diagnostic									54
		-Therapeutic									55
	Radioisotop										56
		Tomography (CT) Scan									57
		Resonance Imaging (MRI)									58
		atheterization									59
	Laboratory										60
		cal Laboratory Service-Program Only									61
		ood & Packed Red Blood Cells								<u> </u>	62
		ring, Processing, & Trans.									63
	Intravenous									<u> </u>	64
	Respiratory										65
	Physical Th										66
		nal Therapy									67
	Speech Pati Electrocard									 	68
		ephalography					<u> </u>			+	70
		applies Charged to Patients					<u> </u>			+	71
		e Devices Charged to Patients								+	72
		rged to Patients								 	73
	Renal Dialy									+	74
		-Distinct Part)					 	+		 	75
		illary (specify)								† 	76
		Stem Cell Acquisition						1		† 	77

⁽A) Worksheet A line numbers

4070 (Cont	•)		V13-2332-10					02-2-	
		TIENT ANCILLARY SERVICE ARY CIRCUMSTANCES				PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART III (CONT.)	
						COMPONENT CCN:	то		
Check applicable boxes:	[] Hospital	[] Title V [] Title XVIII, Part A [] Title XIX				•			
	enter Description			Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)	
(A)	ATIENT SERVICE COS	T CENTEDS		1	2	3	4	3	_
	Health Clinic (RHC)	31 CENTERS							88
	ally Qualified Health Cent	on (FOLIC)		+				 	89
90 Clinic		er (FQHC)		+				 	90
91 Emerg								 	91
	vation Beds							 	92
	Outpatient (specify)							+	93
	Hospitalization Program							+	93.99
	R REIMBURSABLE CO								75.77
	Program Dialysis	STOERTERS							94
	lance Services								95
	le Medical Equipment-Re	ented							96
	le Medical Equipment-Sol								97
	Reimbursable (specify)							1	98
	(sum of lines 50 through 1	199)						1	200

⁽A) Worksheet A line numbers

ANALY	SIS OF HOSPITAL	-BASED RHC/FQHC COSTS						PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET M-1	
Check a	pplicable box:	[] Hospital-based RHC	[] Hospital-based FQHC								
Check a	ppineasie sox.	Trospina based Arre	[] Hospini ouseu i Qile	COMPEN- SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	FACILITY HEALT	TH CARE STAFF COSTS		1	2	3	4	5	6		
1	Physician	III CARE STATT COSTS									1
	Physician Assistant	1								 	2
	Nurse Practitioner										3
	Visiting Nurse										4
	Other Nurse										5
	Clinical Psychologi	ist									6
	Clinical Social Wo									1	7
	Marriage and Fami									1	7.10
7.11	Mental Health Cou	nselor									7.11
8	Laboratory Technic	cian								1	8
9	Other Facility Heal	th Care Staff Costs									9
10	Subtotal (sum of lir	nes 1-9)									10
	COSTS UNDER A	GREEMENT									
	Physician Services										11
		ion Under Agreement									12
13	Other Costs Under	Agreement									13
	Subtotal (sum of lin										14
	OTHER HEALTH	CARE COSTS									
	Medical Supplies										15
	Transportation (He										16
	Depreciation-Medi										17
	Professional Liabili									<u> </u>	18
	Other Health Care										19
	Allowable GME Co										20
	Subtotal (sum of lir									Ļ	21
22	Total Cost of Healt										22
	(sum of lines 10, 14										
		HAN RHC/FQHC SERVICES									- 22
	Pharmacy Dental									 	23 24
	Optometry				+	<u> </u>		+	 	 	25
	Telehealth			_	-			+	 	 	25.01
25.02	Chronic Care Mana	agament							 		25.02
	All other nonreimb	U .			 				 		25.02
	Nonallowable GMI										27
		able Costs (sum of lines 23-27)									28
20	FACILITY OVER										20
29	Facility Costs	ши									29
	Administrative Cos	ats			+				 	 	30
		head (sum of lines 29 and 30)		+	†			1	 	 	31
					1	1	1	1			+ ===

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.

