

Column 9--Add columns 1 through 8 for each line, except lines 14 (EPO) and 15 (Aranesp), and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 18 by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

#### 4050. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10 to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 16--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

**NOTE:** If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your intermediary before the start of your cost reporting period for which the alternative method is used. (See §4017 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 17--Add the statistical basis for each column, except columns 9 and 10.

Line 18--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 17 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

#### Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6 and 7--Use cost of requisitions to allocate drug and medical supply costs.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 17, column 9 to Worksheet I-3, line 17, column 10. Do not allocate overhead costs to lines 14 (EPO) or 15 (Aranesp).

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4051. WORKSHEET I-4 - COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

This worksheet records the apportionment of total outpatient cost to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements for determining the cost of ESRD care.

Complete a separate worksheet for reporting costs for the renal dialysis department and the home program dialysis department. Complete only one Worksheet I-4 as only one average composite rate will apply to each modality.

If you have more than one renal dialysis and/or home dialysis department, submit one Worksheet I-4 combining the renal dialysis departments and/or one Worksheet I-4 combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I-4 for each renal dialysis department and one for each home dialysis department with appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Enter on the combined Worksheet I-4 each provider's satellite number if you are separately certified as a satellite facility.

In accordance with section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of MMA 2003, the ESRD payment is replaced by a calculated ESRD composite rate.

Columns 1 through 3 refer to total outpatient statistics, i.e., to all outpatient dialysis services furnished, whether reimbursed directly by the program or not.

Column 1--Enter on the appropriate lines the total number of outpatient treatments by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients in the outpatient renal department, both Medicare and non-Medicare.

Column 2--Enter on the appropriate lines the total cost transferred from Worksheet I-2, columns 11, lines as appropriate.

Column 3--Determine the amounts entered on the appropriate lines by dividing the cost entered on each line in column 2 by the number of treatments entered on each line in column 1.

Line 9--Report continuous ambulatory peritoneal dialysis (CAPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home using CAPD.

Line 10--Report continuous cycling peritoneal dialysis (CCPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home by CCPD.

Medicare Treatments

Columns 4 through 7 refer only to treatments furnished to Medicare beneficiaries that were billed to the facility and reimbursed by the program directly. (Amounts entered in these columns are reconcilable to your records.)

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records and/or the PS&R.

Column 5--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the average cost per treatment entered on the corresponding line in column 3. Transfer the total expenses from this column, line 11 to Worksheet I-5, line 1. If you complete separate Worksheets I-2 and I-3, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1.

Column 6--Total Program Payment--Enter the total program payment by the type of treatment for the reporting period. Since this amount is calculated on a patient basis and is case mix adjusted, the total program payment will be provider specific for each modality.

The ESRD composite payment rate is an average payment calculated based on the total Medicare payments by type of treatment divided by the total ESRD treatments.

Column 7--Average Payment Rate--Enter the total average payment rate by the type of treatment for the reporting period. Determine the amounts entered on the appropriate lines by dividing the total payments on each corresponding line in column 6 by the number of treatments entered on each line in column 4.

Line 11--Enter in columns 1 and 4 the sum total of lines 1 through 8. Enter in columns 2, 5, 6 and 7 the sum total of lines 1 through 10.

Transfer the total payment from column 6, line 11 to Worksheet I-5, line 2.

4052. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII, PART B

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

Line 1--Enter the amount from Worksheet I-4, column 5, line 11.

Line 2--Enter the amount from Worksheet I-4, column 6, line 11 (net of deductibles).

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) for dialysis treatments.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) for dialysis treatments.

The amounts on lines 3 and 4 must exclude coinsurance and deductible amounts for services other than dialysis treatments (e.g., Epoetin and Aranesp).

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period.

Line 6--Reserved for future use.

Line 7--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 5.

Line 8--Enter the sum of lines 3 and 4, less line 5.

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference.

Line 10--Subtract the sum of lines 8 and 9 from the lesser of lines 1 or 2, and enter the difference. If the result is negative, enter zero and do not complete line 11.

Line 11--Enter the lesser of line 5 or line 10. Transfer this amount to Worksheet E, Part B, line 33.

