[] Desk Reviewed

[] Audited

Contractor No.

[] First Cost Report Processed by Contractor

[] Last Cost Report to be Processed by Contractor

PART II - CERTIFICATION

[1] [2]

[3]

[4]

use only:

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS)

As Submitted:

Reopened: If number 4, Enter

Number of times reopened []

Amended:

Settled:

Balance Sheet and Stat beginning the books and records of	ement of Revenue and Expens and ending of the provider in accordance	ses prepared by and to the best of my kn	{Provid nowledge and belief, it is ept as noted. I further of	ctronically filed or manually submitted cost report and the ler Names) and Numbers)} for the cost reporting period is a true, correct and complete statement prepared from certify that I am familiar with the laws and regulations	
regarding the provision	ror neatur care services identifi	ned in this cost report were prov	ided iii Compilance wi	ui sucii iaws anu regulauons.	
OFFICER OR ADMIN	NISTRATOR OF PROVIDER				
Printed Name			Signed		
Title			Date		

PART III - SETTLEMENT SUMMARY

			TITLE XV	'III		
		TITLE V	A	В	TITLE XIX	
		1	2	3	4	
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	ICF/MR					3
4	SNF - BASED HHA					4
5	SNF - BASED RHC					5
6	SNF - BASED FQHC					6
7	SNF - BASED CMHC					7
8	SNF - BASED O.L.T.C.					8
100	TOTAL					100

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate's) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FACII	LED NURSING FACILITY AND LITY HEALTH CARE COMPLI DIFICATION DATA		PROVI	DER NO.:	PERIO FROM TO			-	WORKS S - 2 Part I	
	Nursing Facility and Skilled Nu	rsing Facility Complex Address:							1 4111	
1	Street:	g, F	1	P.O. Box:						1
2	City:			State:		Zip C	ode:			2
3	County:			CBSA Code:			/ Rural	•		3
	nd SNF-Based Component Identi	fication:								
	_						Pa	yment Syst	em	
		Component Name		Provider No.	Da	ite		, O, or		
	Component	_			Certi	fied	V	XVIII	XIX	
	0	1		2	3	3	4	5	6	
4	SNF									4
5	Nursing Facility									5
6	ICF/MR									6
7	SNF-Based H.H.A.									7
8	SNF-Based RHC									8
9	SNF-Based FQHC									9
10	SNF-Based CMHC									10
11	SNF-Based O.L.T.C.									11
12	SNF-Based HOSPICE									12
13	Cost Reporting Period (mm/dd/yy	ryy)	From:		To:					13
14	Type of Control (See Instructions)								14
Type o	f Freestanding Skilled Nursing F	acility			ļ				Y/N	
15	Is this a distinct part skilled nursi	ng facility that meets the requirements set forth in	42 CFR section	n 483.5?						15
16	Is this a composite distinct part sl	cilled nursing facility that meets the requirements s	set forth in 42 (CFR section 483	.5?					16
17	Are there any costs included in W	orksheet A which resulted from transactions with	related							17
	organizations as defined in CMS	Pub. 15-I, chapter 10? If yes, complete Workshee	et A-8-1.							
Miscel	laneous Cost Reporting informat	ion								
18	If this is a low or no Medicare uti	lization cost report, enter "L" for low Medicare Ut	tilization, or							18
	enter "N" for No Medicare Utiliza	ation.								
19	Other									19
Depre	ciation - Enter the amount of dep	reciation reported in this SNF for the method in	ndicated on Li	ines 22 - 24.						
20	Straight Line									20
21	Declining Balance									21
22	Sum of the Year's Digits									22
23	Sum of line 20 through 22									23
24		e balance as of the end of the period.								24
25		assets during the cost reporting period? (Y/N)			'					25
26		med on any assets in the current or any prior cost i								26
27		Medicare program at end of the period to which t								27
28	Was there a substantial decrease i	n health insurance proportion of allowable cost fro	om prior cost re	eports						28

41-304 Rev. 1

2/11 FORM CMS-2540-10 4190 (Cont.) SKILLED NURSING FACILITY AND SKILLED NURSING **PERIOD PROVIDER NO.:** WORKSHEET **FACILITY HEALTH CARE COMPLEX** FROM S-2 Part I **IDENTIFICATION DATA** TO (Continued) If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges enter "Y" for each component and type of service that qualifies for the exemption. Part A Part B Other Skilled Nursing Facility 29 30 Nursing Facility 30 31 ICF/MR 31 32 SNF-Based H.H.A. 32 SNF-Based RHC 33 SNF-Based FQHC 34 34 SNF-Based CMHC 35 SNF-Based OLTC 36 $\overline{Y/N}$ Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients. 37 Are you legally-required to carry malpractice insurance? 38 Is the malpractice a "claims-made:", or "occurence" policy? If the policy is "claims-maid" enter 1. If policy is "occurence", enter 2. 39 What is the liability limit for the malpractice policy? Enter in column 1 the monetary 40 40 limit per lawsuit. Enter in column 2 the monetary limit per policy year. Premiums Paid Losses Self insurance 41 List malpractice premiums and paid losses: 41 Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? 42 Y / N Enter Y or N. If ves, check box, and submit supporting schedule listing cost centers and amounts. 42 Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10? 43 43 If yes, and there are costs, for the home office, enter the applicable provider number Provider # If this facility is part of a chain organization, enter the name and address of the home office on the lines below 45 Name: Contractor name Contractor Number 46 Street: PO Box 46 City State Zip