ALLOC	ATION OF OVERHEAD SPTIAL-BASED RHC/FQHC SERVICES		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET M-2	-	
				COMI ONEMI CCIV.			
Check a	pplicable box: [] Hospital-based RHC [] H	ospital-based FQHC		•	•	•	
VISITS	AND PRODUCTIVITY						
		Number			Minimum	Greater of	
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
		Personnel	Visits	Standard (1)	x col. 3)	col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1 through 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
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
	MINATION OF ALLOWABLE COST APPLICABLE TO I		RHC/FQHC SERVIC	CES			
	Total costs of health care services (from Worksheet M-1, co	- , ,					10
11	Total nonreimbursable costs (from Worksheet M-1, column						11
12	Cost of all services (excluding overhead) (sum of lines 10 a						12
13	Ratio of hospital-based RHC/FQHC services (line 10 divide	• /					13
14	Total hospital-based RHC/FQHC overhead (from Workshe		: 31)				14
15	Parent provider overhead allocated to facility (see instruction	ons)					15
16	Total overhead (sum of lines 14 and 15)						16
17	Allowable Direct GME overhead (see instructions)						17
18	Enter the amount from line 16						18
19	Overhead applicable to hospital-based RHC/FQHC services						19
20	Total allowable cost of hospital-based RHC/FQHC services	(sum of lines 10 and	19)				20

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

12-24	FORM CMS-2552	-10		4090	(Cont.)
	LATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET M-3	(Cont.)
	MENT FOR HOSPITAL-BASED RHC/FOHC SERVICES	I KO VIDEK CCN.		WORKSHEET W-5	
SETTEL	WENT FOR HOST HAL-BASED RIC/TQUE SERVICES	COMPONENT CCN:	FROM		
		COMI ONENI CCN.			
Check	[] Hospital-based RHC [] Title V		II.		
applicab	le [] Hospital-based FQHC [] Title XVIII				
boxes:	Title XIX				
DETER	MINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1	Total allowable cost of hospital-based RHC/FQHC services (from Worksheet M-2, line 20)				1
2	Cost of injections/infusions and their administration (from Worksheet M-4, line 15)				2
3	Total allowable cost excluding injections/infusions (line 1 minus line 2)				3
4	Total visits (from Worksheet M-2, column 5, line 8)				4
5	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)				5
6	Total adjusted visits (line 4 plus line 5)				6
7	Adjusted cost per visit (line 3 divided by line 6)				7
			Calculation of Limit (1)	
		Payment Limit	Payment Limit	Payment Limit	
		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	Not program out avaluating injustions/infusions (see instructions)				20

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
		Program IOP Visits	Program IOP Costs		
		1	2		
21.55	Total program IOP visits and costs (see instructions)				21.55
21.60	Program IOP deductible and 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.

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	TATION OF HOSPITAL-BASED RHC/FQHC VAC	CCINE		ICIVI CIVID-2332-10	PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-4	12-24
					COMPONENT CCN:	то		
Check applicab boxes:	[] Hospital-based RHC [] Hospital-based FQHC] Title V] Title XVIII] Title XIX					
ooxes.		1 .		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
- 1	health care staff time Injection/infusion health care staff cost (line 1 x line	2)						3
3	Injections/infusion neatth care staff cost (line 1 x line Injections/infusions and related medical supplies cost				<u> </u>			4
4	(from your records)	ıs						4
5	Direct cost of injections/infusions (line 3 plus line 4)							5
6	Total direct cost of the hospital-based RHC/FQHC (from						6
Ü	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							8
	cost (line 5 divided by line 6)							
9	Overhead cost - injection/infusion (line 7 x line 8)							9
10	Total injection/infusion costs and their							10
	administration costs (sum of lines 5 and 9)							
11	Total number of injections/infusions							11
	(from your records)							
12	Cost per injection/infusion (line 10/line 11)							12
13	Number of injection/infusion administered							13
13.01	to Program beneficiaries 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 admin	ictratio	n					14
11	costs (line 12 times the sum of lines 13 and 13.01, as							1
	,	FF	,		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION		•	•
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and (transfer this amount to Worksheet M-3, line 2)	2.02, 1	ine 10)					15
16	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and (transfer this amount to Worksheet M-3, line 21)	2.02, 1	ine 14)					16