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#### 4053. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

Use this worksheet only if you operate as part of your complex a certified hospital-based community mental health center (CMHC) furnishing services to Medicare titles XVIII, title XIX, and V. Additionally, while comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities (ORFs) which generally furnishes outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP) services, do not complete the J series worksheets they must complete the applicable Worksheet A cost center for the purpose of overhead allocation. Only those cost centers that represent services for which the facility is certified are used. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

**4053.1 Part I - Allocation of General Service Costs to Community Mental Health Center Cost Centers.**--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, lines as appropriate:

<u>Component</u>	<u>From Worksheet A, Column 7</u>
CMHC	line 99 and subscripts

Obtain the cost center allocation (column 0, lines 1 through 21) from your records. The amounts on line 22, columns 0 through 23 and column 25 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23 and column 25, lines as appropriate:

<u>Component</u>	<u>Worksheet B, Part I, Columns 0 through 23 and 25</u>
CMHC	line 99 and subscripts

Complete the amounts entered on lines 1 through 21, columns 1 through 23 and column 25 in accordance with the instructions contained in §4053.2.

**NOTE:** Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

Line 23--To calculate the unit cost multiplier for component administrative and general costs divide line 1 by the result of line 22 minus line 1 and round to six decimal places.

**4053.2 Part II - Allocation of General Service Costs to Community Mental Health Center Cost Centers - Statistical Basis.**--Worksheet J-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For subscripted (componentized) A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, is identical. The statistical basis shown at the top of each column on Worksheet J-1, Part II, is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-1, §2313.)

If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313.)

Lines 1 through 21--On Worksheet J-1, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, lines as appropriate:

<u>Component</u>	<u>Worksheet B-1, Corresponding Column</u>
CMHC	line 99

Line 23--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, lines as appropriate (see §4056.1), from the same column used to enter the statistical base on Worksheet J-1, Part II (e.g., for a CMHC provider, in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 99).

Line 24--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, for lines 2 through 21, multiply the amount in column 26 by the unit cost multiplier on line 23, Part I, and enter the result. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 21 the sum of columns 26 and 27. The total on line 22 equals the total in column 26, line 22.



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4054. WORKSHEET J-2 - COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

Use this worksheet only if you operate a hospital-based CMHC. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

4054.1 Part I - Apportionment of CMHC.--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 28. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for the component's title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3.

Line 20--Enter the totals of lines 1 through 19 in columns 1, 2, and 4 through 9.

4054.2 Part II - Apportionment of Cost of CMHC Services Furnished by Shared Hospital Departments.--Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's outpatient rehabilitation provider.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9 from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX CMHC patients, respectively.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3.

Line 28--Enter the totals for columns 4 through 9.

Line 29--Enter the total costs from Part I, columns 5, 7, and 9, line 20 plus columns 5, 7, and 9, line 28 respectively and transfer to Worksheet J-3, line 1.

4055. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT – COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 29 from columns 5, 7, or 9, as applicable (column 5 for title V, column 7 for title XVIII, and column 9 for title XIX).

Line 2--Enter the gross PPS payments received for services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

Line 4--Enter the amounts paid and payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, Columns 4, 6, and 8 as appropriate, lines 20 and 29.

Lines 7 through 10--These lines provide for the reduction of program charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 9 is greater than zero, enter on line 10 the product of multiplying the ratio on line 9 by line 6.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 7, 8, and 9, but enter on line 10 the amount from line 6. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 10 exceed the actual charges on line 6.

Lines 11 and 12--Lines 11 and 12 provide for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e).

Enter on line 11 the excess of total customary charges (line 10) over the total reasonable cost (line 5). In situations when in any column the total charges on line 10 are less than the total cost on line 5, enter zero (0) on line 11.

Enter on line 12 the excess of total reasonable cost (line 5) over total customary charges (line 10). In situations when in any column the total cost on line 5 is less than the customary charges on line 10, enter zero (0) on line 12.

**NOTE:** CMHCs and providers not subject to reasonable cost reimbursement do not complete lines 11 and 12.

Line 13--Enter the total reasonable costs from line 5.

Line 14--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 16--If there is an excess of reasonable cost over customary charges, enter the amount from line 12.

Line 18--CMHCs enter 0 (zero) as these services are reimbursed under PPS. For titles V and XIX, enter 100 percent less the applicable coinsurance.

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative.

Line 22--This line is reserved for future use.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--CMHCs and other provider types enter the result of line 20 plus line 21.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--Enter the result of line 24 plus or minus line 25.

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE:** On lines 3, 5, and 6, when an amount is due from the provider to the 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.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.

Line 8--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

## 4057. WORKSHEET K - ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. The K series Worksheets must be completed by all hospital-based hospices. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 39). Not all of the cost centers listed apply to all providers using these forms.

Column 1--Obtain salaries to be reported from Worksheet K-1, column 9, line 3-38.

Column 2--Obtain employee benefits to be reported from Worksheet K-2 column 9, lines 3-38.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 27.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, col. 9, lines 3-38.