FORM	(12/10)) (INSTI	RUCTIO	NS FO	R THIS	WORI	SHEET	ARE	PUBL	ISHED	IN (CMS	PUB	15-II,	SECT	ION	4104
Rev.1																	

41-305

4190 (Cont.)	FORM CMS-2540-10	2/11

SRILER NIRESING FACILITY AND SKILLER TOKENING PROVIDER NO.: PFRIOD: Part II DENTIFICATION DATA For all the lates responses the format will be (manddity): Completed by All Skilled Nursing Facilities Provider Organization and Operation I 1 2 1 2 3 7 0 0 0 0 0 0 0 0 0	4190 (Cont.)	FORM CMS-254	0-10				2/11
Provider Organization and Operation	FACII	LITY HEALTH CARE COMPLEX	PROVIDER NO.:	FROM			T S-2	
Provider Organization and Operation		al Instruction: For all column 1 responses enter in column						
Has the Provider changed ownership immediately prior to the Jeginning of the cost reporting period? 1 1 1 2 3 3 2 3 3 4 4 5 5 5 5 5 5 5 5	Comp		responses the format will be (r	nm/dd/yyyy)				
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9 Is the provider seeking reimbursement for bad debts? If "Y", see instructions. 9 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy. 10 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions. 11 Bed Complement 12 Have total beds available changed from prior cost reporting period? If "Y", see instructions. 12						ı	'	<u>' </u>
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12 Have total beds available changed from prior cost reporting period? If "Y", see instructions. 12		if the 9 is 4, are patient deductibles and/or comsulance war	veur II 4 , see ilistructions.					
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PS&R information? If "Y", see Instructions.		have been billed but are not included on the PS&R used						
17 If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other?		PS&R information? If "Y", see Instructions.						
Describe the other adjustments:	17		ata for Other?					17
18 Was the cost report prepared only using the provider's records? If "Y" see Instructions.	18	•	cords? If "Y" see Instructions.					18

41-306 Rev. 1

	SKILLED NURSI	NG FACII	LITY AND			PROVIDER NO.: PERIOD			WORKSHEET S-3					
SK	KILLED NURSING FA	ACILITY I	HEALTH (CARE CO	MPLEX				FROM_				PART I	
	STA	TISTICAL	_ DATA											
		Number	Bed		Inpa	atient 1	Days]	Discharge	S		
		of	Days	Title	Title	Title		Total	Title	Title	Title		Total	İ
	Component	Beds	Available	V	XVIII	XIX	Other		V	XVIII	XIX	Other		
		1	2	3	4	5	6	7	8	9	10	11	12	<u> </u>
1	Skilled Nursing Facility													1
2	Nursing Facility													2
3	ICF/MR													3
4	Home Health Agency													4
5	Other Long Term Care													5
6	SNF-Based CMHC													6
7	Hospice													7
8	Total (Sum of lines 1-7)													8

											Full	Time	
			Average Le	ngth of Stay	7		P	Admissi	o n s		Equi	valent	
		Title	Title	Title	Total	Title	Title	Title		Total	Employees	Nonpaid	
		V	XVIII	XIX		V	XVIII	XIX	Other		on Payroll	Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2	Nursing Facility												2
3	ICF/MR												3
4	Home Health Agency												4
5	Other Long Term Care												5
6	SNF-Based CMHC												6
7	Hospice												7
8	Total (Sum of lines 1-7)												8

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4105.

