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

FORM APPROVED
OMB NO. 0938-0463

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT	PROVIDER NO. ______	PERIOD: FROM ______ TO ______	WORKSHEET S PARTS I & II

Intermediary use only:	[ ] Audited [ ] Desk Reviewed	Date Received ______ Intermediary No. ______	[ ] Intial [ ] Re-opened [ ] Final

PART I - CERTIFICATION

Check applicable box	[ ] Electronic filed cost report [ ] Manually submitted cost report	Date:______ Time:______

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

(Signed)______________________________ ______________________________
Officer or Administrator of Provider(s) Title

____
Date

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1.	SKILLED NURSING FACILITY					1.
2.						2
3.	NURSING FACILITY					3
3.1	I C F / M R					3.1
4.	SNF - BASED H H A					4
5.	SNF - BASED OUTPATIENT REHABILITATION PROVIDERS					5
6.	SNF - BASED RHC / FQHC					6
7.	TOTAL					7

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated.
(Indicate Overpayments in Brackets.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated to average 64 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2540-96 (7/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3506 THROUGH 3506.2)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY COMPLEX IDENTIFICATION DATA	PROVIDER NO.:	PERIOD FROM____________ TO______________	WORKSHEET S - 2

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	P.O Box:			1
2	City:	State:		Zip Code:	2
3	County:	MSA Code:		Urban / Rural:	3
3.1	Facility Specific Rate:		Transition Period - enter 1, 2, 3 or 100		3.1
3.2	Wage Index Adjustment Factor: Before October 1		After Sept 30		3.2

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider No.	Date Certified	Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
4	S N F							4
5								5
6	Nursing Facility							6
6.1	I C F / M R							6.1
7	SNF-Based O.L.T.C.							7
8	SNF-Based H.H.A.							8
9								9
10	SNF-Based Outpatient Rehabilitation Providers							10
11	SNF-Based R.H.C.							11
12	SNF-Based HOSPICE							12

13	Cost Reporting Period (mm/dd/yyyy)	From:	To:	13
14	Type of Control (See Instructions)			14

	Type of Freestanding Skilled Nursing Facility			Y / N	
15	Is this an Entirely Participating Skilled Nursing Facility?				15
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I line 1 column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care andrelated expenses for each category. (See instructions)				
15.01	Staffing				15.01
15.02	Recruitment				15.02
15.03	Retention of employees				15.03
15.04	Training				15.04
15.05	Other (Specify)				15.05
16	Is this a Partially Participating Skilled Nursing Facility?				16
17	Is this Skilled Nursing Facility Unit of a Domiciliary Institution?				17
18	Is this Skilled Nursing Facility Unit of a Rehabilitation Center?				18
19	Other (Specify)				19

Miscellaneous Cost Reporting information

20	If this is a low or no Medicare utilization cost report, enter "L" for Low Medicare Utilization, or "N" for No Medicare Utilization.			20
21	If this is an All-Inclusive Provider, enter the method used. (See Instruction)			21
22	Is the difference between total interim payments and the net cost covered service included in the balance sheet?			22

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY COMPLEX IDENTIFICATION DATA	PROVIDER NO.:	PERIOD FROM_____ TO_____	WORKSHEET S - 2 (Continued)

Depreciation Enter the amount of depreciation reported in this SNF for the method indicated.

Line	Description				Line
23	Straight Line				23
24	Declining Balance				24
25	Sum of the Year's Digits				25
26	Sum of line 23 thru 25				26
27	If depreciation is funded, enter the balance as of the end of the period.				27
28	Were there any disposal of capital assets during the cost reporting period? (Y/N)				28
29	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)				29
30	Was accelerated depreciation claimed on assets acquire on or after August 1, 1970 (1) (Y/N)				30
31	Did you cease to participate in the Medicare program at end of the period to which this cost report applies (1)				31
32	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports (1)				32

If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges enter "Y" for each component and type of service that qualifies for the exemption.

Line	Component	Part A	Part B	Other	Line
33	Skilled Nursing Facility				33
34					34
35	Nursing Facility				35
35.1	I C F / M R				35.1
36	SNF-Based O.L.T.C.				36
37	SNF-Based H.H.A.				37
38					38
39	SNF-Based Outpatient Rehabilitation Providers				39
40	SNF-Based R.H.C.				40

Line	Description				Line
41	Is this Skilled Nursing Facility exempt from the cost limits?				41
42	Is this Nursing Facility exempt from the cost limits?				42
43	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for titles V and XIX patients.				43
44	Did the provider participate in the NHCMQ Demonstration during the cost reporting period? (See instructions) If yes, enter Phase #				44
45	List malpractice premiums and paid losses:	Premiums	Paid Losses	Self insurance	45
46	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts				46
47	Are you claiming ambulance costs? Enter Y or N in column 1. If column 1 is Y, enter in column 2 whether this is your first year of operation for rendering ambulance services.				47
48	If line 47, column 1 is yes, enter in column 1 the payment limit provided from your intermediary. If your fiscal year is OTHER than a year beginning on October 1st, enter in column 1 the payment limit for the period prior to October 1, and enter in column 2 the payment limit for the period beginning October 1. NOTE: Ifline 47, column 2 is yes, no entry is required on line 48 (column 1 or 2).				48
49	Did you operate an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under title XIX?				49
50	Did this facility report less than 1500 Medicare days in its pevious year's cost report? (See instructions.)				50
51	If line 50 is yes, did you file your previous years cost report using the "Simplified" step-down method of cost finding? See instructions for qualifications to use the simplified step-down method before answering line 52.				51
52	Is this cost report being filed under 42 CFR 413.321, the "simplified" cost report? Enter "Y" for yes or "N" for no.				52

CMS PUB, 15-II, SECTION 3508)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA | **PROVIDER NO.:** | **PERIOD FROM____ ____** | **WORKSHEET S-3 PART I**

	Component	Number of Beds	Bed Days Available	Inpatient Days					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Facility													1
2														2
3	Nursing Facility													3
3.1	ICF/MR													3.1
4	Other Long Term Care													4
5	Home Health Agency													5
6														6
7	SNF-Based Outpatient Rehabilitation Providers													7
8	Hospice													8
9	Total (Sum of lines 1-8)													9
10	Ambulance Trips													10

		Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2													2
3	Nursing Facility												3
3.1	ICF/MR												3.1
4	Other Long Term Care Facility												4
5	Home Health Agency												5
6													6
7	SNF-Based Outpatient Rehabilitation Providers												7
8	Hospice												8
9	Total (Sum of lines 1-8)												9
10	Ambulance trips												10

FORM CMS 2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3509)

SNF WAGE INDEX INFORMATION	PROVIDER NO.: ____________	PERIOD: FROM __________ TO ____________	WORKSHEET S-3 PARTS II & III

PART II DIRECT SALARIES		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		1	2	3	4	5	6	
1	Total salary (See Instructions)							1
2	Physician salaries-Part A							2
3	Physician salaries-Part B							3
4	Interns & Residents (approved)							4
5	Home office personnel							5
6	Sum of lines 2 thru 5							6
7	Revised wages (line 1 minus line 6)							7
8	Other Long Term Care							8
9	Other Inpatient Routine Service							9
10	Interns & Residents (Not In Approved Program)							10
11	HHA							11
12	Outpatient Rehabilitation Providers							12
13	Hospice							13
14	Non-reimbursable							14
15	Total Excluded salary (Sum of lines 8 through 14)							15
16	Subtotal (line 7 minus line 15)							16
17	Contract Labor: Patient Related & Mgmt						CMS 339	17
18	Home office salaries & wage related costs							18
19	Wage related costs (core)						CMS 339	19
20	Wage related costs (other)						CMS 339	20
21	Wage related costs (excluded units)						CMS 339	21
22	Subtotal (see instructions)							22
23	Total (see instructions)							23
24	Contract Labor: Physician services-Part A							24

PART III - OVERHEAD COST - DIRECT SALARIES

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

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3509.1 - 3509.2)

SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO.: ___________
HHA NO.: ___________

PERIOD:
FROM ____________
TO ______________

WORKSHEET S-4
PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - HOME HEALTH AGENCY VISITS

	DESCRIPTION	Program			Non-Program Data			Total			
		Hours	Visits	Patients	Hours	Visits	Patients	Hours	Visits	Patients	
		1	2	3	4	5	6	7	8	9	
1	Skilled Nursing										1
2	Physical Therapy										2
3	Occupational Therapy										3
4	Speech Pathology										4
5	Medical Social Services										5
6	Home Health Aide										6
7	All Other Services										7
8	Total Visits (Sum of lines 1 - 7)										8
9	Unduplicated Census Count Full Cost Repoting Period										9
9.01	Unduplicated Census Count Pre 10/01/2000										9.01
9.02	Unduplicated Census Count Post 09/30/2000										9.02

PART II - EMPLOYMENT DATA

			HHA NO. OF FTE EMPLOYEES 2080 HRS		
			Staff	Contract	(Sum of Cols. 1+2)
	Enter the number of hours in your normal work week.		1	2	3
1	Nurses - RNs	(1)			
2	Nurses - LPN				
3	Nurses - LVN				
4	Physical Therapists				
5	Occupational Therapists				
6	Speech Pathologists				
7	Medical Social Workers				
8	Home Health Aides				
9	Homemaker				
10	Executive Administrative Personnel	(2)			
11	Financial Administrative Personnel	(3)			
12	General Administrative Personnel	(4)			
13	Other	(5)			
14					
15					

Footnotes:

1. This category includes all nurses, i.e., RNs, LPNs, LVNs. A nurse supervisor (if part of her time is spent performing visits) should be included in this category.
2. Includes administrators, assistant administrators, directors, assistant directors, and supervisors (if sole function is administrative).
3. Includes accountants, internal auditors, statisticians and other professional financial personnel.
4. Includes categories such as billing, payroll clerks, secretaries, telephone operators, personnel specialists, security personnel, maintenance staff, and other administrative employees.
5. All other employee classifications. These include, but are not limited to respiratory therapists, nutritionists, and any other employees not included in any of the other employee classifications.

16	How many MSAs did you provide services to during this cost reporting period.		16
17	List the MSA code(s) serviced during this cost reporting period (line 17 contains the first code). (Subscript this line for each MSA code being reported.)		17

FORM CMS - 2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3511 - 3511.2)

SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: ________ HHA NO.: ________	PERIOD: FROM ________ TO ________	WORKSHEET S-4 PART III

PART III PPS ACTIVITY DATA - Applicable for Services Rendered on and after October 1, 2000

	DESCRIPTION	Full Episodes		L U P A	P E P only	S C I C Within	S C I C Only		
		Without Outliers	With Outliers	Episodes	Episodes	a P E P	Episodes	Totals	
		1	2	3	4	5	6	7	
1	Skilled Nursing Visits								1
2	Skilled Nursing Visit Charges								2
3	Physical Therapy Visits								3
4	Physical Therapy Visit Charges								4
5	Occupational Therapy Visits								5
6	Occupational Therapy Visit Charges								6
7	Speech Pathology Visits								7
8	Speech Pathology Visit Charges								8
9	Medical Social Service Visits								9
10	Medical Social Service Visit Charges								10
11	Home Health Aide Visits								11
12	Home Health Aide Visit Charges								12
13	Total Visits (Sum of lines 1, 3, 5, 7, 9, & 11)								13
14	Other Charges								14
15	Total Charges (Sum of lines 2, 4, 6, 8, 10, 12 & 14)								15
16	Total Number of Episodes								16
17	Total Number of Outlier Episodes								17
18	Total Non-Routine Medical Supply Charges								18

FORM CMS - 2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3511 - 3511.3)

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER NO: ______ COMPONANT NO: ______	PERIOD: FROM______ TO______	WORKSHEET S - 5

Check applicable box: [ ] RHC [ ] FQHC

PART I - STATISTICAL DATA

1	Street:	County:		1
2	City: State:	Zip Code:		2
3	Designation (for FQHC's only) - Enter "R" for rural or "U" for urban			3
Source of Federal funds:		Grant Award	Date	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look - Alikes			8
9	Other (specify)			9
		Physician Name	Billing #	
10	Physician(s) furnishing services at the clinic or under agreement (See instructions)			10
		Physician Name	Hours	
11	Supervisory physician(s) and hours of supervision during period. (See instructions)			11
12	Does the facility operate as other than an RHC or FQHC? If yes, indicate the number of other operations in column 2.	1	2	
	List other type(s) of operation(s) and hours on subscripts of line 13 below. NOTE: line 13 (Clinic) is to be completed reguardless of the response to line 12.			12

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
13	Clinic															13
13.01																13.01
13.02																13.02
13.03																13.03

(1) List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

14	Have you received an approval for an exception to the productivity standard?			14
15	Is this a consolidated cost report in accordance with CMS Pub 27, section 508D. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers on subscripted lines below.			15
15.01	Provider Name	Provider Number		15.01
15.02	Provider Name	Provider Number		15.02
16	Have you provided all or substantially all GME cost. If yes, enter in column 2 the number of Medicare visits performed by I&R			16

FORM CMS-2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 3512)

SKILLED NURSING FACILITY BASED OUTPATIENT REHABILITATION STATISTICAL DATA	PROVIDER NO.: REHAB NO.: ________	PERIOD: FROM ____________ TO _______________	WORKSHEET S-6

Check Applicable Box: [ ] C.M.H.C. [ ] OPT [ ] OSP
[ ] C.O.R.F. [ ] OOT

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

	Employment Category: Enter the number of hours in your normal work week ( ).	Staff	Contract	Total	
		1	2	3	
1	Administrator and Assistant Administrators				1
2	Directors and Assistant Directors				2
3	Other Administrative Personnel				3
4	Directing 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	Psychological Service				16
17	Psychological Service Supervisor				17
18					18
19					19

FORM CMS - 2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3513)

NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA	PROVIDER NO.	PERIOD: FROM ____________ TO	WORKSHEET S-7 PART I

PART I - NHCMQ DEMONSTRATION STATISTICAL DATA

> > FOR COST REPORTING PERIODS BEGINNING PRIOR TO JULY 1, 1998 < <

	GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1ST (1)		SERVICES ON OR AFTER JANUARY 1ST (1)		TOTAL (See Instructions)	
			RATE	DAYS	RATE	DAYS		
	1	2	3	3.01	4	4.01	5	
1	RVC	9044						1
2	RVB	9043						2
3	RVA	9042						3
4	RHD	9041						4
5	RHC	9040						5
6	RHB	9039						6
7	RHA	9038						7
8	RMC	9037						8
9	RMB	9036						9
10	RMA	9035						10
11	RLB	9034						11
12	RLA	9033						12
13	SE3	9032						13
14	SE2	9031						14
15	SE1	9030						15
16	SSC	9029						16
17	SSB	9028						17
18	SSA	9027						18
19	CD2	9026						19
20	CD1	9025						20
21	CC2	9024						21
22	CC1	9023						22
23	CB2	9022						23
24	CB1	9021						24
25	CA2	9020						25
26	CA1	9019						26
27	IB2	9018						27
28	IB1	9017						28
29	IA2	9016						29
30	IA1	9015						30
31	BB2	9014						31
32	BB1	9013						32
33	BA2	9012						33
34	BA1	9011						34
35	PE2	9010						35
36	PE1	9009						36
37	PD2	9008						37
38	PD1	9007						38
39	PC2	9006						39
40	PC1	9005						40
41	PB2	9004						41
42	PB1	9003						42
43	PA2	9002						43
44	PA1	9001						44
45	Other Group	9000						45
46	TOTAL							46

(1) Calendar Year Providers: Complete columns 1, 2, 4, 4.01, and 5
Fiscal Year Providers - Rate change as of January 1st: Complete ALL columns.
Fiscal Year Providers - Rate DOES NOT change as of January 1st: Complete columns 1, 2, 3, 3.01, and 5.