Column 5--Enter in the applicable lines all costs which have not been reported in columns 1 through 4.

Column 6--Enter the sum of columns 1 through 5 for each cost center.

Column 7--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8, line 39 must equal the total of column 6, line 39.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4016.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amount in column 10, line 1 through 38 to the corresponding lines on Worksheet K-4, Part I, column 0, lines 1 through 38.

#### LINE DESCRIPTIONS

Lines 1 and 2--Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment--These cost centers should include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care.

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3--Plant Operation and Maintenance--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of plant, and protecting the employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of building, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalk, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4--Transportation-Staff--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Volunteer Service Coordination--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6--Administrative and General--Use this cost center to record expenses of several costs which benefit the entire facility. If the option to componentize (also known as fragmentation or subscribing) administrative and general costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (i.e., 6.01 A&G shared costs, 6.02 A&G reimbursable costs, etcetera) Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7--Inpatient - General Care--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting services section.

Line 8--Inpatient - Respite Care--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For A hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section.

Line 9--Physician Services--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 10--Nursing Care--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11--Nursing Care-Continuous Home Care--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 12--Physical Therapy--Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13--Occupational Therapy--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenial or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14--Speech/Language Pathology--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 15--Medical Social Services--This cost center includes only direct expenses incurred in providing Medical Social Services. Medical Social Services consist of counseling and assessment activities, which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker, under the direction of a physician.



Lines 16 - 18--Counseling--Counseling Services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling are accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 35.

Line 19--Home Health Aide And Homemaker--Enter the cost of home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 20--Home Health Aide and Homemaker-Continuous Home Care--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 21--Other-- Enter on this line any other visiting cost which can not be appropriately identified in the services already listed.

Line 22--Drugs, Biological and Infusion Therapy--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 22 (drugs and Biologicals) and line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of Worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 23--Analgesics--Enter the cost of analgesics.

Line 24--Sedatives/Hypnotics--Enter the cost of sedatives/hypnotics.

Line 25--Other Specify--Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 26--Durable Medical Equipment/Oxygen--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 27--Patient Transportation--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 28--Imaging Services--Enter the cost of imaging services including MRI.

Line 29--Labs and Diagnostics--Enter the cost of laboratory and diagnostic tests.

Line 30--Medical Supplies--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 31--Outpatient Service--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 32 - 33--Radiation Therapy and Chemotherapy--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 34--Other--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 35 - 38--Non Reimbursable Costs--Enter in the appropriate lines the applicable costs. Bereavement program costs consists of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Social security Act bereavement counseling is a required hospice service, but it is not reimbursable.

Line 39--Total--Line 39 column 10, should agree with Worksheet A, line 116, column 7.

#### 4058. WORKSHEET K-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G) and 25 percent of the administrator's salary enter on line 10 (nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

## Definitions

Salary--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, Chapter 21.)

### Administrator (Column 1)--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments.

The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

### Director (Column 2)--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Medical Social Worker (Column 3)--This individual is a person who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4)--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6)--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 12
Occupational therapy	-	line 13
Speech pathology	-	line 14

Therapy and speech-language pathology may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose ability to work is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

Speech-language pathology is the provision of services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors.

Aides (Column 7)--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws. This function is performed by specially trained personnel who assist individuals in carrying out physician instructions and established plans of care. The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse.

Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Additional services include, but are not limited to, assisting the patient with activities of daily living.

All Other (Column 8)--Employees in this classification are those not included in columns 1 - 7. Included in this classification are dietary, spiritual, and other counselors. Counseling Services must be available to both the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual and other counseling services provided while the individual is enrolled in the hospice.

Total (Column 9)--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 1, lines as applicable. To facilitate transferring amounts from Worksheet K-1 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your hospice.

4059. WORKSHEET K-2 - COMPENSATION ANALYSIS – EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See CMS Pub. 15-1, Chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1, enter

75 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 10 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported.

This assignment can be performed on an actual basis or the following basis:

- o FICA - actual expense by cost center;
- o Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);
- o Union health and welfare (gross salaries of participating union members by cost center); and
- o All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 2, corresponding lines. To facilitate transferring amounts from Worksheet K-2 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

4060. WORKSHEET K-3 - COMPENASATION ANALYSIS - CONTRACTED SERVICES /PURCHASED SERVICES.

The hospice may contract with another entity for the provision of non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care would be recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 12. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

4061. WORKSHEET K-4, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND, PART II - COST ALLOCATION - STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each general service cost center to those cost centers, which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers. Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, Part I, the same cost centers with corresponding line numbers (lines 3 through 39) are listed on both worksheets.