4190(C	ont.)	FURM CM		DEDIOD		WORKSHEE	<u>ZIII</u>
	WASE PUREW PUREPLANTION	PROVIDER N	NO.:	PERIOD:		WORKSHEE	
SNF	WAGE INDEX INFORMATION			FROM		PARTS II &	· III
				<u>TO</u>			
			Reclass.	Adjusted	Paid Hours	Average	
			of Salaries	Salaries	Related	Hourly Wage	
PART	II DIRECT SALARIES	Amount	from Wkst.	(col. 1 ±	to Salary	(col. 3 ÷	
		Reported	A-6	col. 2)	in col. 3	col. 4)	
		1	2	3	4	5	
	SALARIES						
1	Total salary (See Instructions)						1
2	Physician salaries-Part A						2
3	Physician salaries-Part B						3
4	Interns & Residents (approved)						4
5	Home office personnel						5
6	Sum of lines 2 thru 5						6
7	Revised wages (line 1 minus line 6)						7
8	Other Long Term Care						8
9	H.H.A.						9
10	СМНС						10
11	Hospice						11
12	Non-reimbursable						12
13	Total Excluded salary						13
	(Sum of lines 8 through 12)						
14	Subtotal (line 7 minus line 13)						14
	OTHER WAGES AND RELATED COSTS						
15	Contract Labor: Patient Related & Mgmt						
16	Contract Labor: Physician services-Part A						16
17	Home office salaries & wage related costs						17
	WAGE RELATED COSTS						
18	Wage related costs core. (See Part IV)						18
19	Wage related costs other (See Part IV)						19
20	Wage related costs (excluded units)						20
21	Physicians Part A - WRC						21
22	Physicians Part B - WRC						22
23	Subtotal (see instructions)						23

PART III - OVERHEAD COST - DIRECT SALARIES

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

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB.15-II, SECTION 4105.1 - 4105.2)

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Plan Administration fees inting/Management Fees-F	Plan Cost G (Paid to External Organizati Pension Plan	PERIOD: FROM TO ion):	Amount Reported	1 2
ENT COST Oyer Contributions Ed Annuity (TSA) Employed Id Non-Qualified Pension In the service Cost INISTRATIVE COSTS Plan Administration fees Inting/Management Fees-F	Plan Cost G (Paid to External Organizati Pension Plan	on):		
ENT COST oyer Contributions ed Annuity (TSA) Employed d Non-Qualified Pension I ension Service Cost IINISTRATIVE COSTS Plan Administration fees enting/Management Fees-I	Plan Cost G (Paid to External Organizati Pension Plan	on):		
ed Annuity (TSA) Employed Annuity (TSA) Employed Non-Qualified Pension I ension Service Cost MINISTRATIVE COSTS Plan Administration fees unting/Management Fees-F	Plan Cost G (Paid to External Organizati Pension Plan	on):		
ed Annuity (TSA) Employed Annuity (TSA) Employed Non-Qualified Pension I ension Service Cost MINISTRATIVE COSTS Plan Administration fees unting/Management Fees-F	Plan Cost G (Paid to External Organizati Pension Plan	on):		
ed Annuity (TSA) Employed Annuity (TSA) Employed Non-Qualified Pension I ension Service Cost MINISTRATIVE COSTS Plan Administration fees unting/Management Fees-F	Plan Cost G (Paid to External Organizati Pension Plan	ion):		
ed Annuity (TSA) Employed Non-Qualified Pension I ension Service Cost MINISTRATIVE COSTS Plan Administration fees anting/Management Fees-I	Plan Cost G (Paid to External Organizati Pension Plan	ion):		
d Non-Qualified Pension I Pension Service Cost MINISTRATIVE COSTS Plan Administration fees anting/Management Fees-I	Plan Cost G (Paid to External Organizati Pension Plan	ion):		2
Tension Service Cost MINISTRATIVE COSTS Plan Administration fees unting/Management Fees-F	6 (Paid to External Organizati Pension Plan	ion):		
MINISTRATIVE COSTS Plan Administration fees anting/Management Fees-F	Pension Plan	ion):		3
Plan Administration fees inting/Management Fees-F	Pension Plan	ion):		4
ınting/Management Fees-F			-	
				5
10 5				6
Ianaged Care Program Adı				7
ND INSURANCE COS				
irance (Purchased or Se	elf Funded)			8
n Drug Plan				9
aring and Vision Plan				10
nce (If employee is owne				11
Insurance (If employee				12
nsurance (If employee is	s owner or beneficiary)			13
	loyee is owner or beneficiary	y)		14
ompensation Insurance				15
	current year, not the extrao	rdinary		16
quired by FASB 106 No	on cumulative portion)			
				17
	on Only			18
				19
deral Unemployment Ta	axes			20
				21
				22
				23
	ines 1 -23)			24
	oyers Portion Only Taxes - Employers Portion The Insurance The Index of the Insurance The Insurance Insurance The Insurance Insurance The Insurance Insurance Insurance The Insurance Insu	Taxes - Employers Portion Only nent Insurance Ideral Unemployment Taxes Deferred Compensation Cost and Allowances	oyers Portion Only Faxes - Employers Portion Only ment Insurance Ideral Unemployment Taxes Deferred Compensation Cost and Allowances Imbursement	oyers Portion Only Taxes - Employers Portion Only Thent Insurance Tederal Unemployment Taxes Deferred Compensation Cost and Allowances The modern of the compensation of the cost and Allowances The modern of the cost and the cost an

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4105)

25 Other Wage Related Costs (specify)

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25

DRAFT FORM CMS-2540-10 4190 (Cont.)