FORM CMS-2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3514)

PPS STATISTICAL DATA	PROVIDER NO. ______________	PERIOD: FROM ___________ TO ______________	WORKSHEET S-7 PART III

TRANSITION PERIOD: [ ] YEAR # 1 [ ] YEAR # 2 [ ] YEAR # 3 [ ] YEAR # 4 - 100% Federal Case Mix Rate

	HIPPS CODE GROUP	FACILITY SPECIFIC RATE	SERVICES PRIOR TO 10/01		SERVICES AFTER 9/30		SUBTOTAL		YR 1: Col. 9 = Col. 7 X 25% Col. 10 = Col. 8 X 75% YR 2: Col. 9 = Col. 7 X 50% Col. 10 = Col. 8 X 50% YR 3: Col. 9 = Col. 7 X 75% Col. 10 = Col. 8 X 25%		
			FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX (Col. 3 X 4, PLUS Col . 5 X 6)	FACILITY SPECIFIC (Col. 4 + 6 X Col. 2)			
	1	2	3	4	5	6	7	8	9	10	
1	RUC										1
2	RUB										2
3	RUA										3
4	RVC										4
5	RVB										5
6	RVA										6
7	RHC										7
8	RHB										8
9	RHA										9
10	RMC										10
11	RMB										11
12	RMA										12
13	RLB										13
14	RLA										14
15	SE3										15
16	SE2										16
17	SE1										17
18	SSC										18
19	SSB										19
20	SSA										20
21	CC2										21
22	CC1										22

FORM CMS-2540-96 (12/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3514.3)

PPS STATISTICAL DATA	PROVIDER NO. ____________	PERIOD: FROM ____________ TO ____________	WORKSHEET S-7 PART III

TRANSITION PERIOD: [ ] YEAR # 1 [ ] YEAR # 2 [ ] YEAR # 3 [ ] YEAR # 4 - 100% Federal Case Mix Rate

	HIPPS CODE GROUP	FACILITY SPECIFIC RATE	SERVICES PRIOR TO 10/01		SERVICES AFTER 9/30		SUBTOTAL		YR 1: Col. 9 = Col. 7 X 25%, Col. 10 = Col. 8 X 75%; YR 2: Col. 9 = Col. 7 X 50%, Col. 10 = Col. 8 X 50%; YR 3: Col. 9 = Col. 7 X 75%, Col. 10 = Col. 8 X 25%		
			FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX RATE	DAYS	FEDERAL CASE MIX (Col. 3 X 4, PLUS Col . 5 X 6)	FACILITY SPECIFIC (Col. 4 + 6 X Col. 2)			
	1	2	3	4	5	6	7	8	9	10	
23	CB2										23
24	CB1										24
25	CA2										25
26	CA1										26
27	IB2										27
28	IB1										28
29	IA2										29
30	IA1										30
31	BB2										31
32	BB1										32
33	BA2										33
34	BA1										34
35	PE2										35
36	PE1										36
37	PD2										37
38	PD1										38
39	PC2										39
40	PC1										40
41	PB2										41
42	PB1										42
43	PA2										43
44	PA1										44
45	Default Rate										45
75	TOTAL										75

FORM CMS-2540-96 (12/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3514.3)

NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA	PROVIDER NO. ________	PERIOD: FROM ________ TO ________	WORKSHEET S-7 PART II

PART II - PPS STATISTICAL DATA

> > FOR COST REPORTING PERIODS BEGINNING ON AND AFTER JULY 1, 1998 < <

	GROUP	REVENUE CODE	MEDICARE DAYS	
	1	2	3	
1	RUC	9044		1
2	RUB	9043		2
3	RUA	9042		3
4	RVC	9041		4
5	RVB	9040		5
6	RVA	9039		6
7	RHC	9038		7
8	RHB	9037		8
9	RHA	9036		9
10	RMC	9035		10
11	RMB	9034		11
12	RMA	9033		12
13	RLB	9032		13
14	RLA	9031		14
15	SE3	9030		15
16	SE2	9029		16
17	SE1	9028		17
18	SSC	9027		18
19	SSB	9026		19
20	SSA	9025		20
21	CC2	9024		21
22	CC1	9023		22
23	CB2	9022		23
24	CB1	9021		24
25	CA2	9020		25
26	CA1	9019		26
27	IB2	9018		27
28	IB1	9017		28
29	IA2	9016		29
30	IA1	9015		30
31	BB2	9014		31
32	BB1	9013		32
33	BA2	9012		33
34	BA1	9011		34
35	PE2	9010		35
36	PE1	9009		36
37	PD2	9008		37
38	PD1	9007		38
39	PC2	9006		39
40	PC1	9005		40
41	PB2	9004		41
42	PB1	9003		42
43	PA2	9002		43
44	PA1	9001		44
45	Other Group	9000		45
46	TOTAL			46

FORM CMS-2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3514.2)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER NO.:	PERIOD: FROM: TO:	WORKSHEET S-7 PART IV

	GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO October 1 RATE	SERVICES PRIOR TO October 1 DAYS	SERVICES ON OR AFTER October 1 RATE	SERVICES ON OR AFTER October 1 DAYS	HIGH COST RUGs (2) DAYS	TOTAL (see instructions)	
	1	2	3	3.01	4	4.01	4.05	5	
1	RUC								1
2	RUB								2
3	RUA								3
4	RVC								4
5	RVB								5
6	RVA								6
7	RHC								7
8	RHB								8
9	RHA								9
10	RMC								10
11	RMB								11
12	RMA								12
13	RLB								13
14	RLA								14
15	SE3								15
16	SE2								16
17	SE1								17
18	SSC								18
19	SSB								19
20	SSA								20
21	CC2								21
22	CC1								22
23	CB2								23
24	CB1								24
25	CA2								25
26	CA1								26
27	IB2								27
28	IB1								28
29	IA2								29
30	IA1								30
31	BB2								31
32	BB1								32
33	BA2								33
34	BA1								34
35	PE2								35
36	PE1								36
37	PD2								37
38	PD1								38
39	PC2								39
40	PC1								40
41	PB2								41
42	PB1								42
43	PA2								43
44	PA1								44
45	Default rate								45
46	TOTAL								46

(1) The RUG III category represents the PPS period. Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on or after October 1st.

(2) Enter in column 4.05 those days which are contained in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000.
These RUGs receive a 20% payment increase added to the total in column 5.

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3508)

HOSPICE IDENTIFICATION DATA	PROVIDER NO.: HOSPICE NO.: ____________	PERIOD: FROM ____________ TO ______________	WORKSHEET S - 8

PART I

	Enrollment Days	Title XVIII Unduplicated Medicare Days	Title XIX Unduplicated Medicaid Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Title XIX Unduplicated Nursing Facility Days	Other Unduplicated Days	Total Unduplicated Days	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II

		Title XVIII	Title XIX	Title XVIII Skilled Nursing facility	Title XIX Nursing Facility	Other	Total	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay							8
9	Unduplicated Census Count							9

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER NO.: ________________

PERIOD: FROM ______________ TO ______________

WORKSHEET A

			COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)	
A	B	C	D	1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS											
1	0100	x	Captial-Related Costs - Building & Fixture								1
2	0200	x	Capital-Related Costs - Moveable Equipment								2
3	0300	x	Employee Benefits								3
4	0400	x	Administrative and General								4
5	0500	x	Plant Operation, Maintenance and Repairs								5
6	0600	x	Laundry and Linen Service								6
7	0700	x	Housekeeping								7
8	0800	x	Dietary								8
9	0900	x	Nursing Administration								9
10	1000		Central Services and Supply								10
11	1100		Pharmacy								11
12	1200		Medical Records and Library								12
13	1300		Social Service								13
14	1400		Intern & Residents (Apprvd Tchng Prog.)								14
15			Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS											
16	1600	x	Skilled Nursing Facility								16
17											17
18	1800	x	Nursing Facility								18
18.1	1810	x	Intermediate Care Facility - Mentally Retarded								18.1
19	1900	x	Other Long Term Care								19
20			Other Inpatient Routine Cost								20
ANCILLARY SERVICE COST CENTERS											
21	2100	x	Radiology								21
22	2200	x	Laboratory								22
23	2300	x	Intravenous Therapy								23
24	2400	x	Oxygen (Inhalation) Therapy								24
25	2500	x	Physical Therapy								25
26	2600	x	Occupational Therapy								26
27	2700	x	Speech Pathology								27
28	2800	x	Electrocardiology								28
29	2900	x	Medical Supplies Charged to Patients								29
30	3000	x	Drugs Charged to Patients								30
31	3100	x	Dental Care - Title XIX only								31
32	3200	x	Support Surfaces								32
33		x	Other Ancillary Service Cost Center								33
		x	Indicates the lines to be used under the Simplified Method								

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER NO.: ________	PERIOD: FROM ________ TO ________	WORKSHEET A

A	B	C	D COST CENTER (Omit Cents)	SALARIES 1	OTHER 2	TOTAL (Col 1 + Col 2) 3	RECLASSIFICATIONS Increase/Decrease (Fr Wkst A-6) 4	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4) 5	ADJUSTMENTS TO EXPENSES Increase /Decrease (Fr Wkst A-8) 6	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6) 7	
OUTPATIENT SERVICE COST CENTERS											
34	3400		Clinic								34
35	3500		Rural Health Clinic (RHC)								35
36			Other Outpatient Service Cost								36
OTHER REIMBURSABLE COST CENTERS											
37	3700		Administrative and General - HHA								37
38	3800		Skilled Nursing Care - HHA								38
39	3900		Physical Therapy - HHA								39
40	4000		Occupational Therapy - HHA								40
41	4100		Speech Pathology - HHA								41
42	4200		Medical Social Services - HHA								42
43	4300		Home Health Aide - HHA								43
44	4400		Durable Medical Equipment - Rented - HHA								44
45	4500		Durable Medical Equipment - Sold - HHA								45
46	4600		Home Delivered Meals - HHA								46
47	4700		Other Home Health Services - HHA								47
48	4800		Ambulance								48
49	4900		Intern and Resident (Not Apprvd Tchng Prog)								49
50	5000		Outpatient Rehabilitation Provider								50
51			Other Reimbursable Cost								51
SPECIAL PURPOSE COST CENTERS											
52	5200		Malpractice Premiums & Paid Losses								52
53	5300		Interest Expense							- 0 -	53
54	5400	x	Utilization Review -- SNF							- 0 -	54
55	5500		Hospice							- 0 -	55
56		x	Other Special Purpose Cost								56
57	5700		Subtotals								57
NON REIMBURSABLE COST CENTERS											
58	5800		Gift, Flower, Coffee Shops and Canteen								58
59	5900	x	Barber and Beauty Shop								59
60	6000		Physicians' Private Offices								60
61	6100		Nonpaid Workers								61
62	6200		Patients Laundry								62
63		x	Other Non Reimbursable Cost								63
75		x	TOTAL								75

x Indicates the lines to be used under the Simplified Method

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3516)

RECLASSIFICATIONS	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE				DECREASE				
			COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL RECLASSIFICATIONS (Sum of column 4 and 5 must equal sum of column 8 and 9, line 36) (2)										36

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

(2) Transfer to Worksheet A, column 4, line as appropriate.

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3517)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES	PROVIDER NO: ______________	PERIOD: FROM ______________ TO ______________	WORKSHEET A - 7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donation	Total			
		1	2	3	4	5	6	
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	TOTAL					( )		7

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3518)

ADJUSTMENTS TO EXPENSES	PROVIDER NO. ______	PERIOD: FROM ______ TO ______	WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A - TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	
		1	2	3	4	
1	Investment income on restricted funds (ch.2) funds (chapter 2)					1
2	Trade, quantity and time discounts on purchases (chapter 8)					2
3	Refunds and rebates of expenses (Chapter 8)					3
4	Rental of provider space by suppliers (Chapter 8)					4
5	Telephone services (pay stations excluded) (chapter 21)					5
6	Television and radio service (Chapter 21)					6
7	Parking lot (chapter 21)					7
8	Remuneration applicable to provider-based physician adjustment	**Worksheet A-8-2**				8
9	Home office costs (chapter 21)					9
10	Sale of scrap, waste, etc. (chapter 23)					10
11	Nonallowable costs related to certain Capital expenditures (chapter 24)					11
12	Adjustment resulting from transactions with related organizations (chapter 10)	**Worksheet A-8-1**				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Other Adjustment	**(3)**				22
23	Other Adjustment	**(3)**				23
24	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	**(3)**		**Oxygen (Inhalation) Therapy**	**24**	24
25	Adjustment for physical therapy costs in excess of limitation	**(3)**		**Physical Therapy**	**25**	25
26	Adjustment for HHA physical therapy costs in excess of limitation	**See Instructions**		**Physical Therapy--HHA**	**39**	26
27	SUBTOTAL (Sum of lines 1-26)					27
28	Utilization review--physicians' compensation (chapter 21)			**Utilization Review- SNF**	**54**	28
29	Depreciation--buildings and fixtures			**Capital Related Cost- Building**	**1**	29
30	Depreciation--movable equipment			**Capital Related Cost-Movable Equipment**	**2**	30
31	Other Adjustment					31
32	TOTAL (line 27 plus the sum of lines 28 - 31) (Transfer to Worksheet A, col. 6, line 75)					32

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

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

(3) See Instructions to report therapy services provided on and after April 10, 1998.

FORM CMS-2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3519)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER NO: ___________	PERIOD: FROM ________ TO ________	WORKSHEET A-8-1

A. Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10?

[ ] Yes (If "Yes," complete Parts B and C) [ ] No

B. Costs incurred and adjustments required as a result of transactions with related organizations. Location and amount included on Worksheet A, Column 5

	Line No.	Cost Center	Expense Items	Amount	Amount Allowable In Cost	Adjustments (Col 4 minus Col 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS (Sum of lines 1-9) (Transfer column 6, lines as applicable, to Worksheet A, column 6, lines as appropriate) Transfer column. 6, line 5 to Worksheet A-8, column 2, line 12)						10

C. Interrelationship to related organization(s):

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 C of this worksheet.

This information is used by the Health Care Financing Administration and its intermediaries 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.

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

(1) Use the following symbols to indicate interrelationship to related organizations:

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

FORM CMS - 2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 3520)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS	PROVIDER NO:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-2

	Wkst A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
75		TOTAL								75

	Wkst A Line No.	Cost Center / Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of Col 12	Physician Cost of Malpractice Insurance	Provider Component Share of Column 14	Adjusted R C E Limit	R C E Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
75		TOTAL								75

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3521)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO: ___	PERIOD: FROM ___ TO ___	WORKSHEET A-8-3 PARTS I & II

PART I - GENERAL INFORMATION

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

		Supervisors	Therapists	Assistants	Aides	
		1	2	3	4	
9	Total hours worked					9
10	A H S E A (See Instructions)					10
11	Standard Travel Allowance (Cols. 1 and 2, one-half of col. 2, line 10; col. 3, one-half of col 3, line 10)					11
12	Number of travel hours (HHA only)					12
13	Number of miles driven (HHA only)					13

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (Column 1, line 9 times column 1, line 10)		14
15	Therapists (Column 2, line 9 times column 2, line 10)		15
16	Assistants (Column 3, line9 times column 3, line10)		16
17	Subtotal Allowance Amount (Sum of lines 14-16)		17
18	Aides (Column 4, line 9 times column 4, line 10)		18
19	Total Allowance Amount (Sum of lines 17 and 18)		19
	If the sum of columns 1-3, line 9, is greater than line 2, make no entries on lines 20 and 21 and enter on line 22 the amount from line 19. Otherwise complete lines 20 - 22.		
20	Weighted average rate excluding aides (Line 17 divided by the sum of columns 1-3, line 9)		20
21	Weighted allowance excluding aides (Line 2 times line 20)		21
22	Total Salary Equivalency (Line 19 or sum of lines 18 plus 21)		22

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522 THROUGH 3522.07)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-3 PARTS III & IV

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

	Standard Travel Allowance			
23	Therapists (Line 3 times column 2, line 11)			23
24	Assistants (Line 4 times column3, line 11)			24
25	Subtotal (Sum of lines 23 and 24)			25
26	Standard Travel Expense (Line 7 times sum of lines 3 and 4)			26
27	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site (Sum of lines 25 and 26)			27

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

	Standard Travel Expense			
28	Therapists (Line 5 times column 2, line 11)			28
29	Assistants (Line 6 times column 3, line 11)			29
30	Subtotal (Sum of lines 28 and 29)			30
31	Standard Travel Expense (Line 7 times the sum of lines 5 and 6)			31
	Optional Travel Allowance and Optional Travel Expense			
32	Therapists (Sum of columns 1 and 2, line 12 times column 2, line 10)			32
33	Assistants (Column 3, line 12 times column 3, line 10)			33
34	Subtotal (Sum of lines 32 and 33)			34
35	Optional Travel Expense (Line 8 times the sum of columns 1-3, line 13)			35
	Total Travel Allowance and Travel Expense - HHA Services; Complete one of the following three lines 36, 37, or 38, as appropriate.			
36	Standard Travel Allowance and Standard Travel Expense (Sum of lines 30 and 31 - See Instructions)			36
37	Optional Travel Allowance and Standard Travel Expense (Sum of lines 34 and 31 - See Instructions)			37
38	Optional Travel Allowance and Optional Travel Expense (Sum of lines 34 and 35 - See Instructions)			38

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522 THROUGH 3522.7)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO: ____________	PERIOD: FROM ____________ TO ____________	WORKSHEET A-8-3 PARTS V, VI, & VII

PART V - OVERTIME COMPUTATION

	Description	Therapists 1	Assistants 2	Aides 3	Total 4	
39	Overtime hours worked during cost reporting period (If column 4, line 39, is zero or equal to or greater than 2,080, do not complete lines 40-47 and enter zero in each column of line 48)					39
40	Overtime rate (Multiply the amounts in columns 2-4, line 10 (A H S E A) times 1.5)					40
41	Total overtime (Including base and overtime allowance) (Multiply line 39 times line 40)					41
	Calculation of Limit					
42	Percentage of overtime hours by category (Divide the hours in each column on line 39 by the total overtime worked - column 4, line 39)					42
43	Allocation of provider's standard workyear for one full-time employee times the percentages on line 42. (See Instructions)					43
	Determination of Overtime Allowance					
44	Adjusted hourly salary equivalency amount (A H S E A) (From Part I, Columns 2-4, line 10)					44
45	Overtime cost limitation (Line 43 times line 44)					45
46	Maximum overtime cost (Enter the lessor of line 41 or line 45)					46
47	Portion of overtime already included in hourly computation at the A H S E A (Multiply line 39 times line 44)					47
48	Overtime allowance (Line 46 minus 47 - if negative enter zero)(Column 4, sum of cols 1-3)					48