Worksheet K-4, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-4, Part I.

To facilitate the allocation process, the general format of Worksheets K-4, Parts I & II are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3.

The statistical bases shown at the top of each column on Worksheet K-4, Part II are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is clarified in CMS Pub. 15-1, §2306.1, which further clarify the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

**NOTE:** A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary, in writing, within 90 days prior to the end of that fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is accurate, it should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After

receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 39. This enables column 6, line 39, to crossfoot to columns 0 and 5A, line 39. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, Part I, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, Part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, Part II, line 39, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, Part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, Part I, column 1, line 1.

Divide the amount entered on line 39 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 40. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, Part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 39) of all of the cost centers receiving the allocation on Worksheet K-4, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on Worksheets K-4, Part I & II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, Part I, enter in column 7 the sum of the expenses on lines 7 through 38. The total expenses entered in column 7, line 39, must equal the total expenses entered in column 0, line 39.

#### Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, and personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs, which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-1, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, Part I, column 5A, line 39 and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A for (1) any service provided under arrangements to program patients only that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as



an accumulated cost statistic.

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The accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet K-4, Part II, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, enter the amount from Worksheet K-4, Part I, column 5A.

#### 4062. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

This worksheet distributes the hospital's overhead to the specific cost centers of the hospice.

4062.1 Part I - Allocation of General Service Costs to Hospice Cost Centers--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services. Worksheet K-5, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, Part I.

Obtain the direct total expenses (column 0, lines 2 through 33) from worksheet K-4 Part I, lines 7 through 38. The amounts on columns 0 through 22 and column 24, line 34 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 22 and column 24, line 116.

In column 23, enter the total of columns 4A through 22.

In column 26, for lines 2 through 23, multiply the amount in column 25 by the unit cost multiplier on line 35, and enter the result in this column. On line 34, enter the total of the amounts on lines 2 through 33. The total on line 34 equals the amount in column 25, line 1.

In column 27, enter on lines 2 through 34 the sum of columns 25 and 26. The total on line 34 equals the total in column 25, line 34.

4062.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis--To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-1, §2313.)

If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, §2313.)

Lines 1 through 33--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 34--Enter the total of lines 1 through 33 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 116.

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Line 35--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 116.

Line 36--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35 by the total statistic entered in the same column on line 34. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on line 34, Part II.

Perform the preceding procedures for each general service cost center.

4062.3 Part III - Computation of the Total Hospice Shared Costs--This worksheet provides for the shared therapy, drugs, or medical supplies from the hospital to the hospice.

#### Column Description

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I column 9, lines as indicated.

Column 2--Where hospital departments provides services to the hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the hospital-based hospice.

Column 3--Multiply the amount in column 2 by the ratios in column 1 and enter the result in column 3.

Line 11--Sum of column 3 lines 1 through 10.

#### 4063. WORKSHEET K-6 - CALCUALTION OF PER DIEM COSTS

Worksheet K-6 calculates the average cost per day for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1--Transfer the total cost from Worksheet K-5, Part I, column 27, line 34 less column 27, line 33, plus Worksheet K-5, Part III, column 3 line 11. This line reflects the true cost including shared cost and excluding any non-hospice related activity.

Line 2--Enter the total unduplicated days from Worksheet S-9, column 6, line 5.

Line 3--Calculate the aggregate cost per day by dividing the total cost from line 1 by the total number of days from line 2.

Line 4--Enter the unduplicated Medicare days from Worksheet S-9, column 1, line 5.

Line 5--Calculate the aggregate Medicare cost by multiplying the average cost from column 4, line 3 by the number of unduplicated Medicare days on column 1, line 4 to arrive at the average

Medicare cost.

Line 6--Enter the unduplicated Medicaid days from Worksheet S-9, column 2, line 5.

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Line 7--Calculate the aggregate Medicaid cost by multiplying the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8--Enter the unduplicated SNF days from Worksheet S-9, column 3, line 5.

Line 9--Calculate the aggregate SNF cost by multiplying the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10--Enter the unduplicated NF days from Worksheet S-9, column 4, line 5.

Line 11--Calculate the aggregate NF cost by multiplying the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12--Enter the unduplicated Other days from Worksheet S-9, column 5, line 5.

Line 13--Enter the Aggregate Other cost by multiplying the average cost from line 3 by the number of unduplicated Other days on line 12 to arrive at the average other cost.