DRAFT			NO :	DEDIOD.		WORKSHEET		
	CME DEPODEING OF	PROVIDER	NU.:	PERIOD:		S-3	E I	
	SNF REPORTING OF			FROM				
	DIRECT CARE EXPENDITURES			ТО		PART V		
				Adjusted	Paid Hours	Average		
				Salaries	Related	Hourly Wage		
		Amount	Fringe	(col. 1 +	to Salary	(col. 3 ÷		
•		Reported	Benefits	col. 2)	in col. 3	col. 4)		
Occu	pational Category	1	2	3	4	5		
	Direct Salaries							
	Nursing Occupations							
1	Registered Nurses (RNs)						1	
2	Licensed Practical Nurses (LPNs)						2	
3	Nursing Assistants/Aides						3	
	Total Nursing							
4	Physical Therapists						4	
5	Physical Therapy Assistants						5	
6	Physical Therapy Aides						6	
7	Occupational Therapists						7	
8	Occupational Therapy Assistants						8	
9	Occupational Therapy Aides						9	
10	Speech Therapists						10	
11	Respiratory Therapists						11	
12	Other Medical Staff						12	
	Contract Labor							
	Nursing Occupations							
13	Registered Nurses (RNs)						13	
14	Licensed Practical Nurses (LPNs)						14	
15	Nursing Assistants/Aides						15	
	Total Nursing							
16	Physical Therapists						16	
17	Physical Therapy Assistants						17	
18	Physical Therapy Aides						18	
19	Occupational Therapists						19	
20	Occupational Therapy Assistants						20	
21	Occupational Therapy Aides						21	
22	Speech Therapists						22	
23	Respiratory Therapists						23	
24	Other Medical Staff						24	

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_						1	_
3	Unduplicated Census Count (see instructions)						3
Н	OME HEALTH AGENCY - NUMBER OF EMPLOYEES				•		
	(FULL TIME EQUIVALENT)			Staff	Contract	Total	
				1	2	3	
4	Enter the number of hours in your normal work week						4
5	Administrator and Assistant Administrator(s)						5
6	Directors and Assistant Director(s)						6
7	Other Administrative Personnel						7
8	Direct Nursing Service						8
9	Nursing Supervisor						9
10	Physical Therapy Service						10
11	Physical Therapy Supervisor						11
12	Occupational Therapy Service						12
13	Occupational Therapy Supervisor						13
14	Speech Pathology Service						14
15	Speech Pathology Supervisor						15
16	Medical Social Service						16
17	Medical Social Service Supervisor						17
18	Home Health Aide						18
19	Home Health Aide Supervisor						19
20	Other (specify)						20
HOM	E HEALTH AGENCY CBSA CODES				-		
21							21
22	How many CBSAs in column 1 did you provide services to during this cost re	porting period	I.				22
23	List those CBSA code(s) in column 1 serviced during this cost reporting period	od (line 20 cor	itains the first	code).			23

PPS ACTIVITY DATA - Applicable for Medicare Services Rendered on or after October 1, 2000

		Full Ep	oisodes	LUPA	PEP	TOTAL	
		Without	With	1	only		
		Outliers	Outliers	Episodes	Episodes	(cols. 1-4)	
		1	2	3	4	5	
24	Skilled Nursing Visits						24
25	Skilled Nursing Visit Charges						25
26	Physical Therapy Visits						26
27	Physical Therapy Visit Charges						27
28	Occupational Therapy Visits						28
29	Occupational Therapy Visit Charges						29
30	Speech Pathology Visits						30
31	Speech Pathology Visit Charges						31
32	Medical Social Service Visits						32
33	Medical Social Service Visit Charges						33
34	Home Health Aide Visits						34
35	Home Health Aide Visit Charges						35
36	Total visits (sum of lines 24, 25, 28, 29, 31 and 34)						36
37	Other Charges						37
38	Total Charges (sum of lines 25, 27, 29, 31, 33, 35 and 37)						38
39	Total Number of Episodes (standard/non outlier)						39
40	Total Number of Outlier Episodes						40
	Total Non-Routine Medical Supply Charges						41