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

	Description		
49	Salary equivalency amount (from Part II, line 22)		49
50	Travel allowance and expense - provider site (from Part III, line 27)		50
51	Travel allowance and expense - HHA services (from Part IV, lines 36, 37 or 38)		51
52	Overtime allowance (from Part V, col. 4, line 48)		52
53	Equipment cost (See Instructions)		53
54	Supplies (See Instructions)		54
55	Total allowance (Sum of lines 49-54)		55
56	Total cost of outside supplier services (from your records)		56
57	Excess over limitation (line 56 minus line 55 - if negative, enter zero -- See Instructions)		57

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

	Description		
58	Cost of outside supplier services - SNF (from your records)		58
59	Cost of outside supplier services - HHA (from your records)		59
60	Total cost (Sum of lines 58-59) (This line must agree with line 56)		60
61	Ratio of SNF cost of outside supplier services to total cost (Line 58 divided by line 60)		61
62	Ratio of HHA cost of outside supplier services to total cost (Line 59 divided by line 60)		62
63	SNF excess of cost over limitation (Line 57 times line 61) (Transfer to Wkst A-8, line 25)		63
64	HHA excess of cost over limitation (Line 57 times line 62) (Transfer to Wkst A-8, line 26)		64

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522.6 - 3522.7)

REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-4 PARTS I & II

PART I - GENERAL INFORMATION

1	Total number of weeks worked (During which outside suppliers (excluding aides and trainees) worked)		1
2	Line 1 multiplied by 15 hours per week		2
.	**Number of unduplicated days on which the following category, as appropriate, has the highest A H S E A on the provider site (See Instructions):**		
3	Registered Therapist		3
4	Certified Therapist		4
5	Nonregistered, Noncertified Therapist		5
6	Standard travel expense rate		6

	Description	Supervisors			Therapists					
		Registered	Certified	Nonregistered Noncertified	Registered	Certified	Nonregistered Noncertified	Aides	Trainees	
		1	2	3	4	5	6	7	8	
7	Total Hours Worked									7
8	A H S E A (See Instructions)									8
9	Standard Travel Allowance									9
	(Enter in cols 1, 2, or 3, one-half of the amounts on line 8, columns 4, 5 or 6 respectively. Enter in cols. 4, 5 or 6 one-half of the amounts on line 8, columns 4, 5 or 6 respectively.)									

PART II - SALARY EQUIVALENCY COMPUTATION

10	Supervisory Registered Therapist (Col 1, line 7 times col 1, line 8)		10
11	Supervisory Certified Therapist (Col 2, line 7 times col 2, Line 8)		11
12	Supervisory Non-Registered, Non-Certified Therapist (Col 3, line 7 times col 3, line 8)		12
13	Registered Therapists (Col 4, line 7 times col 4, line 8)		13
14	Certified Therapists (Col 5, line 7 times col 5, line 8)		14
15	Non-Registered, Non-Certified Therapists (Col 6, line 7 times col 6, line 8)		15
16	Subtotal Allowance Amount (Sum of lines 10-15)		16
17	Aides (Col 7, line 7 times col 7, line 8)		17
18	Trainees (Col 8, line 7 times col 8, line 8)		18
19	Total Allowance Amount (Sum of lines 16-18)		19
	If the sum of cols 1-6, line 7, is greater than line 2, make no entries on lines 20 and 21 and enter on line 22 the amount from line 19. Otherwise, complete lines 20-22.		
20	Weighted average rate excluding aides and trainees (Line 16 divided by the sum of cols 1-6, line 7)		20
21	Weighted allowance excluding aides and trainees (Line 2 times line 20)		21
22	Total Salary Equivalency (Line 19 or sum of lines 17, 18 and 21)		22

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3523 - 3523.5)

REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-4 PARTS III, IV AND V

PART III - STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION

23	Regeistered Therapists (Line 3 times col 4, line 9)		23
24	Certified Therapists (Line 4 times col 5, line 9)		24
25	Non-Registered, Non-Certified Therapists (Line 5 times col 6, line 9)		25
26	Subtotal (Sum of lines 23-25)		26
27	Standard Travel Expense (Line 6 times sum of lines 3-5)		27
28	Total Standard Travel Allowance and Standard Travel Expense (Sum of lines 26 and 27)		28

PART IV - OVERTIME COMPUTATION

	Description	Therapists			Aides	Trainees	Total	
		Registered	Certified	Nonregistered Noncertified				
		1	2	3	4	5	6	
29	Overtime hours worked during cost reporting period (If col 6, line 29, is zero, or equal to or greater than 2,080, do not complete lines 30 through 37 and enter zero in each column of line 38)							29
30	Overtime rate (Multiply the amounts in cols 4-8, line 8 (the AHSEA) times 1.5)							30
31	Total overtime (Including base and overtime allowance) (Multiply line 29 times line 30)							31
	Calculation of Limitation							
32	Percentage of overtime hours by category (Divide the hours in each column on line 29 by the total overtime worked - column 6, line 29)						100%	32
33	Allocation of provider's standard workyear for one full-time employee times the percentage on line 32. (See Instructions)							33
	Determination of Overtime Allowance							
34	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols. 4-8, line 8)							34
35	Overtime cost limitation (Line 33 times line 34)							35
36	Maximum overtime cost (Enter the lessor of line 31 or 35)							36
37	Portion of overtime already included in hourly computation at the A H S E A. (Multiply line 29 times line 34)							37
38	Overtime allowance (Line 36 minus line 37 - if negative enter zero) (Col. 6, sum of cols. 1 - 5)							38

PART V - COMPUTATION OF RESPIRATORY THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

39	Salary equivalency amount (from Part II, line 22)		39
40	Travel allowance and expense (from Part III, line 28)		40
41	Overtime allowance (from Part IV, col 6, line 38)		41
42	Equipment cost (See Instructions)		42
43	Supplies (See Instructions)		43
44	Total allowance (Sum of lines 39 - 43)		44
45	Total cost of outside supplier services (from your records)		45
46	Excess over limitation (line 45 minus line 44, - if negative, enter zero - See Instructions) (Transfer to Wkst. A-8 line 24)		46

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3523.3 - 3523.5)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-5 PARTS I & II

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

PART I - GENERAL INFORMATION

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

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked						9
10	AHSEA (see instructions)						10
11	Standard Travel Allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)						11
12	Number of travel hours - Provider on site - (see instructions)						12
12.01	Number of travel hours - Provider off site - (see instructions)						12.01
13	Number of miles driven - Provider on site - (see instructions)						13
13.01	Number of miles driven - Provider off site - (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)		15
16	Assistants (column 3, line 9 times column 3, line10)		16
17	Subtotal Allowance Amount (sum of lines 14-16)		17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total Allowance Amount (see instructions)		20

If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than lin make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.

21	Weighted average rate excluding aides and trainees (see instructions)		21
22	Weighted allowance excluding aides and trainees (see instructions)		22
23	Total salary equivalency (see instructions)		23

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3564-3564.6)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-5 PARTS III & IV

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

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

	Standard Travel Allowance		
24	Supervisor and Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (sum of lines 24 and 25)		26
27	Standard Travel Expense (line 7 times sum of lines 3 and 4)		27
28	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site (sum of lines 26 and 27)		28
	Optional Travel Allowance and Optional Travel Expense		
29	Supervisor and Therapists (sum of columns 1 and 2, line 12, times column 2 line 10)		29
30	Assistants (column 3, line 12 times column 3 line 10)		30
31	Subtotal (sum of lines 29 and 30)		31
32	Optional travel expense (line 8 times the sum of columns 1-3, line 13)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

	Standard Travel Expense		
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard Travel Expense (line 7 times the sum of lines 5 and 6)		39
	Optional Travel Allowance and Optional Travel Expense		
40	Therapists (sum of columns 1 and 2, line 12 times column 2, line 10)		40
41	Assistants (column 3, line 12 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optional Travel Expense (line 8 times the sum of columns 1-3, line 13)		43
	Total Travel Allowance and Travel Expense - Complete one of the following three lines 44, 45, or 46, as appropriate.		
44	Standard Travel Allowance and Standard Travel Expense (sum of lines 38 and 39 - see instructions)		44
45	Optional Travel Allowance and Standard Travel Expense (sum of lines 39 and 42 - see instructions)		45
46	Optional Travel Allowance and Optional Travel Expense (sum of lines 42 and 43 - see instructions)		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-5 PARTS V & VI

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from Part II, line 23)		57
58	Travel allowance and expense - provider site (from Part III, lines 33, 34, or 35))		58
59	Travel allowance and expense - HHA services (from Part IV, lines 44, 45, or 46)		59
60	Overtime allowance (from Part V, column 4, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)		63
64	Total cost of outside supplier services (from your records)		64
65	Excess over limitation (line 64 minus line 63 - if negative, enter zero -- See Instructions)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-5 PARTS VII

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	Cost of outside supplier services - SNF (from your records)		66
67	Cost of outside supplier services - CORF (from your records)		67
68	Cost of outside supplier services - CMHC (from your records)		68
69	Cost of outside supplier services - OPT (from your records)		69
70	Cost of outside supplier services - HHA (from your records)		70
71	Total cost (Sum of lines 66 - 70)		71
72	Ratio of SNF cost of outside supplier services to total cost (line 66 divided by line 71)		72
73	Ratio of CORF cost of outside supplier services to total cost (line 67 divided by line 71)		73
74	Ratio of CMHC cost of outside supplier services to total cost (line 68 divided by line 71)		74
75	Ratio of OPT cost of outside supplier services to total cost (line 69 divided by line 71)		75
76	Ratio of HHA cost of outside supplier services to total cost (Line 70 divided by line 71)		76
77	SNF excess of cost over limitation (line 65 times line 72) (Transfer to Worksheet A-8, - see instructions)		77
78	CORF excess of cost over limitation (line 65 times line 73) (Transfer to Worksheet A-8, see instructions)		78
79	CMHC excess of cost over limitation (line 65 times line 74) (Transfer to Worksheet A-8, see instructions)		79
80	OPT excess of cost over limitation (line 65 times line 75) (Transfer to Worksheet A-8, see instructions)		80
81	HHA excess of cost over limitation (line 65 times line 76) (Transfer to Worksheet A-8, see instructions)		81
82	Total excess of cost over limitation (sum of lines 77 through 81 and subscripts) (This line must agree with line 65)		82

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM ______ TO ______		WORKSHEET B PART I		
	COST CENTER (Omit Cents)	NET EXPENSES FOR COST ALLOCATION Fr. Wkst A, Col 7	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (Sum of Columns 0 - 3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3 A	4	
	GENERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - Movable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Intern & Residents (Approved Teaching Program)							14
15	Other General Service Cost							15
	INPATIENT ROUTINE SERVICE COST CENTERS							
16	Skilled Nursing Facility							16
17								17
18	Nursing Facility							18
18.1	Intermediate Care Facility/ Mentally Retarded							18.1
19	Other Long Term Care							19
20	Other Inpatient Routine Services							20
	ANCILLARY SERVICE COST CENTERS							
21	Radiology							21
22	Laboratory							22
23	Intravenous Therapy							23
24	Oxygen (Inhalation) Therapy							24
25	Physical Therapy							25
26	Occupational Therapy							26
27	Speech Pathology							27
28	Electrocardiology							28
29	Medical Supplies Charged to Patients							29
30	Drugs Charged to Patients							30
31	Dental Care - Title XIX only							31
32	Support Surfaces							32
33	Other Ancillary Service Cost							33

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.: ________	PERIOD: FROM ________ TO ________		WORKSHEET B PART I		
COST CENTER (Omit Cents)	NET EXPENSES FOR COST ALLOCATION Fr. Wkst A, Col 7	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (Sum of Columns 0 - 3)	ADMINIS- TRATIVE & GENERAL	
	0	1	2	3	3 A	4	
OUTPATIENT SERVICE COST CENTERS							
34 Clinic							34
35 R H C							35
36 Other Outpatient Service Cost							36
OTHER REIMBURSABLE COST CENTERS							
37 Administrative and General - HHA							37
38 Skilled Nursing Care - HHA							38
39 Physical Therapy - HHA							39
40 Occupational Therapy - HHA							40
41 Speech Pathology - HHA							41
42 Medical Social Services - HHA							42
43 Home Health Aide - HHA							43
44 Durable Medical Equipment - Rented - HHA							44
45 Durable Medical Equipment - Sold - HHA							45
46 Home Delivered Meals - HHA							46
47 Other Home Health Services - HHA							47
48 Ambulance							48
49 Interns and Residents (Not in Approved Teaching Program)							49
50 Outpatient Rehabilitation Provider							50
51 Other Reimbursable Cost							51
SPECIAL PURPOSE COST CENTERS							
55 Hospice							55
56 Other Special Purpose Cost							56
57 Subtotals							57
NON REIMBURSABLE COST CENTERS							
58 Gift, Flower, Coffee Shops and Canteen							58
59 Barber and Beauty Shop							59
60 Physicians' Private Offices							60
61 Nonpaid Workers							61
62 Patients Laundry							62
63 Other Non Reimbursable Cost							63
64 Cross Foot Adjustments							64
65 Negative Cost Center							65
75 TOTAL							75

COST ALLOCATION - GENERAL SERVICE COSTS	**PROVIDER NO.:** ________________	**PERIOD: FROM ________ TO ________**	**WORKSHEET B PART I**

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Intermediate Care Facility/ Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Services								20
	ANCILLARY SERVICE COST CENTERS								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26
27	Speech Pathology								27
28	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30
31	Dental Care - Title XIX only								31
32	Support Surfaces								32
33	Other Ancillary Service Cost								33

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET B PART I

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not in Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60
61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63
64	Cross Foot Adjustments								64
65	Negative Cost Center								65
75	TOTAL								75

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.: ________	PERIOD: FROM ________ TO ________	WORKSHEET B PART I

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Intermediate Care Facility/ Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Services								20
	ANCILLARY SERVICE COST CENTERS								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26
27	Speech Pathology								27
28	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30

31	Dental Care - Title XIX only								31
32	Support Surfaces								32
33	Other Ancillary Service Cost								33

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO.: ____________

PERIOD:
FROM ____________
TO ____________

WORKSHEET B
PART I

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not in Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60
61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63

64	Cross Foot Adjustments								64
65	Negative Cost Center								65
75	TOTAL								75

FORM CMS-2540-96 (10/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3524)

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.: ________	PERIOD: FROM ________ TO ________	WORKSHEET B - 1

	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		0	1	2	3	4 A	4	
	GENERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - Movable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Intern & Residents (Approved Teaching Program)							14
15	Other General Service Cost							15
	INPATIENT ROUTINE SERVICE COST CENTERS							
16	Skilled Nursing Facility							16
17								17
18	Nursing Facility							18
18.1	Interrmediate Care Facility/ Mentally Retarded							18.1
19	Other Long Term Care							19
20	Other Inpatient Routine Services							20
	ANCILLARY SERVICE COST CENTERS							
21	Radiology							21
22	Laboratory							22
23	Intravenous Therapy							23
24	Oxygen (Inhalation) Therapy							24
25	Physical Therapy							25
26	Occupational Therapy							26
27	Speech Pathology							27
28	Electrocardiology							28
29	Medical Supplies Charged to Patients							29
30	Drugs Charged to Patients							30
31	Dental Care - Title XIX only							31
32	Support Surfaces							32
33	Other Ancillary Service Cost							33

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.: ____________	PERIOD: FROM ____________ TO ____________	WORKSHEET B - 1

	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	
		0	1	2	3	4 A	4	
	OUTPATIENT SERVICE COST CENTERS							
34	Clinic							34
35	R H C							35
36	Other Outpatient Service Cost							36
	OTHER REIMBURSABLE COST CENTERS							
37	Administrative and General - HHA							37
38	Skilled Nursing Care - HHA							38
39	Physical Therapy - HHA							39
40	Occupational Therapy - HHA							40
41	Speech Pathology - HHA							41
42	Medical Social Services - HHA							42
43	Home Health Aide - HHA							43
44	Durable Medical Equipment - Rented - HHA							44
45	Durable Medical Equipment - Sold - HHA							45
46	Home Delivered Meals - HHA							46
47	Other Home Health Services - HHA							47
48	Ambulance							48
49	Interns and Residents (Not in Approved Teaching Program)							49
50	Outpatient Rehabilitation Provider							50
51	Other Reimbursable Cost							51
	SPECIAL PURPOSE COST CENTERS							
55	Hospice							55
56	Other Special Purpose Cost							56
57	Subtotals							57
	NON REIMBURSABLE COST CENTERS							
58	Gift, Flower, Coffee Shops and Canteen							58
59	Barber and Beauty Shop							59
60	Physicians' Private Offices							60
61	Nonpaid Workers							61
62	Patients Laundry							62
63	Other Non Reimbursable Cost							63
64	Cross Foot Adjustments							64
65	Negative Cost Center							65
66	Cost to be Allocated (Per Wkst. B, Part I)							66
67	Unit Cost Multiplier (Wkst. B, Part I)							67
68	Cost to be Allocated (Per Wkst. B, Part II)							68