## 4064. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through IV, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See the August 30, 1991 Federal Register.) Only provider components paid under IPPS complete this worksheet.

Worksheet L consists of the following four parts:

- Part I - Fully Prospective Method
- Part II - Payment Under Reasonable Cost
- Part III - Computation of Exception Payments

COMPLETE ONLY PART I, II, OR III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the IPPS capital payment method for which the worksheet is prepared.

4064.1 Part I - Fully Prospective Method.--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for PPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate.

Line Descriptions

Line 1--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period.

Line 2--Enter the amount of the Federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).)

Indirect Medical Education Adjustment

Lines 3 - 6

Line 3--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 8, lines 14 and 30) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 8, line 13), and swing bed days (Worksheet S-3, Part I, column 8, lines 5 and 6).

Line 4--Obtain the intern and resident amount from Worksheet E, Part A, line 18. In addition, if the hospital received additional IME FTE resident cap slots under 42 CFR §413.79(c)(4) (Worksheet S-2, Part I, line 60, column 2, is "Y") add the amount reported on Worksheet E, Part A, line 25).

Line 5--Enter the result of the following calculation:  $\{e^{.2822 \times \text{line 4}/\text{line 3}}\} - 1$  where  $e = 2.71828$ . (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4 divided by line 3 cannot exceed 1.5.

Line 6--Multiply line 5 by the sum of lines 1 and 2.

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### Capital Disproportionate Share Adjustment

#### Lines 7 - 11

Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 45 on Worksheet S-2. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 7 through 9, and enter 11.89 percent on line 10.

Line 7--Enter the percentage of SSI recipient patient days (from your contractor or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 27.

Line 8--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 7, line 14 plus line 2, plus Worksheet S-3, Part I, column 7, line 32, minus the sum of lines 5 and 6) to total days reported on Worksheet S-3, column 8, line 14 plus Worksheet S-3, Part I, line 32, column 8 minus the sum of lines 5 and 6. Increase total patient days by any employee discount days reported on worksheet S-3, Part I, column 8, line 30. This amount agrees with the amount reported on Worksheet E, Part A, line 31.

Line 9--Add lines 7 and 8, and enter the result.

Line 10--Enter the percentage that results from the following calculation:  $(e^{.2025 \times \text{line } 9}) - 1$  where e equals 2.71828.

Line 11--Multiply line 10 by the sum of lines 1 and 2 and enter the result.

Line 12--Enter the sum of lines 1, 2, 6 and 11. For title XVIII, transfer this amount to Worksheet E, Part A, line 50.

4064.2 Part II - Payment Under Reasonable Cost--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers under 42 CFR 412.324(b) for the first two years or for titles V or XIX determinations, if applicable. This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years for new providers under 42 CFR 412.304(c)(2)(i) (response to Worksheet S-2, line 47, column 1 is "Y" and column 2 is "N").

#### Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, column 7, sum of the amounts on lines 30 through 35 and 43 for the hospital (lines 40 through 42 as applicable for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, column 5, line 200.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter a reduction factor of 85 percent.

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 50.

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4064.3 Part III - Computation of Exception Payments--This part computes minimum payment levels by class of provider with an additional special exception payment for hospitals paid under the fully prospective method pursuant to 42 CFR 412.348. Complete this part only if the provider component completed Part I of this worksheet. Complete this part only if the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) (the facility indicates "Y" to question 46 on worksheet S-2).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, column 7, sum of lines 30 through 35 and 43 for the hospital, lines 40 through 42, as applicable for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, column 5, line 200.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(g), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 30 through 35 and 43 for the hospital; lines 40 through 43, as applicable for the subproviders; and Part III, column 5, line 200.

Line 3--Enter line 1 less line 2.

Line 4--Enter the appropriate minimum payment level percentage: The minimum payment levels for portions of cost reporting periods beginning on or after October 1, 2001 are:

- o SCHs (located in either an urban or a rural area) - 90 percent;
- o Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- o All other hospitals - 70 percent.

For providers that qualify for the special exceptions payment pursuant to 42 CFR 412.348(g) the appropriate minimum payment level is 70 percent.

The minimum payment levels in subsequent transition years will be revised, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments.

If you were an SCH during a portion of the cost reporting period, compute the minimum payment level percentage by dividing the number of days in your cost reporting period for which you were not an SCH (70 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 70 percent. Divide the number of days in your cost reporting period for which you were an SCH (90 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 90 percent. Add the amounts from steps 1 and 2 to compute the capital cost minimum payment level percentage. Display exception percentage in decimal format, e.g., 70 percent is displayed as .70 or 0.70.