	SNF - BASED RURAL HEALTH (FEDERALLY QUALIFIED HEA CENTER STATISTICAL DA	ALTH				DER NO: ONENT N	O:		PERIOD FROM_ TO						SHEET - 5	Ī
Check ap	plicable box:			[] F	L <u> </u>	[] F	QHC									
	- STATISTICAL DATA															
1	Street:											County	:			1
2	City:							State:				Zip Co	de:			2
3	Designation (for FQHC's only) - Enter "R"	for rura	ıl or "U'	' for urb	an											3
Source of	Federal funds:											Grant	Award	Da	ate	
4	Community Health Center (Section 330(d)	, PHS A	ct)													4
5	Migrant Health Center (Section 329(d), PH	(S Act)													,	5
6	Health Services for the Homeless (Section	340(d),	PHS A	ct)											,	6
7	Appalachian Regional Commission														,	7
8	Look - Alikes															8
9	Other (specify)															9
10	Does the facility operate as other than an R	HC or F	FQHC?	If yes, i	ndicate	the num	ber of o	ther ope	rations i	n column 2.				1	2	
	(Enter in subscripts of line 10 the type of o	ther ope	ration(s	and the	e operat	ing hour	s.)									10
	NOTE: Line 11 (Clinic) is to be completed	regardl	ess of th	ne respo	nse to li	ne 10.										
	Facility hours of operations (1)															•
		Sun	nday	Moi	nday	Tue	sday	Wedn	esday	Thursda	ay	Fri	day	Satu	rday	
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11
	(1) List hours of operation based on a 24 hour clock.	For exan	ple: 8:00	am is 0800), 6:30pm	is 1830, a	nd midnię	ght is 2400				•	•			
12	Have you received an approval for an exce	-	-													12
13	Is this a consolidated cost report in accord						-									13
14	providers included in this report. List the Provider Name	names 0	n an pro	oviders a	iiiu iiuli	ibers on	Subscri	nea imes		NPI Number						14
14	i riuviuei Naille									iive i ivuiiiDel						14

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4107)

Have you provided all or substantially all GME cost. If yes, enter in column 2 the number of program visits performed as

Nursing and Allied Health Education Activities.

41-311 Rev. 1

15

		PROVIDER NO.:	PERIOD:		
	SKILLED NURSING FACILITY BASED		FROM	_ WORKSHEET S-6	
	C.M.H.C. STATISTICAL DATA	C.M.H.C. NO.:	TO	_	
		·		•	
	NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)				
	Employment Category: Enter the number of hours	Staff	Contract	Total	
	in your normal work week ().	1	2	3	
1	Administrator and Assistant Administrators				1
2	Directors and Assistant Directors				2
3	Other Administrative Personnel				3
4	Directing Nursing Service				4
	Nursing Supervisor				5
	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
	Psychological Service				16
17	Psychological Service Supervisor				17
18	3				18
19					19

4190	(Cont.)	FORM CMS-2	540-10	2/1	1
PRO:	SPECTIVE PAYMENT	PROVIDER NO.:	PERIOD:	WORKSHEET S-7	
FOR	SNF		FROM:		
STAT	TISTICAL DATA		TO:		
	GROUP			Days	
	1			2	
1	RUX				1
2	RUL				2
3	RVX				3
4	RVL				4
5	RHX				5
6	RHL				6
$\frac{0}{7}$	RMX				$\frac{1}{7}$
8	RML				8
9	RLX				9
10	RUC				10
11	RUB				11
12	RUA				12
13	RVC				13
14	RVB				14
15	RVA				15
16	RHC				16
17	RHB				17
18	RHA				18
19	RMC				19
20	RMB				20
21	RMA				21
22	RLB				22
23	RLA				23
$\frac{23}{24}$	ES3				23
	ES2				I
25					25
26	ES1				26
27	HE2				27
28	HE1				28
29	HD2				29
30	HD1				30
31	HC2				31
32	HC1				32
33	HB2				33
34	HB1				34
35	LE2				35
36	LE1			+	36
37	LD2				37
38	LD1				38
39	LC2				39
40	LC1				40
41	LB2				41
42	LB1				41 42
43	CE2				43
44	CE1				44
45	CD2				45
46	CD1				46
47	CC2				47
48	CC1				48
49	CB2				49
50	CB1				50

Rev.1 02/11 FORM CMS-2540-10 4190 (Cont.)

PROS	SPECTIVE PAYMENT FOR SNF	PROVIDER NO.:	PERIOD:	WORKSH	EET
STAT	TISTICAL DATA		FROM:	S-7	,
			TO:		
	GROUP	•	<u>'</u>	Days	
	1			2	
51	CA2				51
52	CA1				52
53	SE3				53
54	SE2				54
55	SE1				55
56	SSC				56
57	SSB				57
58	SSA				58
59	IB2				59
60	IB1				60
61	IA2				61
62	IA1				62
63	BB2				63
64	BB1				64
65	BA2				65
66	BA1				66
67	PE2				67
68	PE1				68
69	PD2				69
70	PD1				70
71	PC2				71
72	PC1				72
73	PB2				73
74	PB1				74
75	PA2				75
76	PA1				76
99	AAA				99
100	Total	<u> </u>			100

Enter in column 1 the expense for each category. Enter in column 2 the percentage of total expense for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)