69	Unit Cost Multiplier (Wkst. B, Part II)								69

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO.: ________________

PERIOD:
FROM ________________
TO ________________

WORKSHEET B - 1

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Interrmediate Care Facility/ Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Services								20
	ANCILLARY SERVICE COST CENTERS								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26
27	Speech Pathology								27
28	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30
31	Dental Care - Title XIX only								31
32	Support Surfaces								32

33	Other Ancillary Service Cost								33

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER NO.: ________________	PERIOD: FROM ____________ TO ____________	WORKSHEET B - 1

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not in Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60
61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63
64	Cross Foot Adjustments								64

65	Negative Cost Center								65
66	Cost to be Allocated (Per Wkst. B, Part I)								66
67	Unit Cost Multiplier (Wkst. B, Part I)								67
68	Cost to be Allocated (Per Wkst. B, Part II)								68
69	Unit Cost Multiplier (Wkst. B, Part II)								69

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO.: ________________

PERIOD:
FROM ________________
TO ________________

WORKSHEET B - 1

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	INTERNS & RESIDENTS (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Interrmediate Care Facility/ Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Services								20
	ANCILLARY SERVICE COST CENTERS								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26

27	Speech Pathology								27
28	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30
31	Dental Care - Title XIX only								31
32	Support Surfaces								32
33	Other Ancillary Service Cost								33

COST ALLOCATION - GENERAL SERVICE COSTS | **PROVIDER NO.:** ________________ | **PERIOD: FROM** ________________ **TO** ________________ | **WORKSHEET B - 1**

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	INTERNS & RESIDENTS (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not in Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60

61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63
64	Cross Foot Adjustments								64
65	Negative Cost Center								65
66	Cost to be Allocated (Per Wkst. B, Part I)								66
67	Unit Cost Multiplier (Wkst. B, Part I)								67
68	Cost to be Allocated (Per Wkst. B, Part II)								68
69	Unit Cost Multiplier (Wkst. B, Part II)								69

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3524)

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET B PART II

	COST CENTER (Omit Cents)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Intermediate Care Facility/Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Service Cost								20
	ANCILLARY SERVICE COST CENTER								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26
27	Speech Pathology								27
	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30
31	Dental Care - Title XIX only								31
32	Support Surfaces								32
33	Other Ancillary Service Cost								33

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER NO.:	PERIOD: FROM ________ TO ________	WORKSHEET B PART II

	COST CENTER (Omit Cents)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not An Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60
61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63
64	Cross Foot Adjustments								64
65	Negative Cost Center								65
75	Total								75

FORM CMS-2540-96 (10/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3525)

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER NO.: ________		PERIOD: FROM ________ TO ________		WORKSHEET B PART II		
	COST CENTER (Omit Cents)	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - Movable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Intern & Residents (Approved Teaching Program)							14
15	Other General Service cost							15
	INPATIENT ROUTINE SERVICE COST CENTERS							
16	Skilled Nursing Facility							16
17								17
18	Nursing Facility							18
18.1	Intermediate Care Facility/Mentally Retarded							18.1
19	Other Long Term Care							19
20	Other Inpatient Routine Service Cost							20
	ANCILLARY SERVICE COST CENTER							
21	Radiology							21
22	Laboratory							22
23	Intravenous Therapy							23
24	Oxygen (Inhalation) Therapy							24
25	Physical Therapy							25
26	Occupational Therapy							26
27	Speech Pathology							27
28	Electrocardiology							28
29	Medical Supplies Charged to Patients							29
30	Drugs Charged to Patients							30
31	Dental Care - Title XIX only							31
32	Support Surfaces							32
33	Other Ancillary Service Cost							33

ALLOCATION OF CAPITAL - RELATED COSTS

PROVIDER NO.: ________

PERIOD: FROM ________ TO ________

WORKSHEET B PART II

	COST CENTER (Omit Cents)	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
	OUTPATIENT SERVICE COST CENTERS							
34	Clinic							34
35	R H C							35
36	Other Outpatient Service Cost							36
	OTHER REIMBURSABLE COST CENTERS							
37	Administrative and General - HHA							37
38	Skilled Nursing Care - HHA							38
39	Physical Therapy - HHA							39
40	Occupational Therapy - HHA							40
41	Speech Pathology - HHA							41
42	Medical Social Services - HHA							42
43	Home Health Aide - HHA							43
44	Durable Medical Equipment - Rented - HHA							44
45	Durable Medical Equipment - Sold - HHA							45
46	Home Delivered Meals - HHA							46
47	Other Home Health Services - HHA							47
48	Ambulance							48
49	Interns and Residents (Not An Approved Teaching Program)							49
50	Outpatient Rehabilitation Provider							50
51	Other Reimbursable Cost							51
	SPECIAL PURPOSE COST CENTERS							
55	Hospice							55
56	Other Special Purpose Cost							56
57	Subtotals							57
	NON REIMBURSABLE COST CENTERS							
58	Gift, Flower, Coffee Shops and Canteen							58
59	Barber and Beauty Shop							59
60	Physicians' Private Offices							60
61	Nonpaid Workers							61
62	Patients Laundry							62
63	Other Non Reimbursable Cost							63
64	Cross Foot Adjustments							64
65	Negative Cost Center							65
75	Total							75

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER NO.:	PERIOD: FROM ____ TO ____	WORKSHEET B PART II

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Intern & Residents (Approved Teaching Program)								14
15	Other General Service cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
16	Skilled Nursing Facility								16
17									17
18	Nursing Facility								18
18.1	Intermediate Care Facility/Mentally Retarded								18.1
19	Other Long Term Care								19
20	Other Inpatient Routine Service Cost								20
	ANCILLARY SERVICE COST CENTER								
21	Radiology								21
22	Laboratory								22
23	Intravenous Therapy								23
24	Oxygen (Inhalation) Therapy								24
25	Physical Therapy								25
26	Occupational Therapy								26
27	Speech Pathology								27
28	Electrocardiology								28
29	Medical Supplies Charged to Patients								29
30	Drugs Charged to Patients								30

31	Dental Care - Title XIX only								31
32	Support Surfaces								32
33	Other Ancillary Service Cost								33

ALLOCATION OF CAPITAL - RELATED COSTS

PROVIDER NO.: ________

PERIOD:
FROM ________
TO ________

WORKSHEET B PART II

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	OUTPATIENT SERVICE COST CENTERS								
34	Clinic								34
35	R H C								35
36	Other Outpatient Service Cost								36
	OTHER REIMBURSABLE COST CENTERS								
37	Administrative and General - HHA								37
38	Skilled Nursing Care - HHA								38
39	Physical Therapy - HHA								39
40	Occupational Therapy - HHA								40
41	Speech Pathology - HHA								41
42	Medical Social Services - HHA								42
43	Home Health Aide - HHA								43
44	Durable Medical Equipment - Rented - HHA								44
45	Durable Medical Equipment - Sold - HHA								45
46	Home Delivered Meals - HHA								46
47	Other Home Health Services - HHA								47
48	Ambulance								48
49	Interns and Residents (Not An Approved Teaching Program)								49
50	Outpatient Rehabilitation Provider								50
51	Other Reimbursable Cost								51
	SPECIAL PURPOSE COST CENTERS								
55	Hospice								55
56	Other Special Purpose Cost								56
57	Subtotals								57
	NON REIMBURSABLE COST CENTERS								
58	Gift, Flower, Coffee Shops and Canteen								58
59	Barber and Beauty Shop								59
60	Physicians' Private Offices								60
61	Nonpaid Workers								61
62	Patients Laundry								62
63	Other Non Reimbursable Cost								63
64	Cross Foot Adjustments								64

65	Negative Cost Center								65
75	Total								75

FORM CMS-2540-96 (10/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3525)

COST ALLOCATION - GENERAL SERVICE COSTS WITH LESS THAN 1500 PROGRAM DAYS	PROVIDER NO.:	PERIOD: FROM ________ TO ________	WORKSHEET B PART III

	COST CENTER (Omit Cents)	NET EXPENSES FOR COST ALLOCATION (Fr. Wkst A, Col 7)	CAP-REL COSTS PLANT OPER. MAINT & REPAIR HOUSEKEEPING	EMPLOYEE BENEFITS	LAUNDRY, DIET NURSE ADMIN. CENT SER & SUPP PHARM/MED REC SOC SERV	ADMIN & GENERAL INTEREST	TOTAL COSTS	
		0	1	2	3	4	5	
	GENERAL SERVICE COST CENTERS							
15.1	Total							15.1
	INPATIENT ROUTINE SERVICE COST CENTERS							
16	Skilled Nursing Facility							16
17								17
18	Nursing Facility							18
18.1	Intermediate Care Facility / Mentally Retarded							18.1
19	Other Long Term Care							19
20	Other Inpatient Routine Services							20
	ANCILLARY SERVICE COST CENTERS							
21	Radiology							21
22	Laboratory							22
23	Intravenous Therapy							23
24	Oxygen (Inhalation) Therapy							24
25	Physical Therapy							25
26	Occupational Therapy							26
27	Speech Pathology							27
28	Electrocardiology							28
29	Medical Supplies Charged to Patients							29
30	Drugs Charged to Patients							30
31	Dental Care - Title XIX only							31
32	Support Surfaces							32
33	Other Ancillary Service Cost							33
56	Other Special Purpose Cost							56
	NON REIMBURSABLE COST CENTERS							
59	Barber and Beauty Shop							59
63	All Other Non Reimbursable Cost							63
75	TOTAL							75

FORM CMS-2540-96 (03/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3525.1)

COST ALLOCATION - STATISTICAL BASIS WITH LESS THAN 1500 PROGRAM DAYS	PROVIDER NO.: ______________	PERIOD: FROM ______________ TO ______________	WORKSHEET B - 1 PART II

	COST CENTER (Omit Cents)		CAPITAL RELATED COSTS PLANT OPERATION MAINTENANCE & REPAIR HOUSEKEEPING (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	LAUNDRY, DIET NURSE ADMIN. CENTRAL SUPPLY PHARM / MEDICAL RECORDS / SOCIAL SERVICES (Patient Days)	ADMIN & GENERAL INTEREST	
		0	1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS						
16	Skilled Nursing Facility						
17							
18	Nursing Facility						
18.1	Intermediate Care Facility / Mentally Retarded						
19	Other Long Term Care						
20	Other Inpatient Routine Services						
	ANCILLARY SERVICE COST CENTERS						
21	Radiology						
22	Laboratory						
23	Intravenous Therapy						
24	Oxygen (Inhalation) Therapy						
25	Physical Therapy						
26	Occupational Therapy						
27	Speech Pathology						
28	Electrocardiology						
29	Medical Supplies Charged to Patients						
30	Drugs Charged to Patients						
31	Dental Care - Title XIX only						
32	Support Surfaces						
33	Other Ancillary Service Cost						
56	Other Special Purpose Cost						
	NON REIMBURSABLE COST CENTERS						
59	Barber and Beauty Shop						
63	All Other Non Reimbursable Cost						
70	Total General Services Costs						
71	Total Statistics						
72	Unit Cost Multipliers (Line 70 divided by line 71)						

FORM CMS-2540-96 (03/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3525.1)

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POST STEP DOWN ADJUSTMENTS	PROVIDER NO.: ____________	PERIOD FROM____________ TO____________		WORKSHEET B-2	
	DESCRIPTION	WORKSHEET B - PART NO.	WORKSHEET B - LINE NO.	AMOUNT	
	1	2	3	4	
1					1
2					2
3					3
4					4
5					5
6					6
7					7
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9					9
10					10
11					11
12					12
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FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 3526)

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER NO. : ________	PERIOD : FROM ________ TO ________	WORKSHEET C

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1	2	3	
ANCILLARY SERVICE COST CENTERS					
21	Radiology				21
22	Laboratory				22
23	Intravenous Therapy				23
24	Oxygen (Inhalation) Therapy				24
25	Physical Therapy				25
26	Occupational Therapy				26
27	Speech Pathology				27
28	Electrocardiology				28
29	Medical Supplies Charged				29
30	Drugs Charged to Patients				30
31	Dental Care - Title XIX only				31
32	Support Surfaces				32
33	Other Ancillary Service Cost				33
OUTPATIENT SERVICE COST CENTERS					
34	Clinic				34
35	R H C				35
36	Other Outpatient Service Cost				36
48	Ambulance				48
75	Total				75

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST AND REDUCTION OF THERAPY COST	PROVIDER NO. : ______________	PERIOD : FROM __________ TO __________	WORKSHEET D PART I

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

Check One: [ ] Title V (1) [ ] Title XVIII [ ] Title XIX (1)

Check One: [ ] SNF [ ] NF [ ] ICF/MR [ ] Other ______________
[ ] PPS (For cost reporting periods beginning before 07/01/98)

>PPS FISCAL YEARS BEGINNING 07/01/98 MUST ALSO COMPLETE PART III<

	Cost Center	RATIO OF COST TO CHARGES (Fr. Wkst. C Column 3)	HEALTH CARE PROGRAM CHARGES		HEALTH CARE PROGRAM COST		TITLE XVIII CHARGES ON AND AFTER 1/1/1998	PART B THERAPY COSTS ON AND AFTER 1/1/1998 Col. 1 X 6)	10% REDUCTION OF THERAPY (Col. 7 X 10%)	NET ALLOWABLE PART B COSTS Col. 5 less Col. 8)	
			Part A	Part B	Part A (Col. 1 X Col. 2)	Part B (Col. 1 X Col. 3)					
		1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS										
21	Radiology										21
22	Laboratory										22
23	Intravenous Therapy										23
24	Oxygen (Inhalation) Therapy										24
25	Physical Therapy										25
26	Occupational Therapy										26
27	Speech Pathology										27
28	Electrocardiology										28
29	Medical Supplies Charged To Patients										29
30	Drugs Charged to Patients										30
31	Dental Care - Title XIX										31
32	Support Surfaces										32
33	Other Ancillary Services										33
	OUTPATIENT COST CENTERS										
34	Clinic										34
35	R H C										35
36	Other Outpatient Services										36
48	Ambulance (2)										48
75	Total (Sum of lines 21 - 48)										75

(1) For titles V and XIX use columns 1, 2 and 4 only.

(2) Line 48 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST AND REDUCTION OF THERAPY COST FOR TITLE XVIII	PROVIDER NO. : ____________	PERIOD : FROM ____________ TO ____________	WORKSHEET D PARTS II & III

Check One: [ ] SNF [ ] NF [ ] ICF/MR

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 30)		1
2	Program vaccine charges (From your records, or the P S & R.)		2
3	Program costs (Line 1 X line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part III, line 20)		3

PART III - CALCULATION OF PASS THROUGH COSTS FOR INTERNS & RESIDENTS

>> FOR COST REPORTING PERIODS BEGINNING ON AND AFTER 07/01/98 <<

	Cost Centers	Total Cost (From Worksheet B, Part I, Col 18)	Intern and Residents Costs (From Wkst. B, Part I, Column 14)	Ratio of Intern & Residents Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D. Part 1, Col. 4)	Program Intern & Residents Costs for Pass Through (Col. 3 X Col. 4)	
		1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS							
21	Radiology						21
22	Laboratory						22
23	Intravenous Therapy						23
24	Oxygen (Inhalation) Therapy						24
25	Physical Therapy						25
26	Occupational Therapy						26
27	Speech Pathology						27
28	Electrocardiology						28
29	Medical Supplies						29
30	Drugs Charged to Patients						30
31	Dental Care - Title XIX only						31
32	Support Surfaces						32
33	Other Ancillary Service Costs						33
75	Total (Sum of lines 21 - 33)						75

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER NO.:	PERIOD: FROM ____ TO ____	WORKSHEET D-1 PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

Check One: [ ] SNF [ ] NF [ ] ICF/MR

PART I CALCULATION OF INPATIENT ROUTINE COSTS

	INPATIENT DAYS		
1	Inpatient days including private room days		1
2	Private room days		2
3	Inpatient days including private room days applicable to the Program		3
4	Medically necessary private room days applicable to the Program		4
5	Total general inpatient routine service cost		5
	PRIVATE ROOM DIFFERENTAL ADJUSTMENT		
6	General inpatient routine service charges		6
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		7
8	Enter private room charges from your records		8
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		9
10	Enter semi-private room charges from your records		10
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		11
12	Average per diem private room charge differental (Line 9 minus line 11)		12
13	Average per diem private room cost differental (Line 7 times line 12)		13
14	Private room cost differental adjustment (Line 2 times line 13)		14
15	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		16
17	Program routine service cost (Line 3 times line 16)		17
18	Medically necessary private room cost applicable to program (line 4 times line 13)		18
19	Total program general inpatient routine service cost (Line 17 plus line 18)		19
20	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 16 for SNF; line 18 for NF.		20
21	Per diem capital related costs (Line 20 divided by line 1)		21
22	Program capital related cost (Line 3 times line 21)		22
23	Inpatient routine service cost (Line 19 minus line 22)		23
24	Aggregate charges to beneficiaries for excess costs (From provider records)		24
25	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		25
26	Enter the per diem limitation *SEE NOTE BELOW*		26
27	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) *SEE NOTE BELOW*		27
28	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part I, line 4)(See instructions)		28

NOTE: Lines 26 and 27 will not be used for cost reporting periods beginning on and after 7/1/98.