Line 5--Enter the product of line 3 multiplied by line 4.

Line 6--Hospitals that did not qualify as sole community providers during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a sole community hospital during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a sole community hospital (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent and subtract the amount from 100. Enter the resulting extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 8, if applicable.

Line 10--Enter line 8 less line 9.

Lines 11 through 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels. The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the subsequent cost reporting period.

Line 11--The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the prospective payment system for capital related costs. Enter the appropriate offset amount as computed pursuant to 42 CFR 412.312(e)(3).

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

Complete lines 15 through 17 only when line 12 is a positive amount.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 47, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on

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Line 16--Current years operating and capital costs from worksheet D-1, line 49 minus the sum of D, Part III, lines 30 through 35, column 9 (PPS subproviders use lines 40 through 42, as applicable, column 9), and D, Part IV, column 11, line 200.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 15 minus line 16. If this amount is negative, enter zero on this line. If the amount on line 13 is greater than line 17, transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 51.

#### 4065. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348(g) (the facility indicates "Y" to question 46 on worksheet S-2).

4065.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances--Use this part in conjunction with Worksheet B-1. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscribed lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column 0--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part II. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

**NOTE:** Recognize capital expenditures relating to extraordinary costs as new capital-related costs.

Columns 1 through 23--Transfer amounts on the top lines of columns 1 and 2 from column 0, line as applicable. For example, transfer line 1, column 0 to line 1, column 1. For all other columns, the top line represents the cross total amount.

For each column, enter on line 197 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain this amount from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of new capital-related costs - buildings and fixtures from Worksheet B-1, column 1, line 1.)

Divide the amount entered on line 197 by the total capital expenses entered in the same column on the first line. Enter the resulting unit cost multiplier on line 198. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Report applicable cost center statistics on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §4000.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 197) of all the cost centers receiving the allocation on this worksheet must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for one cost center before proceeding to the column for the next cost center.

After the capital-related costs of all the general service cost centers have been allocated, enter in column 24 the sum of columns 2A through 23 for lines 30 through 196. (See §4020 for exception regarding negative cost centers.)

When an adjustment is required to capital costs for extraordinary circumstances after cost allocation, show the amount applicable to each cost center in column 25. Submit a supporting schedule showing the computation of the adjustment.

Transfer From Worksheet:  
L-1, Part I, Column 26

To Worksheet L-1, Part II

Line 30 - Adults and Pediatrics

Column 1, line 30 for the hospital

Lines 31 through 35 - Intensive  
Care Type Inpatient Hospital  
Units

Column 1, lines 31 through 35

Lines 40 through 42, as  
applicable - Subprovider

Column 1, lines 40 through 42, as applicable

Line 43 - Nursery

Column 1, line 43 for titles V and XIX

To Worksheet L-1, Part III

Lines 50 through 76 - Ancillary  
Services

Column 1, lines 50 through 76

Lines 88 through 91 and 93 -  
Outpatient Service Cost

Column 1, lines 88 through 91 and 93

Subscripts of line 92 - Distinct  
Part Observation Bed Units

Column 1, subscripts of line 92

Lines 94, 97, and 98 - Other  
Reimbursable Cost Centers

Column 1, lines 94, 97, and 98

4065.2 Part II - Computation of Program Inpatient Routine Service Capital Costs for Extraordinary Circumstances.--This part computes the amount of capital costs for extraordinary circumstances applicable to hospital inpatient routine service costs. Complete only one Worksheet L-1, Part II for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate.

Column 1--Enter on each line the capital costs for extraordinary circumstances as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

Column 2--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the amount in column 1 by the ratio of the amount entered on Worksheet D-1, line 26 to the amount entered on Worksheet D-1, line 21.

Column 3--Enter column 1 minus column 2.

Column 4--Enter on each line the total patient days, excluding swing bed days, by cost center from the corresponding lines of Worksheet D, Part I, column 4.

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Column 5--Divide the cost of each cost center in column 3 by the total patient days in column 4 for each line to determine the per diem cost capital cost for extraordinary circumstances. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the corresponding cost centers from Worksheet D, Part I, column 6.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs for extraordinary circumstances applicable to inpatient routine services, as applicable, and enter the result.