02-24	FORM	CIVIS-2332-10		4090	(Cont.)		
	SIS OF PAYMENTS TO HOSPITAL-BASED HC FOR SERVICES RENDERED	PROVIDER CO	CN: PERIOD: FROM	WORKSHEET M-5			
TO PROC	GRAM BENEFICIARIES	COMPONENT	CCN: TO	-			
Check an	plicable box: [] Hospital-based RHC [] Hospital-based FQF	IC					
Circuit up	Troopius cused rate Troopius cused 1 V.		Part B				
	DESCRIPTION		1	2			
			mm/did/ivy	Amount			
	Total interim payments paid to hospital-based RHC/FQHC				1		
	Interim payments payable on individual bills, either				2		
	submitted or to be submitted to the intermediary, for						
	services rendered in the cost reporting periods. If						
	none, write "NONE", or enter zero.		Los				
	List separately each retroactive	l.,	.01		3.01		
	lump sum adjustment amount	Program	.02		3.02		
	based on subsequent revision of	to	.03		3.03		
	the interim rate for the	Provider	.04		3.04		
	cost reporting period. Also show		.05		3.05		
	date of each payment.	L	.50		3.50		
	If none, write "NONE",	Provider	.51		3.51		
'	or enter zero ⁽¹⁾ .	to	.52		3.52		
		Program	.53		3.53		
			.54		3.54		
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		3.99		
	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)				4		
	, ,						
	TO BE COMPLETED BY CONTRACTOR						
	List separately each tentative	Program	.01		5.01		
	settlement payment after desk review.	to	.02		5.02		
	Also show date of each payment.	Provider	.03		5.03		
	If none, write "NONE,"	Provider	.50		5.50		
	or enter zero (1).	to	.51		5.51		
		Program	.52		5.52		
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		5.99		
-	Determine net settlement amount	Program					
	(balance due) based on the cost	to					
	report (see instructions). (1)	Provider	.01		6.01		
		Provider					
		to					
		Program	.02		6.02		
	Total Medicare liability (see instructions)				7		
8	Name of Contractor		Contractor Number	NPR Date	8		
J				(Month/Day/Year)			
					ı		

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

FOR HOSPITAL-BASED FQHC						PROVIDER CCN: COMPONENT CCN:	PERIOD: WORKSHEET N-1 FROM: TO:		
COST CENTER DESCRIPTIONS (omit cents)		SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
GENIED	AL SERVICE COST CENTERS	1	2	3	4	5	6	/	-
	Cap Rel Costs-Bldg and Fix								+
2	Cap Rel Costs-Myble Equip							 	2
3	Employee Benefits								3
	Administrative and General								4
	Plant Operation and Maintenance								5
6	Janitorial								6
7	Medical Records								7
- 8	Subtotal - Administrative Overhead								8
9	Pharmacy								9
10	Medical Supplies								10
11	Transportation								11
	Other General Service								12
13	Subtotal - Total Overhead								13
	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
	Clinical Psychologist								30
	Clinical Social Worker								31
	Marriage and Family Therapist								31.10
	Mental Health Counselor								31.11
	Laboratory Technician								32
	Reg Dietician/Cert DSMT/MNT Educator								33
	Physical Therapist								34
	Occupational Therapist								35
	Other Allied Health Personnel								36
37	Subtotal - Direct Patient Care Services								37

RECLASSIFICATION AND ADJUSTMENT OF T FOR HOSPITAL-BASED FQHC	CLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES R HOSPITAL-BASED FQHC						PERIOD: FROM: TO:	WORKSHEET N-1	
COST CENTER DESCRIPTIONS (omit cents)		SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
REIMBURSABLE PASS THROUGH COSTS		1	2	3	4	3	6	/	
47 Pneumococcal Vaccines & Med Supplies									47
48 Influenza Vaccines & Med Supplies									48
48.10 COVID-19 Vaccine & Med Supplies						+			48.10
48.11 Monoclonal Antibody Products									48.11
49 Subtotal - Reimbursable Pass through Cost	's								49
OTHER FQHC SERVICES	-								-
60 Medicare Excluded Services									60
61 Diagnostic & Screening Lab Tests									61
62 Radiology - Diagnostic									62
63 Prosthetic Devices									63
64 Durable Medical Equipment									64
65 Ambulance Services									65
66 Telehealth									66
67 Drugs Charged to Patients									67
68 Chronic Care Management									68
69 Other									69
70 Subtotal - Other FQHC Services									70
NONREIMBURSABLE COST CENTERS									
77 Retail Pharmacy									77
78 Other Nonreimbursable									78
79 Subtotal - Non-Reimbursable Costs									79
100 TOTAL (sum of lines 13, 37, 49, 70, and 7	79)								100