PART II CALCULATION OF INPATIENT INTERN AND RESIDENTS COST FOR PPS PASSTHROUGH
>> FOR COST REPORTING PERIODS BEGINNING ON AND AFTER 07/01/98 <<

1	Total inpatient days. (From Worksheet S-3, Part I, column 7, line 9, less line 8)		1
2	Program inpatient days. (From Worksheet S-3, Part I, cols. 3, 4, or 5, lines 1 or 2 , as applicable)		2
3	Total intern and residence cost. (From Worksheet B, Part I, column 14, line 14)		3
4	Intern and residents retio. (Line 2 divided by line 1)		4
5	Program Intern and resident cost for passthrough. (Line 3 times line 4)		5

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

PROVIDER NO.: ____________

PERIOD FROM ____________ **TO** ____________

WORKSHEET D-2 PARTS I & II

PART I - NOT IN APPROVED TEACHING PROGRAM

	Cost Centers	Percent of Assigned Time	Expense	Total Inpatient Days All Patients	Average Cost Per Day (Col. 2 ÷ 3)	Health Care Program Inpatient Days			Health Care program inpatient cost		
						Title V	Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		1	2	3	4	5	6	7	8	9	10
1	Total cost of services rendered	100.00									
	SNF Inpatient Routine Services:										
2	SNF										
3											
4	Nursing Facility										
4.1	ICF/MR										
5	Other Long Term Care										
6	Home Health Agency										
7											
8	Outpatient Rehabilitation Provider										
9	Ambulatory Surgical Center										
10	Hospice										
11	Other Inpatient Routine Service Costs										
12	Subtotal (Sum of lines 2 through 11)										

	SNF Outpatient Services:			Total Charges (From Wkst. C. Col. 2, lines 34 & 35)	Ratio of Cost to Charges (Col. 2 ÷ by Col. 3)	Titles V and XIX Outpatient and Title XVIII, Part B Charges			Titles V and XIX Outpatient and Title XVIII, Part B Costs		
						Title V	Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
				3	4	5	6	7	8	9	10
13	Clinic										
14	R H C										
15	Subtotal (Sum of lines 13 and 14)										
16	Total (Sum of lines 12 and 15)	100.00									

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

		Exp. allocated to cost centers on Wkst. B, Part I Col. 14	Total Inpatient Days All Patients	Average Cost Per Day (Col. 1 ÷ Col. 2)	Title XVIII Part B Inpatient Days	Expenses Applicable To Title XVIII (Col. 4 X Col. 3)	Enter the amounts from Part I, Column 9, lines as indicated		Total title XVIII Costs (Sum of Cols 5 + 7)
		1	2	3	4	5	6	7	8
17	SNF						2		
18									
19									
20	Total (Sum of lines 17 through 19)								

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CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: ____________	PERIOD: FROM ________ TO ________	WORKSHEET E PART I

PART I - PART A INPATIENT SERVICES

Check one: [ ] Title XVIII [ ] Title V [ ] Title XIX

Check one: [ ] SNF [ ] NF [ ] ICF/MR

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	Inpatient ancillary services (See Instructions)		1
2	Intern and Resident Cost (From Supplemental Worksheet D-2)		2
3	Outpatient services		3
4	Inpatient routine services (See instructions)		4
5	Utilization review--physicians' compensation (From provider records)		5
6	Cost of covered services (Sum of lines 1 - 5)		6
7	Differential in charges between semiprivate accomodations and less than semiprivate accomodations		7
8	SUBTOTAL (Line 6 minus line 7)		8
9	Primary payor amounts		9
10	Total Reasonable Cost (Line 8 minus line 9)		10
	REASONABLE CHARGES		
11	Inpatient ancillary service charges		11
12	Intern and Resident Charges (From Provider Records)		12
13	Outpatient service charges		13
14	Inpatient routine service charges		14
15	Differential in charges between semiprivate accomodations and less than semiprivate accomodations		15
16	Total reasonable charges		16
	CUSTOMARY CHARGES		
17	Aggregate amount actually collected from patients liable for payment for services on a charge basis		17
18	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)		19
20	Total customary charges (See instructions)		20
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
21	Cost of covered services (See Instructions)		21
22	Deductibles (Titles V and XIX only)		22
23	Subtotal (Line 21 minus line 22)		23
24	Coinsurance		24
25	Subtotal (Line 23 minus line 24)		25
26	Reimbursable bad debts (From your records)		26
27	Subtotal (Sum of lines 25 and 26)		27
28	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		29
30	Other Adjustments (See instructions) Specify		30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (If minus, enter amount in brackets)		31
32	Subtotal (Line 27 plus or minus lines 30, and 31, minus lines 28 and 29)		32
33	Sequestration amount		33
34	Sub total (Line 32 minus line 33)		34
35	Interim payments		35
36	Balance due provider/program (Line 34 minus line 35) (Indicate overpayments in brackets) (See Instructions)		36
37	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2)		37

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: ______	PERIOD: FROM ______ TO ______	WORKSHEET E PART II

PART II - PART B - MEDICAL AND OTHER HEALTH SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient ancillary services (See Instructions)		1
2	Outpatient services		2
3	Vaccine cost (From Wkst D., Part II, line 3)		3
4	Interns and Residents (From Supp. Wkst. D-2)		4
5	Subtotal (Sum of lines 1, 2, 3 and 4)		5
6	Primary payor amounts		6
7	Total Reasonable Cost (Line 5 minus line 6)		7
REASONABLE CHARGES			
8	Inpatient ancillary service charges		8
9	Outpatient service charges		9
10	Intern & Resident Charges (From Provider Records)		10
11	Total reasonable charges (See Instructions)		11
CUSTOMARY CHARGES			
12	Aggregate amount actually collected from patients liable for payment for services on a charge basis		12
13	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		13
14	Ratio of line 12 to line 13 (not to exceed 1.000000)		14
15	Total customary charges (See instructions)		15
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
16	Cost of covered services (Lesser of Cost or Charges) (Lesser of ln 5 or ln 15 minus ln 6)		16
17	Deductibles and coinsurance		17
18	Subtotal (Line 16 minus line 17)		18
19	Reimbursable bad debts (From your records)		19
20	Subtotal (Sum of lines 18, and 19)		20
21	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		21
22	Other Adjustments (See instructions) Specify		22
23	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (If minus, enter amount in brackets)		23
24	Subtotal (Line 20 minus line 21 plus or minus lines 22 and 23)		24
25	Sequestration amount		25
26	Subtotal (Line 24 minus line 25)		26
27	Interim payments		27
28	Balance due provider/program (Line 26 minus line 27) (Indicate overpayments in brackets) (See Instructions)		28
29	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2)		29

FORM CMS 2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3534.2)

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: ________________	PERIOD: FROM ____________ TO ______________	WORKSHEET E PART III

PART III - SNF REIMBURSEMENT UNDER PPS

Check one: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES

1	Inpatient ancillary services - Part A - (See Instructions)		1
2	Interns & Residents and Medical Education cost for Title XVIII (See Instructions)		2
3	Total cost (Sum of lines 1 and 2)		3
4	Medicare inpatient ancillary charges (see instructions)		4
5	Intern and Resident Charges (From Provider Records)		5
6	Cost of covered services (lesser of line 3, or the sum of lines 4 and 5)		6
7	Inpatient PPS amount (see instructions)		7
8	Primary payor amounts		8
9	Coinsurance		9
10	Reimbursable bad debts (From your records)		10
11	Utilization review		11
12	Recovery of excess depreciation resulting from provider termination or a decrease in Program utilization.		12
13	Amounts applicable to prior cost reporting periods resulting from disposition of assets. (If minus, enter amount in brackets)		13
14	Subtotal (Sum of lines 3, 7, 10 and 11, minus lines 12, 8 & 9, plus or minus line 13)		14
15	Sequestration adjustment		15
16	Interim payments (See instructions)		16
17	Balance due provider/program (Line 14 minus the sum of lines 15 and 16) (Indicate overpayments in brackets) (See Instructions)		17
18	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)		18

PART B - ANCILLARY SERVICES COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY

19	Ancillary services Part B		19
20	Vaccine cost (From Wkst D, Part II, line 3)		20
21	Intern and Resident Cost (From Worksheet D-2)		21
22	Total reasonable costs (Sum of lines 19 to 21)		22
23	Medicare Part B ancillary charges (See instructions)		23
24	Intern and Resident Charges (From Provider Records)		24
25	Cost of covered services (Lesser of line 22, or sum of lines 23 and 24)		25
26	Primary payor amounts		26
27	Coinsurance and deductibles		27
28	Reimbursable bad debts (From your records)		28
29	Recovery of unreimbursed cost under the lesser of reasonable cost or customary charges		29
30	80% of recovery of unreimbursed cost under the lesser of reasonable cost or customary charges (Line 29 times 0.80)		30
31	Recovery of excess depreciation resulting from provider termination or a decrease in Program utilization.		31
32	Other Adjustments (See instructions) Specify		32
33	Amounts applicable to prior cost reporting periods resulting from disposition of assets. (If minus, enter amount in brackets)		33
34	Subtotal (Sum of lines 25, 28, & 30, minus lines 26, 27, and 31, plus or minus line 32 and 33)		34
35	Sequestration adjustment		35
36	Interim payments (See instructions)		36
37	Balance due provider/program (Line 34 minus the sum of lines 35 and 36) (Indicate overpayments in brackets) (See Instructions)		37
38	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2)		38

CALCULATION OF PPS REIMBURSEMENT SETTLEMENT	PROVIDER NO.: ______________	PERIOD: FROM ________ TO ________	WORKSHEET E, PART V

PART V - REIMBURSEMENT UNDER NHCMQ DEMONSTRATION

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER JULY 1, 1998.

	PART A - INPATIENT SERVICES: PROVIDER COMPUTATION OF REIMBURSEMENT		
	INPATIENT DAYS		
1	Total Title XVIII Days (From Wkst. S-3, Part I, col 4, sum of lines 1 and 2)		1
2	Program Days (From Wkst. S-7, Part I, line 46, sum of cols. 3.01 and 4.01)		2
	INPATIENT ANCILLARY SERVICES - PART A		
3	Total Part A Ancillary Program Costs (From Wks. D, Col. 4, line 75)		3
4	Less Physical, Occupational and Speech Therapy (Complete this line for Phase 3 only) (From Wks. D, Col. 4, sum of lines 25 - 27)		4
5	Net Non-NHCMQ Demonstration Ancillary Services (Line 3 less line 4)		5
	NHCMQ DEMONSTRATION INPATIENT/ANCILLARY SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
6	Inpatient routine/ancillary PPS amount paid (From Supp. Wkst. S-7, Part I, Col 5, line 46)		6
	PROGRAM INPATIENT CAPITAL COSTS		
7	Capital related cost allocated to inpatient routine service cost (From Worksheet B, Part II column 18, sum of lines 16, 17 and 18)		7
8	Per diem capital related costs (See instructions)		8
9	Program capital related cost (Line 8 times line 1)		9
	NHCMQ DEMONSTRATION ANCILLARY SERVICES: INDIRECT COST COMPONENT		
	Total general service cost allocation - (Lines 10 through 24 are completed only for Phase 3)		
10	Physical Therapy (Wkst. B, Part I, Col 18, line 25)		10
11	Occupational Therapy (Wkst B, Part I, Col 18 line 26)		11
12	Speech Therapy (Wkst B, Part I, Col 18 line 27)		12
	Direct cost -		
13	Physical Therapy (Wkst. B, Part I, Col 0, line 25)		13
14	Occupational Therapy (Wkst B, Part I, Col 0 line 26)		14
15	Speech Therapy (Wkst B, Part I, Col 0 line 27)		15
	Indirect Cost -		
16	Physical Therapy (Line 10 less line 13)		16
17	Occupational Therapy (Line 11 less line 14)		17
18	Speech Therapy (Line 12 less line 15)		18
	Charge to Charge Ratio -		
19	Physical Therapy (Wkst D, col 2, line 25 divided by Wkst C, Col 2, line 25)		19
20	Occupational Therapy (Wkst D, Col 2, line 26 divided by Wkst C, Col 2, line 26)		20
21	Speech Therapy (Wkst D, Col 2, line 27 divided by Wkst C, Col 2, line 27)		21
	Demonstration Indirect Cost -		
22	Physical Therapy (Line 16 times line 19)		22
23	Occupational Therapy (Line 17 times line 20)		23
24	Speech Therapy (Line 18 times line 21)		24
	Total Reimbursed NHCMQ Demonstration		
25	NHCMQ Demonstration Inpatient/Ancillary Services - Part A - PPS Provider Computation of Reimbursement (Phase II - enter sum of lines 5,6 and 9)(Phase III - enter the sum of lines 5, 6, 9, 22, 23 and 24.) Transfer this amount to Worksheet E, Part III, line 7		25

FORM CMS 2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3534.4)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER NO.: ________________	PERIOD: FROM ________________ TO ________________	WORKSHEET E - 1

	Description			Inpatient Part A		Part B		
				Mo / Day / Yr	Amount	Mo / Day / Yr	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, enter zero							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.54)		.99					3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Wkst E, Part I line 35; Wkst E, Part II line 27; or Wkst E, Part III, line 16 for Part A, and line 36 for Part B)							4

TO BE COMPLETED BY INTERMEDIARY

	Description			1	2	3	4	
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to provider	.01					6.01
		Provider to program	.50					6.50
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)							7

Name of Intermediary	Intermediary Number	Signature of Authorized Person	Date (Mo/Day/Yr)

(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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)	PROVIDER NO.:	PERIOD: FROM ________ TO ___________	WORKSHEET G

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

( ) = contra amount

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)	PROVIDER NO.:	PERIOD: FROM ________ TO ___________	WORKSHEET G (Cont.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
34	Accounts payable					34
35	Salaries, wages & fees payable					35
36	Payroll taxes payable					36
37	Notes & loans payable (Short term)					37
38	Deferred income					38
39	Accelerated payments					39
40	Due to other funds					40
41	Other current liabilities					41
42	TOTAL CURRENT LIABILITIES (Sum of lines 34 - 41)					42
	LONG TERM LIABILITIES					
43	Mortgage payable					43
44	Notes payable					44
45	Unsecured loans					45
46	Loans from owners: a. Prior to 7/1/66 b. On or after 7/1/66					46
47	Other long term liabilities					47
48						48
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43 - 48)					49
50	TOTAL LIABILITIES (Sum of lines 42 and 49)					50
	CAPITAL ACCOUNTS					
51	General fund balance					51
52	Specific purpose fund					52
53	Donor created - endowment fund balance - restricted					53
54	Donor created - endowment fund balance - unrestricted					54
55	Governing body created - endowment fund balance					55
56	Plant fund balance - invested in plant					56
57	Plant fund balance - reserve for plant improvement, replacement and expansion					57
58	TOTAL FUND BALANCES (Sum of lines 51 thru 57)					58
59	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 50 and 58)					59

( ) = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET G - 1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1		2		3		4		
1	Fund balances at beginning of period									1
2	Net income (loss) (From Wkst. G-3, line 32)									2
3	Total (Sum of line 1 and line 2)									3
4	Additions (Credit adjustments)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (Sum of lines 4 - 9)									10
11	Subtotal (Line 3 plus line 10)									11
12	Deductions (Debit adjustments)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (Sum of lines 12 - 17)									18
19	Fund balance at end of period per balance sheet (Line 11 - line 18)									19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER NO:	PERIOD: FROM ________ TO ________	WORKSHEET G - 2 PARTS I & II

PART I - PATIENT REVENUES

	Revenue Center	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Skilled Nursing Facility				1
2					2
3	Nursing facility				3
4	Other long term care				4
5	Total general inpatient care services (Sum of lines 1 - 4)				5
	All Other Care Service				
6	Ancillary services				6
7	Clinic				7
8	Home health agency				8
9					9
10	Ambulance				10
11	Hospice				11
12	Outpatient Rehabilitation Provider				12
13					13
14	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)				14

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 75)			1
2	Add (Specify)			2
3				3
4				4
5				5
6				6
7				7
8	Total Additions (Sum of lines 2 - 7)			8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (Sum of lines 9 - 13)			14
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14) (Transfer to Worksheet G-3, Line 4)			15