4065.3 Part III - Computation of Program Inpatient Ancillary Service Capital Costs For Extraordinary Circumstances--This part computes the program inpatient ancillary capital costs for extraordinary circumstances for titles V, XVIII, Part A, and XIX. Complete a separate copy of this part for the hospital and each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Enter on each line the capital-related costs for each cost center as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

**NOTE:** Compute capital costs for extraordinary circumstances relating to non-distinct observation bed units. To compute extraordinary circumstances relating to non-distinct observation bed units, develop a ratio of total observation bed costs to total general routine costs. Compute this ratio, rounded to six decimal places, by dividing the amount from Worksheet L-1, Part I, column 26, line 30 by the amount on Worksheet D-1, line 37. Then multiply this ratio by the general routine capital costs for extraordinary circumstances from Supplemental Worksheet L-1, Part I, column 26, line 30 to obtain the capital costs for extraordinary circumstances relating to non-distinct observation bed units for line 92, column 1. Transfer distinct part observation bed unit costs from Worksheet L-1, Part I, the appropriate subscript of column 26, line 92.

Column 2--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 6.

Column 3--Divide the cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to 032151. Enter the resultant departmental ratios in column 3.

Column 4--Enter on each line the appropriate titles V, XVIII, Part A, or XIX inpatient charges. Transfer these charges from the corresponding lines of Worksheet D, Part II, column 4.

Column 5--Multiply the ratio in column 3 by the charges in column 4 to determine the program's share of capital costs for extraordinary circumstances applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

#### 4066. WORKSHEET M-1 - ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Use this worksheet only if you operate a certified rural health clinic (RHC) or federally qualified health center (FQHC). Use only those cost centers that represent services for which the facility is certified. If you have more than one provider-based RHC and/or FQHC, complete separate worksheets for each RHC and FQHC facility, unless the facility has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-4, chapter 9, §30).

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This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

### Column Descriptions

Columns 1 through 3--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your intermediary.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Salaries (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4--Enter any reclassifications among the cost center expenses listed in column 3 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4014 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column.

The net total of the entries in column 4 must equal zero on line 30 if no reclassifications were reported on worksheet A, column 4, of the appropriate line 88 and/or 89.

Column 5--Add column 4 to column 3, and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 30, if no reclassifications were reported on worksheet A, column 4, of the appropriate line 88 and/or 89.

Column 6--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

**NOTE:** The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your contractor, and include this as an adjustment to the appropriate lines on column 6.

Column 7--Adjust the amounts in column 5 by the amounts in column 6, and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

### Line Descriptions

Lines 1 through 9--Enter the costs of your health care staff.

Line 10--Enter the sum of the amounts on lines 1 through 9.

Line 11--Enter the cost of physician medical services furnished under agreement.

Line 12--Enter the expenses of physician supervisory services furnished under agreement.

Line 14--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20--Enter the expenses of other health care costs.

Line 20--If you answered yes on Worksheet S-8, line 15 report on this line the amount of reimbursable graduate medical education costs from Worksheet B, Part I, sum of columns 21 and 22, lines 88 (RHC) and/or 89 (FQHC), as applicable. To claim GME the RHC/FQHC must have provided a "substantial amount" toward the cost of the intern and residents.

Line 21--Enter the sum of the amounts on lines 15 through 20.

Line 22--Enter the sum of the amounts on lines 10, 14, and 21. Reduce that result by the amount reported on line 20 if you are entitled to claim GME costs on line 20. Transfer this amount to Worksheet M-2, line 10.

Lines 23 through 27--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27--If you have incurred non-allowable costs associated with graduated medical education, report on line 26 the non-allowable costs.

Line 28--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet M-2, line 11.

Line 29--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet M-2, line 14.

Line 32--Enter the sum of the amounts on lines 22, 28, and 31. Do not include the amount reported on line 20 for GME. This is the total facility cost. This amount should agree with the amount reported for RHC and FQHC on Worksheet A, column 7 reduced by any amounts claimed on line 20 above.

#### 4067. WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your complex. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each RHC and FQHC facility.

Visits and Productivity--Worksheet M-2 summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

#### Column descriptions

Column 1--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS Pub. 27, §503 for a definition of FTEs).

Column 2--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. You are not subject to the productivity standards if you answered "Yes" to question 14 of Worksheet S-8. If so, then enter the revised standards established by you and your contractor.

Column 4--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

Contractors have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor will substitute your actual visits if an exception is granted.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

#### Line descriptions

Line 1--Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC facility. These physicians are subject to productivity standards. (See 42 CFR 491.8.)

Line 8--Enter the total of lines 4 through 7.

Line 9--Enter the number of visits furnished to facility patients by physicians under agreement with you who do not furnish services to patients on a regular ongoing basis in the RHC facility. Physicians services under agreements with you are (1) all medical services performed at your site by a nonstaff physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

Determination of Total Allowable Cost Applicable To RHC/FQHC Services--Lines 10 through 18 determine the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC or FQHC services.