		Expenses	Percentage	Y/N	
		1	2	3	
101	Staffing				101
	Recruitment				102
103	Retention of employees				103
104	Training				104
105	Other (Specify)				105

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

PART I Enrollment Days Based on Level of Care

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

PART II Census Data

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

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4110)

41-315 Rev. 1

02/11	<u> </u>			FURNI CIVIS-					4130 (Cont.
				PROVIDE	R NO.:	PERIOD:				
	RECLASSIFICATION AND	ADJUSTMEN	T			FROM		WORKS	SHEET A	
	OF TRIAL BALANCE OF	F EXPENSES	}			TO				
						RECLASSI-	RECLASSIFIED	ADJUSTMENTS	NET EXPENSES	
						FICATIONS	TRIAL	TO EXPENSES	FOR COST	
	COST CENTER		SALARIES	OTHER	TOTAL	Increase/Decrease	BALANCE	Increase/Decrease	ALLOCATION	
	(Omit Cents)				(Col 1 + Col 2)	(Fr Wkst A-6)	(Col 3 +/- Col 4)	(Fr Wkst A-8)	(Col 5 +/- Col 6)	
A	B D		1	2	3	4	5	6	7	A
GENI	ERAL SERVICE COST CENTERS					<u> </u>				
1	00100 Capital-Related Costs - Building &									1
2	00200 Capital-Related Costs - Moveable	Equipment								2
3	00300 Employee Benefits									3
4	00400 Administrative and General									4
5	00500 Plant Operation, Maintenance and	Repairs								5
6	00600 Laundry and Linen Service									6
7	00700 Housekeeping									7
8	00800 Dietary									8
9	00900 Nursing Administration									9
10	01000 Central Services and Supply									10
11	01100 Pharmacy									11
12	01200 Medical Records and Library									12
13	01300 Social Service									13
14	01400 Nursing and Allied Health Educati	ion Activities								14
15	Other General Service Cost									15
DIRE	CT CARE EXPENDITURES	I	LINES 16 THROU	GH 29 ARE RESE	RVED FOR FUTU	RE USE				
INPA	HENT ROUTINE SERVICE COST CENT	ERS								
30	03000 Skilled Nursing Facility									30
31	03100 Nursing Facility									31
32	03200 Intermediate Care Facility - Menta	ally Challenged								32
33	Other Long Term Care									33
ANCI	LLARY SERVICE COST CENTERS									
40	04000 Radiology									40
41	04100 Laboratory									41
42	04200 Intravenous Therapy									42
43	04300 Oxygen (Inhalation) Therapy									43
44	04400 Physical Therapy									44
45	04500 Occupational Therapy									45
46	04600 Speech Pathology									46
47	04700 Electro cardiology									47
									1	

4190 (Cont.) FORM CMS-2540-10 02/11

4150 (Cont.)		PROVIDE		PERIOD:				
RECLASSIFICATION AND ADJUSTMENT				FROM		WORKS	SHEET A	
OF TRIAL BALANCE OF EXPENSES				TO		1		
COST CENTER				RECLASSI-	RECLASSIFIED	ADJUSTMENTS	NET EXPENSES	
	SALARIES	OTHER	TOTAL	FICATIONS	TRIAL	TO EXPENSES	FOR COST	
(Omit Cents)				Increase/Decrease	BALANCE	Increase /Decrease		
(Omit Cents)			(Col 1 + Col 2)		(Col 3 +/- Col 4)		(Col 5 +/- Col 6)	
A B D	1	2	3	4	5	6	7	
A B D 48 04800 Medical Supplies Charged to Patients	1		3	4	3	- 0	/	48
49 04900 Drugs Charged to Patients								49
50 05000 Dental Care - Title XIX only								50
51 05100 Support Surfaces								51
52 Other Ancillary Service Cost Center								52
OUTPATIENT SERVICE COST CENTERS								32
		Т		T	T	T	T	L CO
								60
61 06100 Rural Health Clinic (RHC)								61
62 6200 FQHC 63 6300 Other Outpatient Service Cost								62
63 6300 Other Outpatient Service Cost OTHER REIMBURSABLE COST CENTERS								63
								70
70 07000 Home Health Agency Cost								70 71
71 07100 Ambulance								72
72 07200 Nursing and Allied Health Education Activities 73 07300 C.M.H.C.								73
								74
								/4
SPECIAL PURPOSE COST CENTERS							0	100
80 08000 Malpractice Premiums & Paid Losses							-0-	80
81 08100 Interest Expense							- 0 -	81
82 08200 Utilization Review SNF							- 0 -	82
83 08300 Hospice								83
84 Other Special Purpose Cost								84
NON REIMBURSABLE COST CENTERS								<u> </u>
90 09000 Gift, Flower, Coffee Shops and Canteen								90
91 09100 Barber and Beauty Shop								91
92 09200 Physicians' Private Offices								92
93 09300 Nonpaid Workers								93
94 09400 Patients Laundry								94
95 Other Non Reimbursable Cost								95
100 TOTAL								100