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3536.2)

STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO: ____________	PERIOD: FROM ________ TO ___________	WORKSHEET G - 3	
1	Total patient revenues (From Wkst. G - 2, Part I, col. 3, line 14)			1
2	Less: contractual allowances and discounts on patients accounts			2
3	Net patient revenues (Line 1 minus line 2)			3
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)			4
5	Net income from service to patients (Line 3 minus 4)			5
6	Other income:			6
7	Contributions, donations, bequests, etc			7
8	Income from investments			8
9	Revenues from telephone and telegraph service			9
10	Revenue from television and radio service			10
11	Purchase discounts			11
12	Rebates and refunds of expenses			12
13	Parking lot receipts			13
14	Revenue from laundry and linen service			14
15	Revenue from meals sold to employees and guests			15
16	Revenue from rental of living quarters			16
17	Revenue from sale of medical and surgical supplies to other than patients			17
18	Revenue from sale of drugs to other than patients			18
19	Revenue from sale of medical records and abstracts			19
20	Tuition (fees, sale of textbooks, uniforms, etc.)			20
21	Revenue from gifts, flower, coffee shops, canteen			21
22	Rental of vending machines			22
23	Rental of skilled nursing space			23
24	Governmental appropriations			24
25	Other (specify)			25
26	Total other income (Sum of lines 7 - 25)			26
27	Total (Line 5 plus line 26)			27
28	Other expenses (specify)			28
29				29
30				30
31	Total other expenses (Sum of lines 28 - 30)			31
32	Net income (or loss) for the period (Line 27 minus line 31)			32

ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS

PROVIDER NO.: ________

HHA NO.: ________

PERIOD: FROM ________ **TO** ________

WORKSHEET H

		SALARIES (FROM WKST. H-1)	EMPLOYEE BENEFITS (FROM WKST. H-2)	TRANSPORT-ATION (SEE INSTRUCTIONS)	CONTRACTED/ PURCHASED SRVS (FROM WKST. H-3)	OTHER COSTS	TOTAL HHA COST	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTER							
1	Capital Related - Bldg. and Fixtures							1
2	Capital Related - Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (See Instructions)							4
5	Administrative - General -HHA							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	DME - Rented							12
13	DME - Sold							13
14	Supplies (See Instructions)							14
	HHA NONREIMBURSABLE SERVICES							
15	Respiratory Therapy							15
16	Private Duty Nursing							16
17	Clinic							17
18	Health Promotion Activities							18
19	Day Care Program							19
20	Home Delivered Meals Program							20
21	Homemaker Service							21
22								22
23								23
24								24
25	Total							25

COMPENSATION ANALYSIS SALARIES AND WAGES	PROVIDER NO.:____________ HHA NO.:________________	PERIOD: FROM ____________ TO ____________	WORKSHEET H - 1

		ADMINISTRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22											22
23											23
24											24
25	Total										25

(1) See Instructions

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3540)

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO.:______________

HHA NO.:____________________

PERIOD:
FROM ________________
TO ________________

WORKSHEET H - 2

		ADMINIS-TRATORS	DIRECTORS	CONSULT-ANTS	SUPER-VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22											22
23											23
24											24
25	Total										25

(1) See Instructions

COMPENSATION ANALYSIS CONTRACTED SERVICES PURCHASED SERVICES	PROVIDER NO.:____________ HHA NO.:__________________	PERIOD: FROM ______________ TO ______________	WORKSHEET H - 3

		ADMINIS-TRATORS	DIRECTORS	CONSULT-ANTS	SUPER-VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22	All Other										22
23											23
24											24
25	Total										25

(1) See Instructions

Form 3569

ALLOCATION OF H H A ADMINISTRATIVE AND GENERAL COSTS	PROVIDER NO.: ________ HHA NO.:________	PERIOD: FROM________ TO________	WORKSHEET H - 4 PARTS I & II

PART I - ALLOCATION OF HHA ADMINISTRATIVE AND GENERAL COSTS

	Cost Center	From Wkst B. Part I, Col 18 Lines as Indicated		Shared Ancillary Costs, from Wkst H-4, Part II Lines as Indicated		Subtotal (Sum of Cols. 1 and 2)	Allocation of H H A A & G Costs	Total H H A Costs (Col. 3 + Col. 4)	
		1		2		3	4	5	
1	Administrative and General--HHA	37					( )	-0-	1
2	Skilled Nursing Care--HHA	38							2
3	Physical Therapy--HHA	39		1					3
4	Occupational Therapy--HHA	40		2					4
5	Speech Pathology--HHA	41		3					5
6	Medical Social Services--HHA	42							6
7	Home Health Aide--HHA	43							7
8	Durable Medical Equipment Rented--HHA	44							8
9	Durable Medical Equipment Sold--HHA	45							9
10	Medical Supplies Charged to Patients			4					10
11	Drugs Charged to Patients			5					11
12	Home Delivered Meals--HHA	46							12
13	Other Home Health Services--HHA	47		6 / 7					13
14	TOTAL (Sum of lines 1 thru 13)			8			-0-		14
15	BASIS FOR ALLOCATION (Sum of lines 2 thru 13)								15
16	UNIT COST MULTIPLIER (Line 1 divided by line 15)								16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED S N F DEPARTMENTS

	Cost Center	Total H H A Charges - From Provider Records	Cost/Charge Ratio Fr. Wkst. C. Col. 3, Lines as indicated		H H A Shared Ancillary Costs (Col. 1 X Col. 2)	Transfer Column 3 to Part I as indicated		
		1	2		3	4		
1	Physical Therapy		25			Col. 2, line 3		1
2	Occupational Therapy		26			Col. 2, line 4		2
3	Speech Pathology		27			Col. 2, line 5		3
4	Medical Supplies Charged to Patients		29			Col. 2, line 10		4
5	Drugs Charged to Patients		30			Col. 2, line 11		5
6	Dental Care (Title XIX Only)		31			Col. 2, line 13		6
7	Other Ancillary Service Cost		33			Col. 2, line 13		7
8	TOTAL					Col. 2, line 14		8

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: ____________________ HHA NO:	PERIOD: From: __________________ To: __________________	WORKSHEET H-5 PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATION

	Cost Per Visit Computation Patient Services	From Wkst H-4 Pt I, Col. 5, Line	Total Cost	Total Visits	Average Cost Per Visit (Cols 2 ÷ 3) (1)	
		1	2	3	4	
1	Skilled Nursing	*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 Services	*7*				6
7	Total (Sum of lines 1-6)					7

PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)

	Total Medicare Patient Service Cost Computation	Average Cost Per Visit: From Part I Column 4 Line ___	Average Cost Per Visit	Medicare Program Visits: Part A	Medicare Program Visits: Part B Not Subject to Deductibles & Coinsurance	Medicare Program Visits: Part B Subject to Deductibles & Coinsurance	
	MSA Code: __________		4	5	6	7	
1	Skilled Nursing - pre 10/1/2000	*1*					1
1.01	Skilled Nursing -post 9/30/2000	*1*					1.01
2	Physical Therapy - pre 10/1/2000	*2*					2
2.01	Physical Therapy - post 9/30/2000	*2*					2.01
3	Occupational Therapy - pre 10/1/2000	*3*					3
3.01	Occupational Therapy - post 9/30/2000	*3*					3.01
4	Speech Pathology - pre 10/1/2000	*4*					4
4.01	Speech Pathology - post 9/1/2000	*4*					4.01
5	Medical Social Services - pre 10/1/00	*5*					5
5.01	Medical Social Services - post 9/30/00	*5*					5.01
6	Home Health Aide Svcs pre 10/1/2000	*6*					6
6.01	Home Health Aide Svcs - post 9/30/00	*6*					6.01
7	Total (Sum of lines 1-6)						7

(1) Compute the average cost per visit one time for each discipline (column 4, lines 1 through 6) for the entire home health agency.
(2) Complete Part II once for each SMSA where Medicare covered services were furnished during the cost reporting period.

FORM CMS-2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3544)

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: ______ HHA NO:	PERIOD: From: ______ To: ______	WORKSHEET H-5 PART II (Cont.)

PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)

Total Medicare Patient Service Cost Computation		Cost of Medicare Services					
			Part B				
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total (Sum of Cols 8 & 9 Pre 10/01/2000	Total (Sum of Cols 8 & 9 Post 9/30/2000	
		8	9	10	11	11.01	
1	Skilled Nursing - pre 10/1/2000						1
1.01	Skilled Nursing -post 9/30/2000						1.01
2	Physical Therapy - pre 10/1/2000						2
2.01	Physical Therapy - post 9/30/2000						2.01
3	Occupational Therapy - pre 10/1/2000						3
3.01	Occupational Therapy - post 9/30/2000						3.01
4	Speech Pathology - pre 10/1/2000						4
4.01	Speech Pathology - post 9/1/2000						4.01
5	Medical Social Services - pre 10/1/00						5
5.01	Medical Social Services - post 9/30/00						5.01
6	Home Health Aide Svcs pre 10/1/2000						6
6.01	Home Health Aide Svcs - post 9/30/00						6.01
7	Total (Sum of lines 1-6)						7

(1) Compute the average cost per visit one time for each discipline (column 4, lines 1 through 6) for the entire home health agency.
(2) Complete Part II once for each SMSA where Medicare covered services were furnished during the cost reporting period.

Total Medicare Patient Service Cost Limitation Computation		Program Cost Limit	Medicare Program Visits			Cost of Medicare Services			Total (Sum of Cols 8 & 9	
			Part A	Part B Deductibles and Coinsurance		Part A	Part B Deductibles and Coinsurance			
				(Not Subject to)	(Subject to)		(Not Subject to)	(Subject to)		
		4	5	6	7	8	9	10	11	
8	Skilled Nursing									8
9	Physical Therapy									9
10	Occupational Therapy									10
11	Speech Pathology									11
12	Medical Social Services									12
13	Home Health Aide Svcs									13
14	Total (Sum of lines 8-13)									14

FORM CMS-2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3544)

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: ____________ HHA NO:	PERIOD: From: ____________ To: ____________	WORKSHEET H-5 PART III

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	Other Patient Services	From Wkst. H-4, Part I, Col. 5 Line -	Total HHA Cost	Total Charges from HHA Record)	Ratio (Col 2 ÷ 3)	Part A Covered Charges	Part B Charges Not Subject to Deductibles & Coinsurance	Part B Charges Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	
15	Cost of Medical Supplies-Pre 10/01/2000	*10*							15
15.01	Cost of Medical Supplies-Post 10/01/2000	*10*							15.01
16	Cost of Drugs-Pre 10/01/200	*11*							16
16.01	Cost of Drugs-Post 10/01/2000	*11*							16.01
17	Total								17

		Part A Cost of Services	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		8	9	10	
15	Cost of Medical Supplies - Pre 10/01/2000				15
15.01	Cost of Medical Supplies - Post 09/30/2000				15.01
16	Cost of Drugs-Pre 10/0/2000				16
16.01	Cost of Drugs-Post 10/01/2000				16.01
17	Total				17

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: ______ HHA NO:	PERIOD: From: ______ To: ______	WORKSHEET H-5 PARTS IV & V

PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION

		Medicare Program Unduplicated Census Count For Each MSA	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From your FI)	Cost of Medicre Services			Total (Sum of Columns 3 and 4)	
					Part B			
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1	2	3	4	5	6	
18	Total Cost of Medicare Services (Sum of the amounts for each Whst. H-5 Part II, columns 8, 9 & 11, respectively, line1-6)(exclusive of subscripts)							18
19	Cost of Medical Supplies (From Part III, columns 8 and 9, line 15)(exclusive of subscripts)							19
20	Total (Sum of lines 18 and 19).							20
21	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. H-5, Pt II, cols. 8 & 9 respectively, line 14)							21
22	Cost of Medical Supplies (From Part III, cols. 8 & 9, line 15)(exclusive of subscripts)							22
23	Total (Sum of lines 21 and 22)							23

		MSA Code	Medicare Program Unduplicated Census Count For Each MSA	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From your FI)	Cost of Medicare Services			Total (Sum of Columns 3 and 4)	
						Part B			
					Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		0	1	2	3	4	5	6	
24	Per Beneficiary Cost Limitation for MSA:								24
24.01	Per Beneficiary Cost Limitation for MSA:								24.01
24.02	Per Beneficiary Cost Limitation for MSA:								24.02
24.03	Per Beneficiary Cost Limitation for MSA:								24.03
24.04	Per Beneficiary Cost Limitation for MSA:								24.04
24.05	Per Beneficiary Cost Limitation for MSA:								24.05
24.06	Per Beneficiary Cost Limitation for MSA:								24.06
24.07	Per Beneficiary Cost Limitation for MSA:								24.07
24.08	Per Beneficiary Cost Limitation for MSA:								24.08
24.09	Per Beneficiary Cost Limitation for MSA:								24.09
25	Aggregate Per Beneficiary Cost Limitation (Sum of lines 24 and subscripts thereof)								25

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION

	Patient Services	From Part I, Col. 4 Line:	Average Cost Per Visit	Part B - Subject to Deductibles and Coinsurance								
				Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services on & After 1/1/98	Medicare Program Visits for Services on & After 1/1/99	Medicare Program Costs for Services on & After 1/1/98	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
		1	2	3	4	5	5.01	6	7	8	
26	Physical Therapy	2									26
27	Occupational Therapy	3									27
28	Speech Pathology	4									28
29	Total (Sum of lines 26-28)										29

FORM CMS-2540-96 (06/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3544)

CALCULATION OF H H A REIMBURSEMENT SETTLEMENT PART A & PART B SERVICES	PROVIDER NO.: _______ HHA NO.:	PERIOD: FROM_______ TO_______	WORKSHEET H-6 PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

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

	Description	PART A	PART B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
Reasonable Cost of Program		1	2	3	
1	Cost of Services (See Instructions)				1
2	Total program charges for title XVIII Part A and Part B Services - Pre 10/01/2000				2
2.01	Total program charges for title XVIII Part A and Part B Services - Post 9/30/2000				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 1 to 2 (Not to exceed 1.0000)				5
6	Total customary program charges (Line 5 X line 2 - each column)				6
7	Primary Payor Amounts				7

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
8	Lesser of Cost or Charges (See Instructions)			8
8.01	Total PPS Reimbursement - Full Episodes without Outliers			8.01
8.02	Total PPS Reimbursement - Full Episodes with Outliers			8.02
8.03	Total PPS Reimbursement - LUPA Episodes			8.03
8.04	Total PPS Reimbursement - PEP Episodes			8.04
8.05	Total PPS Reimbursement - SCIC within a PEP Episode			8.05
8.06	Total PPS Reimbursement - SCIC Episodes			8.06
8.07	Total PPS Outlier Reimbursement - Full Episodes with Outliers			8.07
8.08	Total PPS Outlier Reimbursement - PEP Episodes			8.08
8.09	Total PPS Outlier Reimbursement - SCIC within a PEP Episode			8.09
8.10	Total PPS Outlier Reimbursement - SCIC Episodes			8.10
8.11	Total Other Payments			8.11
8.12	DME Payment			8.12
8.13	Oxygen ayment			8.13
8.14	Prosthetics and Orthotic Payment			8.14
9	Part B deductibles billed to Medicare patients (exclude coinsurance)			9
10	Subtotal (Line 8 minus line 9)			10
11	Coinsurance billed to Program patients (From your records)			11
12	Net cost (Line 10 minus line 11)			12
13	Reimbursable bad debts (From your records)			13
14	Total Costs - Current cost reporting period (Line 12 plus line 13)			14
15	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			15
16	Recovery of excess depreciation resulting from agencies' termination or decrease in Program utilization			16
17	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit			17
18	Total cost - before sequestration & other Adjustments (Line 14, minus the sum of lines 16 and 17 plus or minus the amount on line 15)			18
18.01	Other adjustments (see instructions) (Specify)			18.01
19	Sequestration Adjustment (See Instructions)			19
20	Amount due to you after sequestration adjustment & other adjustments (Line 18 plus line 18.01 minus line 19)			20
21	Total interim payments (From Worksheet H-7, line 4)			21
21.01	Tentative Settlement (For Intermediary Use Only)			
22	Balance due HHA/Program (Line 20, Plus Line 20.01, minus line 21) (Indicate overpayments in brackets)			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			23

FORM CMS 2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 3545 - 3545.2)

ANALYSIS OF PAYMENTS TO PROVIDER - BASED H H A's FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: ______ HHA NO.: ______	PERIOD: FROM ______ TO ______	WORKSHEET H-7

	Description			PART A Mo/Day/Yr 1	PART A Amount 2	PART B Mo/Day/Yr 3	PART B Amount 4	
1	Total interim payments paid to provider							1
2	Interim pymts payable on individual bills either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment . If none, write "NONE", or enter a zero, (1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (Sum of lines 3.01-3.05, minus sum of lines 3.50-3.54)		.99					3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99) (Transfer to Workseet H-6, Part II, column as appropriate, line 21)							4
	TO BE COMPLETED BY INTERMEDIARY							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE", or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	SUBTOTAL (Sum of lines 5.01-5.03 minus sum of lines 5.50-5.52)		.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	.50					6.50
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)							7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	Date: Month, Day, Year