Line 10--Enter the cost of health care services from Worksheet M-1, column 7, line 22.

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 27.

Line 12--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13--Enter the percentage of RHC or FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14--Enter the total facility overhead costs incurred from Worksheet M-1, column 7, line 31.



Line 15--Enter the overhead costs incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 26 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the RHC/FQHC.

Line 17--If you are claiming allowable GME cost (line 20 of worksheet M-1 completed), divide the total visits reported on line 15 of Worksheet S-8 by the total visits for the facility, sum of lines 8 and 9, column 5 above, multiply the result by line 16 above, and enter that amount. If you are not claiming GME enter -0-.

Line 18--Subtract the amount on line 17 from line 16 and enter the result.

Line 19--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

#### 4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total program payment due you for the reporting period for each RHC or FQHC being reported.

Determination of Rate For RHC/FQHC Services--Worksheet M-3 calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

#### Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Report vaccine costs on this line from Worksheet M-4.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Lines 8 and 9--The limits are updated every January 1. However, the possibility exists that limits may also be updated other than on January 1. Complete columns 1, 2 and 3, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) of lines 8 and 9 to identify costs and visits affected by different payment limits for a cost reporting period that overlaps January 1. If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your contractor.

**NOTE:** If you are based in a small rural hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR §412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

**NOTE:** RHCs that are based in small urban hospital with less than 50 beds (as calculated above) will also be exempt from the per visit limit.

For RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

Calculation of Settlement--Complete lines 10 through 29 to determine the total program payment due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

#### Line descriptions

Line 10--Enter the number of program covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for RHC/FQHC services during the reporting period).

Line 12--Enter the number of program covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15--Enter the amount of GME pass through costs determined by dividing the (program intern and resident visits reported on Worksheet S-8, line 17 by the total visits reported on Worksheet M-2, column 5,) sum of lines 8 and 9. Multiply that result by the allowable GME costs equal to the sum of Worksheet M-1, column 7, line 20 and Worksheet M-2, line 17.

Line 16--Enter the total program cost. This is equal to the sum of the amounts in columns 1 and 2 (and 3 if applicable), lines 11, 14, and 15.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amounts on lines 17 and 18 from the amount on line 16.

Line 20--For title XVIII, enter 80 percent of the amount on line 19.

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 22--Enter the total allowable Medicare cost, sum of the amounts on lines 20 and 21.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative.

Line 24--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see PRM-1, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 26--This is the sum of lines 22 and 23 plus or minus line 25.

Line 27--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records).

Line 28--For final settlement, report on line 28 the amount on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus line 27 and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal costfinding process. (See PRM-1, §115.2.) A schedule showing the supporting details and computations must be attached.

4069. WORKSHEET M-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines.

Line 1--Enter the health care staff cost from Worksheet M-1, column 7, line 10.

Line 2--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4--Enter the cost of the pneumococcal and influenza vaccine medical supplies from your records.

Line 5--Enter the sum of lines 3 and 4.

Line 6--Enter the amount from Worksheet M-1, column 7, line 22. This is your total direct cost of the facility.

Line 7--Enter the amount from Worksheet M-2, line 16.

Line 8--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10--Enter the sum of the amounts on lines 5 and 9.

Line 11--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12--Enter the cost per pneumococcal and influenza vaccine injections by dividing the amount on line 10 by the number on line 11.

Line 13--Enter the number of program pneumococcal and influenza vaccine injections from your records or the PS&R.

Line 14--Enter the program cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15--Enter the total cost of pneumococcal and influenza vaccine and its(their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 plus column 2, line 14.

Transfer the result to Worksheet M-3, line 21.

**4070. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES**

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

**Line Descriptions**

**Line 1**--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

**Line 2**--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

**Line 3**--Enter the amount of each retroactive lump sum adjustment and the applicable date.

**Line 4**--Transfer the total interim payments to the title XVIII Worksheet M-3, line 27.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY.**

**Line 5**--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

**Line 6**--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE:** On lines 3, 5, and 6, when an amount is due from the provider to the 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.

**Line 7**--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet M-3, line 26.

**Line 8**--Enter the contractor name and the contractor number in columns 1 and 2, respectively.

## EXHIBIT 1 - Form CMS-2552-10 Worksheets

The following is a listing of the Form CMS-2552-10 worksheets and the page number location. Changes to worksheets are indicated by redline on this and the subsequent page for this transmittal. Where only the page number changes, no redlining is indicated.

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