4090 (Cont.)										02-24
CALCULATION OF HOSPITAL-BASED FQHC CO	OST PER VISIT						PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET N-2	
			T = 134 E 1	Lot ping						ı
	Wkst. N-1, col. 7,	Direct Cost by Practitioner from Wkst. N-1	Total Medical, Mental Health, & IOP Visits by Practitioner	Other Direct Care Costs & Pharmacy Costs (see instructions)	General Service Cost (see instructions)	Total Costs by Practitioner	Average Cost Per Visit by Practitioner			
Positions	line:	1	2	3	4	5	6			
1 Physician	23									1
2 Physician Services Under Agreement	24									2
3 Physician Assistant	25									3
4 Nurse Practitioner	26								_	4

12 Unit Cost Multiplier	11	Totals										11
Total Visits Mental Health Medical Visits by Practitioner Positions Position	12	Unit Cost Multiplier										12
Medical Visits Medical Visits by Practitioner by Practitio	13	Total Cost Per Visit										13
Medical Visits Medical Visits by Practitioner by Practitio												
Medical Visits by Practitioner Positions Posit				Total V	isits		Title XV	III Visits		Title XVIII Co	sts	
Positions				Mental H	lealth		Mental	Health		Mental Healt	h	
Positions 7 8 8.01 9 10 10.01 11 12 12.01			Medical Vis	sits (Non IOP)	Visits IOP V	isits Medical	Visits (Non IO	P) Visits IOP	Visits Medica	l Visits (Non IOP) Vis	its IOP Visits	
1 Physician 1 2 Physician Services Under Agreement 2 3 Physician Assistant 3 4 Nurse Practitioner 3 5 Visiting Registered Nurse 4 5 Visiting Licensed Practical Nurse 5 6 Visiting Licensed Practical Nurse 6 7 Certified Nurse Midwife 7 8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9 9.11 Mental Health Counselor 9.10 10 Reg Dictician/Cert DSMT/MNT Educator 9.11 11 Totals 11			by Practition	ner by Practit	tioner by Pract	itioner by Pract	tioner by Prac	titioner by Pra	ctitioner by Prac	titioner by Practitione	r by Practitioner	
2 Physician Services Under Agreement 2 3 Physician Assistant 3 4 Nurse Practitioner 4 5 Visiting Registered Nurse 5 6 Visiting Licensed Practical Nurse 6 7 Certified Nurse Midwife 7 8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11		Positions	7	8	8.0	1 9	1	0 10	0.01	1 12	12.01	
3 Physician Assistant 3 3 4 Nurse Practitioner 4 5 Visiting Registered Nurse 5 6 Visiting Licensed Practical Nurse 5 6 Visiting Licensed Practical Nurse 6 6 6 6 7 7 7 8 Clinical Psychologist 7 8 Clinical Psychologist 8 8 9 Clinical Social Worker 9 9 9 9 9 9 9 9 10 Marriage and Family Therapist 9 9 9 9 11 Mental Health Counselor 9 9 11 11 10 10 10 10	1	Physician										1
4 Nurse Practitioner 4 5 Visiting Registered Nurse 5 6 Visiting Licensed Practical Nurse 6 7 Certified Nurse Midwife 7 8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dictician/Cert DSMT/MNT Educator 10 11 Totals 11	2	Physician Services Under Agreement										2
5 Visiting Registered Nurse 5 6 Visiting Licensed Practical Nurse 6 7 Certified Nurse Midwife 7 8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11	3	Physician Assistant										3
6 Visiting Licensed Practical Nurse 7 Certified Nurse Midwife 8 Clinical Psychologist 9 Clinical Social Worker 9.10 Marriage and Family Therapist 9.11 Mental Health Counselor 10 Reg Dietician/Cert DSMT/MNT Educator 11 Totals 1 Totals	4	Nurse Practitioner										4
7 Certified Nurse Midwife 7 8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.10 10 Reg Dictician/Cert DSMT/MNT Educator 10 11 Totals 11												5
8 Clinical Psychologist 8 9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11	6	Visiting Licensed Practical Nurse										6
9 Clinical Social Worker 9 9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11	7	Certified Nurse Midwife										7
9.10 Marriage and Family Therapist 9.10 9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11												8
9.11 Mental Health Counselor 9.11 10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11	9	Clinical Social Worker										9
10 Reg Dietician/Cert DSMT/MNT Educator 10 11 Totals 11	9.10	Marriage and Family Therapist										9.10
11 Totals 11												9.11
	10	Reg Dietician/Cert DSMT/MNT Educator		·								10
12 Unit Cost Multiplier 12	11											
	12	Unit Cost Multiplier										12