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

FORM CMS 2540-96 (08/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3546)

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	**PROVIDER NO.:** **COMPONENT NO.: ________**	**PERIOD:** **FROM ____________** **TO _______________**	**WORKSHEET J - 1** **PART I**
Check Applicable Box:	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	NET EXPENSES FOR COST ALLOCATION	CAPITAL REL. COST BUILDS. & FIXTURES	CAPITAL REL. COST MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (COLS. 0-3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3a	4	
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	Appr. 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	Other General Service Cost							21
22	Totals (Sum of lines 1-21) (1)							22

(1) Columns 0 through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 50, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: COMPONENT NO.: ________	PERIOD: FROM ____________ TO _______________	WORKSHEET J - 1 PART I (CONT.)
Check Applicable Box:	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS- TRATION	
		5	6	7	8	9	
1	Administrative and General						1
2	Skilled Nursing						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	Appr. 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	Other General Service Cost						21
22	Totals (Sum of lines 1-21) (1)						22

(1) Columns 0 through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 50, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: COMPONENT NO.: ______	PERIOD: FROM ___________ TO ______________	WORKSHEET J-1 PART I (CONT.)
Check Applicable Box	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	INTERNS & RESIDENTS	OTHER GENERAL SERVICES	
		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	Other General Service Cost							21
22	Totals (Sum of lines 1-21) (1)							22

(1) Columns o through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 50, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: COMPONENT NO.: ______	PERIOD: FROM ____________ TO _______________	WORKSHEET J-1 PART I (CONT.) PART II
Check Applicable Box	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	SUBTOTAL	POST STEPDOWN ADJUSTMENTS	SUBTOTAL	ALLOCATED A & G (SEE PART II)	TOTAL (SUM OF COLS 18 AND 19)	
		16	17	18	19	20	
1	Administrative and General						1
2	Skilled Nursing						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	App. Patient Training & Education						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21	Other General Service Cost						21
22	Totals (Sum of lines 1-21)						22

PART II - COMPUTATION OF UNIT COST MULTIPLIER FOR ALLOCATION OF COMPONENT ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 18, line 22		1
2	Amount from Part I, column 18, line 1		2
3	Line 1 minus line 2		3
4	Unit cost multiplier for A & G costs (Line 2 divided by line 3) (Multiply each amount in column 18, lines 2 through 21, Part I, by the unit cost multiplier and enter the result on the corresponding line of column 19)		4

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: COMPONENT NO.: ______	PERIOD: FROM ____________ TO ______________	WORKSHEET J - 1 PART III
Check Applicable Box:	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	0	CAPITAL REL. COST BUILDS. & FIXTURES (Square Feet) 1	CAPITAL REL. COST MOVABLE EQUIPMENT (Value or Square Feet 2	EMPLOYEE BENEFITS (Gross Salaries) 3		ADMINIS-TRATIVE & GENERAL (Accumulated Cost) 4	
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	Other General Service Cost							21
22	Totals (Sum of lines 1-21)							22
23	Total Cost to be Allocated							23
24	Unit Cost Multiplier							24

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	**PROVIDER NO.:** **COMPONENT NO.: ______**	**PERIOD:** **FROM ____________** **TO _______________**	**WORKSHEET J - 1** **PART III (Cont.)**
Check Applicable Box:	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet) 5	LAUNDRY & LINEN SERVICE (Pounds of Laundry) 6	HOUSE - KEEPING (Hours of Service) 7	DIETARY (Meals Served) 8	NURSING ADMINIS TRATION (Direct Nursing Hours of Service) 9	
1	Administrative and General						1
2	Skilled Nursing						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	App. Patient Training & Education						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21	Other General Service Cost						21
22	Totals (Sum of lines 1-21)						22
23	Total Cost to be Allocated						23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: COMPONENT NO.: ______	PERIOD: FROM ____________ TO ____________	WORKSHEET J - 1 PART III (Cont.)
Check Applicable Box:	[ ] C. M. H. C. [ ] C. O. R. F.	[ ] OPT [ ] OOT	[ ] OSP

	COMPONENT COST CENTER (Omit Cents)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	INTERNS & RESIDENTS (Assigned Time)	OTHER GENERAL SERVICE ( )	
		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	Other General Service Cost							21
22	Totals (Sum of lines 1-21)							22
23	Total Cost to be Allocated							23
24	Unit Cost Multiplier							24

COMPUTATION OF OUTPATIENT REHABILITATION PROVIDER COSTS	PROVIDER NO.: COMPONENT NO.: _______	PERIOD: FROM ____________ TO _______________	WORKSHEET J - 2 PARTS I, II, AND III

Check Applicable Box: [ ] C.M.H.C. [ ] C.O.R.F. [ ] OPT [ ] OOT [ ] OSP

	PART I - APPORTIONMENT OF REHABILITATION COST CENTERS	TOTAL COSTS (FR. WKST. J-1 PART I, COL. 20)	TOTAL CHARGES	RATIO OF COSTS TO CHARGES (1)	TITLE V CHARGES	TITLE V (COL. 3 X COL 4)	TITLE XIX CHARGES	TITLE XIX (COL. 3 X COL 6)	
		1	2	3	4	5	6	7	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Respiratory Therapy								7
8	Psychiatric/Psychological Services								8
9	Individual Therapy								9
10	Group Therapy								10
11	Individualized Activity Therapy								11
12	Family Counseling								12
13	Diagnostic Services								13
14	App. Patient Training & Education								14
15	Prosthetic and Orthotic Devices								15
16	Drugs and Biologicals								16
17	Medical Supplies								17
18	Medical Appliances								18
19	Durable Medical Equipment - Rented								19
20	Durable Medical Equipment - Sold								20
21	Other General Service Cost								21
22	Totals (Sum of lines 2-21) (2)								22
	PART II - APPORTIONMENT OF COST OF REHAB SERVICES FURNISHED BY SHARED DEPARTMENTS								
23	Oxygen (Inhalation) Therapy		(2)						23
24	Physical Therapy		(2)						24
25	Occupational Therapy		(2)						25
26	Speech Pathology		(2)						26
27	Medical Supplies Charged to Patients		(2)						27
28	Drugs Charged to Patients		(2)						28
29	Other Costs Furnished by shared Departments		(2)						29
30	Total (Sum of lines 23 through 29)								30
	PART III - TOTAL REHAB COSTS								
31	Total rehab costs - Add Part I, columns 5 , 7 and 9 respectively, line 22, and Part II, columns 5, 7, and 9 line 30. (Transfer Titles V and XIX amounts to Worksheet J-3, column 1 or 3, line 1)								31

(1) Ratio of cost to charges: Part I - column 1 divided by column 2; Part II - From Wkst. C, col. 3, lines as applicable (2) Charges for Part II, col. 2 are obtained from provider records

COMPUTATION OF OUTPATIENT REHABILITATION PROVIDER COSTS	PROVIDER NO.: COMPONENT NO.: ________	PERIOD: FROM ____________ TO _______________	WORKSHEET J - 2 PARTS I, II, AND III (Cont.)

Check Applicable Box: [ ] C.M.H.C. [ ] C.O.R.F. [ ] OPT [ ] OOT [ ] OSP

	PART I - APPORTIONMENT OF REHABILITATION COST CENTERS	TITLE XVIII				REASONABLE COST REDUCTION AMOUNT	COST, NET OF REASONABLE COST REDUCTION	
		CHARGES	COSTS (COL. 3 X COL 8)	CHARGES ON & AFTER 1/1/98	COSTS - ON & AFTER 01/01/98 (Col. 3 X Col. 10)			
		8	9	10	11	12	13	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	Other General Service Cost							21
22	Totals (Sum of lines 2-21)							22
	PART II - APPORTIONMENT OF COST OF REHAB SERVICES FURNISHED BY SHARED DEPARTMENTS							
23	Oxygen (Inhalation) Therapy							23
24	Physical Therapy							24
25	Occupational Therapy							25
26	Speech Pathology							26
27	Medical Supplies Charged to Patients							27
28	Drugs Charged to Patients							28
29	Other Costs Furnished by shared Departments							29
30	Total (Sum of lines 23 through 29)							30
	PART III - TOTAL REHAB COSTS							
31	Total Rehab costs - Add the amount from Part I, column 13, line 22 and the amount from Part II, column 13, line 30. Add the amounts from Part I line 22 and Part II line 30 for columns 8 through 11, respectively.							31

CALCULATION OF REIMBURSEMENT SETTLEMENT OF OUTPATIENT REHABILITATION SERVICES	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM ____________ TO ______________	WORKSHEET J - 3 PART I

Check Applicable Box: [ ] C. M. H. C. [ ] OPT [ ] OSP [ ] C. O. R. F. (Title V & XIX) [ ] OOT

		Title V PROGRAM COST	Title XVIII PROGRAM COST	Title XIX PROGRAM COST	
		1	2	3	
1	Cost of REHAB services (From Wkst. J-2, Part II, ln. 31: Title V - col. 5; Title XIX - col 7; Title XVIII - see instructions.)				1
2	Amounts paid and payable by Worker's Compensation and other primary payers				2
3	Subtotal (Line 1 minus line 2)				3
4	Part B deductible billed to Program patients (Exclude coinsurance amounts)				4
5	Net Cost (Line 3 minus line 4)				5
6	80% of Part B cost (80% X line 5)				6
7	Actual coinsurance billed to Program patients (From provider records)				7
8	Net cost less actual billed coinsurance (Line 5 minus line 7)				8
9	Reimbursable bad debts (See Instructions)				9
10	Net reimbursable amount (See Instructions)				10
11	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				11
12	Recovery of excess depreciation resulting from facilitie's termination or a decrease in Program utilization				12
13	Total cost - reimbursable to provider (From line 10)				13
14	Sequestration Amount (See instructions)				14
15	Subtotal (Line 13 minus line 14)				15
16	Interim payments				16
17	Balance due Component/Program (Line 15 minus line 16) (Indicate overpayments in brackets)				17
18	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				18

CALCULATION OF REIMBURSEMENT SETTLEMENT OF OUTPATIENT REHABILITATION SERVICES	PROVIDER NO.:	PERIOD: FROM ____________	WORKSHEET J - 3
	COMPONENT NO.:	TO ______________	PARTS II & III

Check Applicable Box:	[ ] Title V	[ ] Title XVIII	[ ] Title XIX
Check Applicable Box:	[ ] C. O. R. F.	[ ] O. S. P.	
	[ ] O. S. P.	[ ] O. O. T.	

PART II - COMPUTATION OF CUSTOMARY CHARGES FOR REHAB SERVICES

		1	
1	Total reasonable cost of REHAB services (From Wkst. J-2, Part II, line 31 (See instructions)		1
1.1	Total reasonable cost of REHAB services prior to 1/1/98 (See instructions)		1.1
1.2	Total reasonable cost of REHAB services after 1/1/98 (See instructions)		1.2
2	Amounts paid and payable by Worker's Compensation and other primary payers.		2
3	Subtotal (Line 1 minus line 2)		3
4	Total Charges		4
	CUSTOMARY CHARGES		
5	Amounts actually collected from patients liable for payments for rehab services on a charge basis had such payment been made in accordance with (42CFR 413.13(b).		5
6	Amount that would have been realized from patients liable for payment for rehab services on a charge basis had such payment been made in accordance with 42CFR 413.13(b)		6
7	Ratio of line 5 to line 6 (Not to exceed 1.000000)		7
8	Total customary charges - Rehab services (Multiply line 7 X line 4)		8
8.1	Total customary charges - Rehab services prior to 1/1/98		8.1
8.2	Total customary charges - Rehab services on or after 1/1/98		8
	COMPUTATION OF LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES FOR REHAB SERVICES FURNISHED IN CALENDAR YEAR 1998		
8.3	Excess of customary charges over reasonable costs. Complete only if line 8.2 exceeds line 1.2. (See instructions)		8.3
8.4	Excess of reasonable cost over customary charges. Complete only if line 1.2 exceeds line 8.2. (See instructions)		8.4

PART III - COMPUTATION OF REIMBURSEMENT SETTLEMENT OF OUTPATIENT REHABILITATION SERVICES

9	Cost of Rehab services (From line 3)		9
10	Part B deductible billed to Program patients (exclude coinsurance amounts)		10
11	Net Cost (Line 9 minus line 10)		11
11.1	Excess of reasonable costs over customary charges for services rendered on or after 1/1/98		11.1
11.2	Subtotal (Line 11 minus 11.1)		11.2
12	80% of Part B cost (80% X line 11.2)		12
13	Actual coinsurance billed to Program patients (from provider records)		13
14	Net cost less actual billed coinsurance (Line 11.2 minus line 13)		14
15	Reimbursable bad debts (See Instructions)		15
16	Net reimbursable amount (Line 15 plus the lesser of line 12 or line 14		16
17	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets.		17
18	Recovery of excess depreciation resulting from facility's termination or a decrease in Program utilization		18
19	Other adjustments		19
20	Total Cost - reimbursable to provider (line 16 minus lines 17 & 18 plus or minus line 19)		20
21	Sequestration Amount (See instructions)		21
22	Amount due provider after sequestration adjustment (Line 20 minus line 21)Amount		22
23	Interim payments		23
24	Balance due provider/Program (Line 22 minus line 23)(Indicate overpayment in brackets)		24
25	Protested amounts (Nonallowable cost report items) in accordance with PRM II, Sec. 115.2(B)		25
26	Balance due provider/Program (Line 24 minus line 25)(Indicate overpayment in brackets)		26

FORM CMS 2540-96 (12/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 3553)

ANALYSIS OF PAYMENTS TO PROVIDER - BASED COMPONENT FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: ____________ COMPONENT NO.: ____________	PERIOD: FROM ____________ TO	WORKSHEET J - 4

Check Applicable Box: [ ] C.M.H.C. [ ] C.O.R.F. [ ] OPT [ ] OOT [ ] OSP

	Description			Mo / Day / Yr 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "none", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period.	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
	Also show date of each payment.	Provider to Program	.50			3.50
			.51			3.51
	If none, write "NONE," or enter a zero.(1)		.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.55)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Worksheet J-3: Part I line 16, Part III line 23)					4

TO BE COMPLETED BY INTERMEDIARY

	Description			Mo / Day / Yr 1	Amount 2	
5	List separately each tentative settlement payment after desk review.	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
	Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99			5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to Provider	.01			6.01
			.02			6.02
		Provider to Program	.50			6.50
			.51			6.51
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	Date (Mo/Day/Yr)

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

ANALYSIS OF SNF-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	PROVIDER NO: COMPONENT NO:	PERIOD: FROM___________________ TO____________________	WORKSHEET I-1

Check Applicable Box: [ ] RHC [ ] FQHC

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

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

ALLOCATION OF OVERHEAD TO RHC / FQHC SERVICES	PROVIDER NO: COMPONENT NO:	PERIOD: FROM___________________ TO___________________	WORKSHEET I - 2

Check Applicable Box: [ ] RHC [ ] FQHC

PART I - VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits Col. 1 X Col. 3)	Greater of Column 2 or Column 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (Sum of lines 1 - 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Total Staff Costs (Sum of lines 4 - 7)						8
9	Physician Services Under Agreements						9

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

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of Health Care Services (From Worksheet I - 1, column 7, line 22)		10
11	Total nonreimbursable costs (From Worksheet I - 1, column 7, line 28)		11
12	Cost of all services - excluding overhead (Sum of lines 10 and 11)		12
13	Ratio of RHC / FQHC services (Line 10 divided by line 12)		13
14	Total facility overhead (From Worksheet I - 1, column 7, line 31)		14
15	GME Overhead (See instructions)		15
16	Net Facility Overhead		16
17	Parent provider overhead allocated to facility (See instructions)		17
18	Total overhead (Sum of lines 16 and 17)		18
19	Overhead applicable to RHC / FQHC services (Lines 13 X line 18)		19
20	Total allowable cost of RHC / FQHC services (Sum of lines 10 and 19)		20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	PROVIDER NO.: ____________________ COMPONENT NO.: ______________	PERIOD: FROM________________ TO____________________	WORKSHEET I - 3