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4113) 41-317

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	RECLASSIFICATIONS			PROVIDER	NO:	PERIOD: FROMTO		WORKSHEET A-6			
	EXPLANATION OF	CODE	ī	NCREA	C E			ECREA	S E		
	RECLASSIFICATION ENTRY	(1)	COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.		NON SALARY	1
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL RECLASSIFICATIO equal total line - sum	NS (Sum of column	n of column 4 and 5 n 8 and 9	nust (2)							36

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

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

4190 (Cont.) FORM CMS-2540-10	2/11
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	RECONCILIATION OF CAPITAL COSTS CENTERS			PROVIDER NO	.:	FROMTO	WORKSHEET A-7		
AN	ALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			1		<u> </u>			
				Acquisitions		Disposals		Fully	
		Beginning				and	Ending	Depreciated	l
Description		Balances	Purchases	Donation	Total	Retirements	Balance	Assets	l
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3

J	Buildings and Fixtures				, ,
4	Building Improvements				4
	Fixed Equipment				5
6	Movable Equipment				6
7	Subtotal (sum of lines 1-6)				7
	Reconciling Items				8
9	Total (line 6 minus line 8)				9

	ADJUSTMENTS TO EXPENSES	PROVID	ER NO.	PERIOD: FROM	WORKSH	WORKSHEET A-8			
	(1)	(2) BASIS FOR		EXPENSE CLASSIFICATIO WORKSHEET A, TO / FROM					
	DESCRIPTION	ADJUST-	AMOUNT	THE AMOUNT IS TO BE AD					
		MENT		COST CENTER		LINE NO	1		
	1	2	3	4		5			
1	Investment income on restricted funds (Chapter 2)						1		
2	Trade, quantity and time discounts on purchases (Chapter 8)						2		
3	Refunds and rebates of expenses Chapter 8)						3		
4	Rental of provider space by suppliers Chapter 8)						4		
5	Telephone services (pay stations excluded) (Chapter 21)						5		
6	Television and radio service						6		
7	(Chapter 21) Parking lot (chapter 21)						7		
8	Remuneration applicable to provider-	Worksheet					8		
	based physician adjustment	A-8-2							
9	Home office costs (chapter 21)						9		
10	Sale of scrap, waste, etc. (Chapter23)						10		
11	Nonallowable costs related to certain						11		
	Capital expenditures (chapter 24)								
12	Adjustment resulting from transactions with related organizations (chapter 10)	Worksheet A-8-1		_			12		
13	Laundry and Linen service						13		
14	Revenue - Employee meals						14		
15	Cost of meals - Guests						15		
16	Sale of medical supplies to other than patients						16		
17	Sale of drugs to other than patients						17		
18	Sale of medical records and abstracts						18		
19	Vending machines						19		
20	Income from imposition of interest,						20		
71	finance or penalty charges (chapter 21) Interest expense on Medicare overpayments						21		
21	and borrowings to repay Medicare overpayments						21		
22	Depreciationbuildings and fixtures			Capital Related Cost- B	uilding	1	22		
23	Depreciationmovable equipment			Capital Related Cost-M	lovable	2	23		
24	Other Adjustment			Equipment		2	24		
100	TOTAL (Sum of lines 1 through 24) (Transfer to Worksheet A, col. 6, line 100)						100		

⁽²⁾ Basis for adjustment

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

B. Amount Received--if cost cannot be determined.

STATEMENT OF COSTS
OF SERVICES FROM
RELATED ORGANIZATIONS

PERIOD:
FROM

WORKSHEET A-8-1

Part	I Cost	s incurred and adjustments requi	red as a result of transactio	ns with relate	d							
		organizations. Location and amour	nt included on Worksheet A,	Column 5	Amount	Adjustments						
					Allowable	(Col 4 minus						
Line No.		Cost Center	Expense Items	Amount	In Cost	Col 5)						
1		2	3	3 4 5		6						
1							1					
2							2					
3							3					
4							4					
5							5					
6							6					
7							7					
8							8					
9							9					
100	TOT	ALS (Sum of lines 1-9)			100							
	Trans	sfer column 6, line 100 to Workshee	et A-8, column 3, line 12)									

Part II Interrelationship to related organization(s):

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

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

•				Related Org	anization(s)		
(2	1)		Percentage		Percentage		
Sym	ıbol	Name	of	Name	of	Type of	
			Ownership		Ownership	Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

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

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

G. Other	(Illialicial of	non-manciar)	specify	

FORM CMS - 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 4117)