27

28

29

30

31

31.10

31.11

33

Visiting Registered Nurse Visiting Licensed Practical Nurse

Certified Nurse Midwife

Clinical Psychologist

Clinical Social Worker

9.11 Mental Health Counselor

13 Total Cost Per Visit

11 Totals

Marriage and Family Therapist

10 Reg Dietician/Cert DSMT/MNT Educator

9.10

9.11

10 11

02-24	FOR	FORM CMS-2552-10 409							
COMPL	TATION OF HOSPITAL-BASED FQHC VACCINE COST		PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-3	`			
			COMPONENT CCN:	TO:	-				
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS				
		1	2	2.01	2.02	1			
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)					1			
2	Ratio of injection/infusion staff time to total health care staff time					2			
3	Injection/infusion health care staff cost (line 1 x line 2)					3			
4	Injections/infusions and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, 48.10, and 48.11, respectively)					4			
5	Direct cost of injections/infusions (line 3 + line 4)					5			
6	Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8)					6			
7	Total administrative overhead (from Worksheet N-1, column 7, line 8)					7			
- 8	Ratio of injection/infusion direct cost to total direct					8			
	cost (line 5 / line 6)								
9	Overhead cost - injections/infusions (line 7 x line 8)					9			
10	Total cost of injections/infusions and their administration (sum of lines 5 and 9)					10			
11) () /					11			
	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			

4090 (Cont.)	FURIN CMS-2	FORM CMS-2552-10						
CALCULATION OF HOS	PITAL-BASED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET N-4				
1 FOUC DDS amou	nt (see instructions)	•						
`	njections/infusions and administration (From Worksheet N-3, line 16)				2			
	ge supplemental payments (for information only)				7			
4 Total (sum of line								
5 Primary payer pay	,							
	able for program beneficiaries (line 4 minus line 5)							
1.7	d to program beneficiaries				1			
	nbursement excluding bad debts (line 6 minus line 7)							
	bts (see instructions)							
10 Adjusted reimburg	sable bad debts (see instructions)				10			
11 Allowable bad de	bts for dual eligible beneficiaries (see instructions)				1			
12 Subtotal (line 8 pl	us line 10)				12			
13 Other adjustments	(specify) (see instructions)				1.			
13.99 Demonstration pa	yment adjustment amount before sequestration				13.9			
14 Amount due hosp	ital-based FQHC prior to the sequestration adjustment (see instructions)				14			
15 Sequestration adjusted	astment (see instructions)				15			
15.25 Sequestration for	non-claims based amounts (see instructions)				15.25			
	ital-based FQHC after sequestration adjustment (see instructions)				10			
	yment adjustment amount after sequestration				16.0			
	(from Worksheet N-5, col. 2, line 4)				17			
	ent (for contractor use only)				18			
	ital-based FQHC/program (line 16 minus lines 16.01, 17 and 18)				19			
20 Protested amounts	s (nonallowable cost report items) in accordance with CMS Pub. 15-2, chap	pter 1, §115.2			20			