Check one: [ ] Title V [ ] Title XVIII [ ] Title XIX

Check Applicable Box: [ ] RHC [ ] FQHC

	PART I - DETERMINATION OF RATE FOR RHC / FQHC SERVICES		
1	Total Allowable Cost of RHC/FQHC Services (From Worksheet I - 2, Part II, line 20)		
2			
3	Total Allowable Cost Excluding Vaccine (Line 1 minus line 2)		
4	Total FTE's and VISITS (From Worksheet I-2, column 5, line 8)		
5	Physicians Visits Under Agreement (From Worksheet I - 2, column 5, line 9)		
6	Total Adjusted Visits (line 4 plus line 5)		
7	Adjusted Cost Per Visit (line 3 divided by line 6)		
		Calculation of limit (1)	
		Prior to January 1	On or after January 1
		1	2
8	Rate per visit limit (From your intermediary)		
9	Rate for Medicare Covered Visits (See instructions)		
	PART II - CALCULATION OF SETTLEMENT		
10	Medicare Covered Visits Excluding Mental Health Services (From Intermediary Records)		
11	Medicare Cost Excluding Costs for Mental Health Services (Line 9 x line 10)		
12	Medicare Covered Visits for Mental Health Services (From Intermediary Records)		
13	Medicare Covered Cost from Mental Health Services (Line 9 x line 12)		
14	Limit Adjustment for Mental Health Services (Line 13 x 62 1/2 %)		
15	Allowable GME Pass-through Cost (See instructions)		
16	Total Medicare Cost (Sum of line 11 column 1 and 2, plus line 14 columns 1 and 2, plus line 15.)		
17	Less: Beneficiary Deductible (From intermediary records)		
18	Net Medicare Cost Excluding Vaccines (Line 16 - line 17)		
19	Reimbursable Cost of RHC/FQHC Services, Excluding Vaccine (80% of line 18)		
20			
21	Total Reimbursable Medicare Cost (Line 19 plus 20)		
22	Reimbursable Bad Debts		
23	Other Adjustments		
24	Net reimbursable amount (Line 21 plus line 22, plus or minus line 23)		
25	Interim payments		
26	Balance due Component/Program (line 24 minus line 25)		
27	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		

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

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COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER NO.: ______________ COMPONENT NO.: ______________	PERIOD: FROM____________ TO______________	WORKSHEET I - 4
Check one:	[ ] Title V	[ ] Title XVIII	[ ] Title XIX
Check Applicable Box:	[ ] RHC	[ ] FQHC	

	CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Worksheet I -1, column 7, line 10)			1
2	Ratio of pneomococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (Line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (From your records)			4
5	Direct cost of pneumococcal and influenza vaccine (Sum of lines 3 and 4)			5
6	Total direct cost of the facility (From Wkst. I -1, col. 7, line 22)			6
7	Total overhead (From Worksheet I - 2, line 18)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to Total direct cost (Line 5 divided by Line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (Line 7 x Line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (Sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (From your records)			11
12	Cost per pneumococcal and influenza vaccine injection (Line 10 divided by Line 11)			12
13	Number of pneumococcal and influenza vaccine injections Adminstered to medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and its (their) adminstration (Line 12 x line 13)			14

15	Total Cost of pneumococcal and influenza vaccine and its (their) administration (Sum of columns 1 and 2, line 10) (Transfer this amount to Worksheet I-3, line 2)		15
16	Total medicare cost of pneumococcal and influenza vaccine and its (their) administration (Sum of columns 1 and 2, line 14) (Transfer this amount to Worksheet I-3, line 20)		16

FORM CMS 2540-96 (07/99) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3562)

ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS	**PROVIDER NO.:** ____________ **COMPONENT NO.:** ____________	**PERIOD: FROM** ____________ **TO**	**WORKSHEET I - 5**

Check Applicable Box: [ ] **R.H.C.** [ ] **F.Q.H.C.**

	Description			Mo / Day / Yr	Amount	
				1	2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "none", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period.	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
	Also show date of each payment.	Provider to Program	.50			3.50
			.51			3.51
	If none, write "NONE," or enter a zero.(1)		.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.55)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Worksheet I-3: Part II line 24)					4

TO BE COMPLETED BY INTERMEDIARY

5	List separately each tentative settlement payment after desk review.	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
	Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99			5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to Provider	.01			6.01
			.02			6.02
		Provider to Program	.50			6.50
			.51			6.51
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	Date (Mo/Day/Yr)

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

ANALYSIS OF SNF - BASED HOSPICE COST	PROVIDER NO:	HOSPICE NO.	PERIOD: FROM _______ TO _______	WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (From Wkst K-1)	EMPLOYEE BENEFITS (From Wkst K-2)	TRANSPOR-TATION (See inst.)	CONTRACTED SERVICES (From Wkst K-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease)	TOTAL (col.8 ± col.9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Moveable 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	Physical Therapy											11
12	Occupational Therapy											12
13	Speech/ Language Pathology											13
14	Medical Social Services											14
15	Spiritual Counseling											15
16	Dietary Counseling											16
17	Counseling - Other											17
18	Home Health Aide and Homemaker											18
19	Other											19
	OTHER HOSPICE SERVICE COSTS											
20	Drugs, Biological and Infusion Therapy											20
21	Durable Medical Equipment/Oxygen											21
22	Patient Transportation											22
23	Imaging Services											23
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (incl. E/R Dept.)											26
27	Radiation Therapy											27
28	Chemotherapy											28
29	Other											29
	HOSPICE NONREIMBURSABLE SERV.											
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
32	Fundraising											32
33	Other Program Costs											33
34	Total											34

FORM CMS-2540-96 (01-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3565)

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	PROVIDER NO:	HOSPICE NO:	PERIOD: FROM ______ TO ______	WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable 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	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biological and Infusion Therapy										20
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total										34

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

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3566)

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)	PROVIDER NO:	HOSPICE NO:	PERIOD: FROM ___ TO ___	WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR 1	DIRECTOR 2	SOCIAL SERVICES 3	SUPER- VISORS 4	NURSES 5	TOTAL THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL (1) 9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable 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	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
21	Durable Medical Equipment/ Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total										34

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES / PURCHASED SERVICES		PROVIDER NO:		HOSPICE NO:		PERIOD: FROM ____ TO ____		WORKSHEET K-3		
COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Bldg and Fixt.										1
2 Capital Related Costs-Moveable 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 Physical Therapy										11
12 Occupational Therapy										12
13 Speech/ Language Pathology										13
14 Medical Social Services										14
15 Spiritual Counseling										15
16 Dietary Counseling										16
17 Counseling - Other										17
18 Home Health Aide and Homemaker										18
19 Other										19
OTHER HOSPICE SERVICE COSTS										
20 Drugs, Biological and Infusion Therapy										20
21 Durable Medical Equipment/Oxygen										21
22 Patient Transportation										22
23 Imaging Services										23
24 Labs and Diagnostics										24
25 Medical Supplies										25
26 Outpatient Services (incl. E/R Dept.)										26
27 Radiation Therapy										27
28 Chemotherapy										28
29 Other										29
HOSPICE NONREIMBURSABLE SERV.										
30 Bereavement Program Costs										30
31 Volunteer Program Costs										31
32 Fundraising										32
33 Other Program Costs										33
34 Total										34

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST	PROVIDER NO:	HOSPICE NO: ____________	PERIOD: FROM ____________ TO ______________	WORKSHEET K-4 PART I

	COST CENTER DESCRIPTIONS	FR. WKST. K COL. 10: NET EXPENSES FOR COST ALLOC. (1)	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	PORTATION	VOLUNTEER SERV. COORDI- NATOR	SUBTOTAL (col. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL	
		0	1	2	3	4	5	5A	6	7	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable 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	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services - Direct										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemakers										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biologicals and Infusion										20
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total										34

(1) Column 0, line 29 must agree with Wkst. A, column 7, line 55.

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3569)

COST ALLOCATION - HOSPICE STATISTICAL BASIS	PROVIDER NO:		HOSPICE NO:		PERIOD: FROM ____________ TO ______________		WORKSHEET K-4 PART II	

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION MILEAGE	VOLUNTEER SERV. COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Moveable Equipment								2
3	Plant Operation and Maintenance								3
4	Transportation-staff								5
5	Volunteer Service Coordination								5
6	Administrative and General								6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care								10
11	Physical Therapy								11
12	Occupational Therapy								12
13	Speech/ Language Pathology								13
14	Medical Social Services - Direct								14
15	Spiritual Counseling								15
16	Dietary Counseling								16
17	Counseling - Other								17
18	Home Health Aide and Homemakers								18
19	Other								19
	OTHER HOSPICE SERVICE COSTS								
20	Drugs, Biologicals and Infusion								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
34	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
	HOSPICE NONREIMBURSABLE SERV.								
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Cost To be Allocated (per Wkst K-4, Part I)								34
35	Unit Cost Multiplier								35

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3569)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:		PERIOD FROM:______________ TO: ______________		WORKSHEET K-5, PART I		
HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 6, line -	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED BLDGS. & FIXTURES	CAPITAL RELATED MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	4a	4	
1 Administrative and General	6							1
2 Inpatient - General Care	7							2
3 Inpatient - Respite Care	8							3
4 Physician Services	9							4
5 Nursing Care	10							5
6 Physical Therapy	11							6
7 Occupational Therapy	12							7
8 Speech/ Language Pathology	13							8
9 Medical Social Services - Direct	14							9
10 Spiritual Counseling	15							10
11 Dietary Counseling	16							11
12 Counseling - Other	17							12
13 Home Health Aide and Homemakers	18							13
14 Other	19							14
15 Drugs, Biologicals and Infusion	20							15
16 Durable Medical Equipment/Oxygen	21							16
17 Patient Transportation	22							17
18 Imaging Services	23							18
19 Labs and Diagnostics	24							19
20 Medical Supplies	25							20
21 Outpatient Services (incl. E/R Dept.)	26							21
22 Radiation Therapy	27							22
23 Chemotherapy	28							23
24 Other	29							24
25 Bereavement Program Costs	30							25
26 Volunteer Program Costs	31							26
27 Fundraising	32							27
28 Other Program Costs	33							28
29 Totals (sum of lines 1-28) (2)								29
30 Unit Cost Multiplier: Column 16, line 1 divided by the sum of column 16, line 29, minus column 16, line 1, rounded to 6 decimal places.								30

(2) Columns 0 through 16 , line 29 must agree with the corresponding columns of Wkst. B, Part I, line 55.

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3570.1)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:		PERIOD FROM:______________ TO: ________________		WORKSHEET K-5, Part I (Cont.)		
	HOSPICE COST CENTER (omit cents)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Physical Therapy								6
7	Occupational Therapy								7
8	Speech/ Language Pathology								8
9	Medical Social Services - Direct								9
10	Spiritual Counseling								10
11	Dietary Counseling								11
12	Counseling - Other								12
13	Home Health Aide and Homemakers								13
14	Other								14
15	Drugs, Biologicals and Infusion								15
16	Durable Medical Equipment/Oxygen								16
17	Patient Transportation								17
18	Imaging Services								18
19	Labs and Diagnostics								19
20	Medical Supplies								20
21	Outpatient Services (incl. E/R Dept.)								21
22	Radiation Therapy								22
23	Chemotherapy								23
24	Other								24
25	Bereavement Program Costs								25
26	Volunteer Program Costs								26
27	Fundraising								27
28	Other Program Costs								28
29	Totals (sum of lines 1-28) (2)								29
30	Unit Cost Multiplier: Column 16, line 1 divided by the sum of column 16, line 29, minus column 16, line 1, rounded to 6 decimal places.								30

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3570.1)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER NO.: HOSPICE NO.:	PERIOD FROM:______________ TO: ________________	WORKSHEET K-5, Part I (Cont.)

	HOSPICE COST CENTER (omit cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE	SUBTOTAL (Sum of Columns 4a through 15)	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Physical Therapy								6
7	Occupational Therapy								7
8	Speech/ Language Pathology								8
9	Medical Social Services - Direct								9
10	Spiritual Counseling								10
11	Dietary Counseling								11
12	Counseling - Other								12
13	Home Health Aide and Homemakers								13
14	Other								14
15	Drugs, Biologicals and Infusion								15
16	Durable Medical Equipment/Oxygen								16
17	Patient Transportation								17
18	Imaging Services								18
19	Labs and Diagnostics								19
20	Medical Supplies								20
21	Outpatient Services (incl. E/R Dept.)								21
22	Radiation Therapy								22
23	Chemotherapy								23
24	Other								24
25	Bereavement Program Costs								25
26	Volunteer Program Costs								26
27	Fundraising								27
28	Other Program Costs								28
29	Totals (sum of lines 1-28) (2)								29
30	Unit Cost Multiplier: Column 16, line 1 divided by the sum of column 16, line 29, minus column 16, line 1, rounded to 6 decimal places.								30

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3570.1)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER NO.: HOSPICE NO.:	PERIOD FROM:______________ TO: ________________	WORKSHEET K-5, PART II

	HOSPICE COST CENTER (omit cents)			CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL LATION	ADMINIS-TRATIVE & GENERAL (Accum. Cost)	
				1	2	3	4a	4	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Physical Therapy								6
7	Occupational Therapy								7
8	Speech/ Language Pathology								8
9	Medical Social Services - Direct								9
10	Spiritual Counseling								10
11	Dietary Counseling								11
12	Counseling - Other								12
13	Home Health Aide and Homemakers								13
14	Other								14
15	Drugs, Biologicals and Infusion								15
16	Durable Medical Equipment/Oxygen								16
17	Patient Transportation								17
18	Imaging Services								18
19	Labs and Diagnostics								19
20	Medical Supplies								20
21	Outpatient Services (incl. E/R Dept.)								21
22	Radiation Therapy								22
23	Chemotherapy								23
24	Other								24
25	Bereavement Program Costs								25
26	Volunteer Program Costs								26
27	Fundraising								27
28	Other Program Costs								28
29	Totals (sum of lines 1-28) (2)								29
30	Unit Cost Multiplier								30

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER NO.: HOSPICE NO.:	PERIOD FROM:______________ TO: ________________	WORKSHEET K-5, Part II (Cont.)

	HOSPICE COST CENTER (omit cents)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Physical Therapy								6
7	Occupational Therapy								7
8	Speech/ Language Pathology								8
9	Medical Social Services - Direct								9
10	Spiritual Counseling								10
11	Dietary Counseling								11
12	Counseling - Other								12
13	Home Health Aide and Homemakers								13
14	Other								14
15	Drugs, Biologicals and Infusion								15
16	Durable Medical Equipment/Oxygen								16
17	Patient Transportation								17
18	Imaging Services								18
19	Labs and Diagnostics								19
20	Medical Supplies								20
21	Outpatient Services (incl. E/R Dept.)								21
22	Radiation Therapy								22
23	Chemotherapy								23
24	Other								24
25	Bereavement Program Costs								25
26	Volunteer Program Costs								26
27	Fundraising								27
28	Other Program Costs								28
29	Totals (sum of lines 1-28) (2)								29
30	Unit Cost Multiplier								30

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER NO.: HOSPICE NO.:	PERIOD FROM:______________ TO: ________________	WORKSHEET K-5, Part II (Cont.)

	HOSPICE COST CENTER (omit cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	INTERNS & RESIDENTS (Assigned Time)	OTHER GENERAL SERVICE (Specify)				
		12	13	14	15				
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Physical Therapy								6
7	Occupational Therapy								7
8	Speech/ Language Pathology								8
9	Medical Social Services - Direct								9
10	Spiritual Counseling								10
11	Dietary Counseling								11
12	Counseling - Other								12
13	Home Health Aide and Homemakers								13
14	Other								14
15	Drugs, Biologicals and Infusion								15
16	Durable Medical Equipment/Oxygen								16
17	Patient Transportation								17
18	Imaging Services								18
19	Labs and Diagnostics								19
20	Medical Supplies								20
21	Outpatient Services (incl. E/R Dept.)								21
22	Radiation Therapy								22
23	Chemotherapy								23
24	Other								24
25	Bereavement Program Costs								25
26	Volunteer Program Costs								26
27	Fundraising								27
28	Other Program Costs								28
29	Totals (sum of lines 1-28) (2)								29
30	Unit Cost Multiplier								30

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER NO.: 00-5000 HOSPICE NO.: 14-1590	PERIOD: From: 05-01-00 To: 04-30-01	WORKSHEET K-5 Part III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	Hospice shared cost computation	Facility Cost From Worksheet K-5, Part I		Cost to Charge Ratio From Worksheet C, Col. 3		Total Hospice Charges (From Provider Records)	Hospice Shared Ancillary Costs (col. 4 x col. 5)	Total Hospice Cost (col. 2 and 6)	
	COST CENTER	Line:	Amount:	Line :	Ratio				
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
1	Physical Therapy	*6*		*25*					1
2	Occupational Therapy	*7*		*26*					2
3	Speech/ Language Pathology	*8*		*27*					3
4	Drugs, Biologicals and Infusion	*15*		*30*					4
5	Labs and Diagnostics	*19*		*22*					5
6	Medical Supplies	*20*		*29*					6
7	Radiation Therapy	*22*		*21*					7
8	Other	*24*		*33*					8
9	Total (sum of lines 1-8)								9

FORM CMS-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3570.3)

CALCULATION OF PER DIEM COST	PROVIDER NO. ________________	PERIOD: FROM ________________ TO ________________	WORKSHEET K-6

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (Worksheet K, line 34 less line 33, col. 7)					1
2	Total Unduplicated Days (Worksheet S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Worksheet S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-8, line 5, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13
14	Total cost (see instructions)					14
15	Total days (see instructions)					15