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR	SERVICES RENDERED	PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-5	
		COMPONENT CO		_	
				Part B	
			mm/dd/yyy	y Amount	
Description			1	2	
1 Total interim payments paid to hospital-based FQHC					1
2 Interim payments payable on individual bills, either submitt for services rendered in the cost reporting period. If none, v		r			2
3 List separately each retroactive			.01		3.01
lump sum adjustment amount based			.02		3.02
on subsequent revision of the		ram to	.03		3.03
interim rate for the cost reporting period.	Prov	der	.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
	Prov	der to	.52		3.52
	Prog	ram	.53		3.53
			.54		3.54
Subtotal (sum of lines 3.01 through 3.49 minus sum of lines	s 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		am to	.01		5.01
payment after desk review. Also show	Prov	der	.02		5.02
date of each payment.			.03		5.03
If none, write "NONE" or enter a zero. (1)			.50		5.5
	Prov	der to	.51		5.51
	Prog	ram	.52		5.52
Subtotal (sum of lines 5.01 through 5.49 minus sum of lines			.99		5.99
6 Determine net settlement amount (balance		am to provider	.01		6.01
due) based on the cost report (1)	Prov	der to program	.02		6.02
7 Total Medicare program liability (see instructions)	·				7

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

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

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

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

ANALY	ALYSIS OF HOSPITAL-BASED HOSPICE COSTS						PERIOD: FROM TO	WORKSHEET O	
		SALARIES 1	OTHER 2	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	
DIRECT	PATIENT CARE SERVICE COST CENTERS (Cont.)	1		J	7	J	0	/	\vdash
	Imaging Services**								40
	Labs and Diagnostics**								41
	Medical Supplies-Non-routine**								42
	Drugs Charged to Patients**								42.50
	Outpatient Services**								43
	Palliative Radiation Therapy**								44
	Palliative Chemotherapy**								45
46	Other Patient Care Services**								46
NONRE	EIMBURSABLE COST CENTERS								
60	Bereavement Program *								60
61	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
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.

TU/U	Cont.)	1 '	OICIVI CIVID-2332-	10					05-10
	SIS OF HOSPITAL-BASED HOSPICE COSTS CE CONTINUOUS HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROMTO	WORKSHEET O-1	
		SALARIES	OTHER 2	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	
DIREC	F PATIENT CARE SERVICE COST CENTERS	1		,	7	,	•	,	
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
	LPN/LVN								29
	Physical Therapy								30
	Occupational Therapy								31
	Speech/ Language Pathology								32
	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
	Drugs Charged to Patients								42.50
	Outpatient Services							-	43
	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
	Other Patient Care Svc								46
100	Total *								100

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

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

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

	ALYSIS OF HOSPITAL-BASED HOSPICE COSTS SPICE INPATIENT RESPITE CARE						PERIOD: FROM TO	WORKSHEET O-3	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
	LPN/LVN								29
	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
	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
	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 E GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-4	
						HOSPICE CCN:	ТО		
		GAY A DYEG	OTTAND	SUBTOTAL (col. 1 plus	RECLASSI-	gypmon.y	ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	(col. 5 ± col. 6)	4
DIRECT	PATIENT CARE SERVICE COST CENTERS	1	2	3	4	5	6	7	_
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
	LPN/LVN								29
	Physical Therapy								30
31	Occupational Therapy								31
	Speech/ Language Pathology								32
	Medical Social Services								33
	Spiritual Counseling								34
	Dietary Counseling								35
	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
	Durable Medical Equipment/Oxygen								38
	Patient Transportation								39
	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
	Other Patient Care Svc								46
100	Total *								100

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

4090 ((Cont.) FORM (CMS-2552-10			10-18
COST A	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET EX	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	1
GENER	AL SERVICE COST CENTERS				
1					1
2	Cap Rel Costs-Myble Equip				2
3	Employee Benefits			1	3
4	<u> </u>	i		1	4
5	Plant Operation and Maintenance	i		1	5
6	Laundry & Linen Service	i		1	6
7	Housekeeping			1	7
- 8	Dietary			1	8
9	Nursing Administration			1	9
	Routine Medical Supplies			1	10
11	Medical Records			 	11
12					12
13	±				13
14					14
15	ž				15
16					16
17	Patient/Residential Care Services			 	17
	OF CARE				17
	Hospice Continuous Home Care				50
	Hospice Routine Home Care				51
	Hospice Inpatient Respite Care				52
	Hospice General Inpatient Care			-	53
	EIMBURSABLE COST CENTERS				33
	Bereavement Program				60
61	, and the second			-	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					69
70				 	70
71	Other Nonreimbursable				71
99	Negative Cost Center				99
	Total				100
100	10(a)			I	100

COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS									WORKSHEET OP PART I	WORKSHEET 0-6 PART I	
		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	
	Descriptions	0	1	2	3	3A	4	5	6	7	8	1
GENER	AL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
4	Administrative & General											4
	Plant Operation and Maintenance								7			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
	Other General Service										_	16
	Patient/Residential Care Services										_	17
	OF CARE											17
	Hospice Continuous Home Care											50
	Hospice Routine Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care										+	53
	EIMBURSABLE COST CENTERS											33
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows	- 									_	63
	Palliative Care Program										_	64
	Other Physician Services											65
	Residential Care	- 			1						+	66
	Advertising	- 			1						+	67
	Telehealth/Telemonitoring	- 			1							68
	Thrift Store	- 			1							69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center	- 			1						+	99
	Total				+						+	100
100	10141											100

COST	ALLOCATION - HOSPITAL-BASED HOSPIC	CE GENERAL SERVICE	COSTS				PROVIDER CCN:		PERIOD: FROMTO		WORKSHEET C PART I)-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	
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
	Laundry & Linen Service											6
7	Housekeeping											7
- 8	Dietary											8
9	Nursing Administration											9
	Routine Medical Supplies			1								10
	Medical Records											11
	Staff Transportation											12
	Volunteer Service Coordination						1					13
	Pharmacy							1				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											- 33
	Bereavement Program											60
	Volunteer Program					1	1					61
	Fundraising					1	1					62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program					1	1					64
	Other Physician Services					İ						65
	Residential Care					1	1					66
	Advertising					1	1					67
	Telehealth/Telemonitoring					1	1					68
	Thrift Store					1	1					69
	Nursing Facility Room & Board											70
	Other Nonreimbursable (specify)											71
	Negative Cost Center						 		1			99
	Total											100

COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SER	PROVIDER CCN:		PERIOD: FROMTO	WORKSHEET O-6 PART II						
		CAP REL BLDG & FIX (Square Feet)	CAP REL MVBLE EQUIP (Dollar Value)	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT (Square Feet)	LAUNDRY & LINEN (In-Facil- ity Days)	HOUSE- KEEPING (Square Feet)	OIETARY (In-Facility Days)	
C	Cost Center Descriptions	1	2	3	4A	4	5	fly Days)	7	8	-
	AL SERVICE COST CENTERS	•	2	J			J	Ů	,		
	Cap Rel Costs-Bldg & Fixt										1
	Cap Rel Costs-Myble Equip			-							2
3	Employee Benefits										3
4	Administrative & General										4
5	Plant Operation and Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping										7
8	Dietary										8
9	Nursing Administration										9
10	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation										12
13	Volunteer Service Coordination										13
14	Pharmacy										14
15	Physician Administrative Services										15
	Other General Service										16
	Patient/Residential Care Services										17
	OF CARE										
	Hospice Continuous Home Care										50
	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
	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
71	Other Nonreimbursable										71
	Negative Cost Center										99
	Cost to be allocated (per Wkst. O-6, Part I)										100
101	Unit cost multiplier										101

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS							PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM TO	_	WORKSHEET O-6 PART II		
		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		
C	ost Center Descriptions	9	10	11	12	13	14	15	16	17	18		
	AL SERVICE COST CENTERS												
1	Cap Rel Costs-Bldg & Fixt											1	
	Cap Rel Costs-Mvble Equip	1										2	
3	Employee Benefits	1										3	
4	Administrative & General	1										4	
5	Plant Operation and Maintenance	1										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	
	Pharmacy											14	
15	Physician Administrative Services											15	
16	Other General Service											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	
66	Residential Care											66	
67												67	
68												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											101	

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

	Wkst. C,	Cost to	C	harges by LOC (fr	om Provider Recor	ds)	Shared Service Costs by LOC				
	Pt. I, col. 9,	Charge					HCHC	HRHC	HIRC	HGIP	1
	line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	66										I
2 Occupational Therapy	67										T
3 Speech/ Language Pathology	68										П
4 Drugs, Biological and Infusion Therapy	73										П
5 Durable Medical Equipment/Oxygen	96										П
6 Labs and Diagnostics	60										٦
7 Medical Supplies	71										П
8 Outpatient Services (including E/R Dept.)	93										ī
9 Radiation Therapy	55										
10 Other	76										
11 Totals (sum of lines 1 through 10)											П

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