41-321 Rev. 1

	PROVIDER-BASED PHYSICIANS ADJUSTMENTS		JSTMENTS	PROVIDER	NO:	PERIOD: FROM TO		WORKSHEET A-8-2		
		Cost Center /					Physician /		5 Percent of	
	Wkst A	Physician	Total	Professional	Provider	RCE	Provider	Unadjusted	Unadjusted	
	Line No.	Identifier	Remuneration	Component	Component	Amount	Component	RCE Limit	RCE Limit	
							Hours			
	1	2	3	4	5	6	7	8	9	
1 2 3 4										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100
			Cost of	Provider	Physician	Provider				Т
		Cost Center /	Memberships	Component	Cost of	Component	Adjusted	RCE		
	Wkst A	Physician	& Continuing	Share of	Malpractice	Share of	RCE Limit	Disallowance	Adjustment	
	Line No.	Identifier	Education	Col 12	Insurance	Column 14				
	10	11	12	13	14	15	16	17	18	+
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4118)

4190	(Cont.)	FORM CMS-2540-10						
	COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDE	то		WORK PAR			
	COST CENTER (Omit Cents)	NET EXPENSES FOR COST ALLOCATION Fr. Wkst A, Col 7	BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (Sum of Columns 0 - 3)		
CEN	ERAL SERVICE COST CENTERS	0	1	2	3	3 A	4	
1	Capital-Related Costs - Building & Fixture							1
$\frac{1}{2}$	Capital-Related Costs - Moveable Equipment							2
$\frac{-2}{3}$	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
-8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education Activities							14
	Other General Service Cost							15
	THENT ROUTINE SERVICE COST CENTERS							
	Skilled Nursing Facility							30
31								31
	Intermediate Care Facility - Mentally Retarded							32
33	Other Long Term Care ILLARY SERVICE COST CENTERS							33
								40
41	Radiology Laboratory							41
42								42
43	Oxygen (Inhalation) Therapy							43
44								44
45	Occupational Therapy							45
46	Speech Pathology							46
47	Electro cardiology							47
48	Medical Supplies Charged to Patients							48
49	Drugs Charged to Patients							49
50	Dental Care - Title XIX only					1		50
51	Support Surfaces							51
52	Other Ancillary Service Cost Center							52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDE	ER NO.:	PERIOD: FROM _ TO		WORKSHEET B PART I		
	NET EXPENSES		CAP. REL.	EMPLOYEE		ADMINIS-	
	FOR COST	BUILDINGS	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE	
COST CENTER	ALLOCATION	& FIXTURES	EQUIPMENT		(Sum of	& GENERAL	
(Omit Cents)	Fr. Wkst A, Col 7				Columns 0-3)		
	0	1	2	3	3 A	4	
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							-
70 Home Health Agency Cost							70
71 Ambulance							71
72 Nursing and Allied Health Education Activities							72
73 C.M.H.C.							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients Laundry							94
95 Other Non Reimbursable Cost							95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
100 Total							100

4190 (Cont.) FORM CMS-2540-10 2/11

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B PART I			
	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
GEN	ERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								$\frac{1}{1}$
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education Activities								14
15	Other General Service Cost								15
	THENT ROUTINE SERVICE COST CENTERS								
	Skilled Nursing Facility								30
31									31
32	Intermediate Care Facility - Mentally Retarded								32
33	Other Long Term Care								33
	ILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electro cardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost Center								52

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120)

41-325 Rev. 1

4190 (Cont.) 2/11 FORM CMS-2540-10 PROVIDER NO.: PERIOD: COST ALLOCATION - GENERAL SERVICE COSTS $FROM_{_}$ **WORKSHEET B** TO PART I PLANT OPER. LAUNDRY HOUSE DIETARY NURSING CENTRAL PHARMACY MAINTENANCE & LINEN KEEPING ADMINIS-SERVICES COST CENTER & REPAIRS SERVICE TRATION & SUPPLY (Omit Cents) 5 6 8 10 11 **OUTPATIENT SERVICE COST CENTERS** 60 Clinic 60 61 Rural Health Clinic (RHC) 61 62 FQHC 62 63 Other Outpatient Service Cost 63 OTHER REIMBURSABLE COST CENTERS 70 Home Health Agency Cost 70 71 71 Ambulance 72 Nursing and Allied Health Education Activities 72 73 C.M.H.C. 73 74 Other Reimbursable Cost 74 SPECIAL PURPOSE COST CENTERS 83 Hospice 83 84 Other Special Purpose Cost 84 89 Subtotals 89 NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen 90 91 Barber and Beauty Shop 91 92 Physicians' Private Offices 92 93 Nonpaid Workers 93 94 94 Patients Laundry 95 95 Other Non Reimbursable Cost 98 Cross Foot Adjustments 98 99 99 Negative Cost Center 100 Total 100

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120)

4190	(Cont.)		FORM CMS						2/11
	COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B PART I	
	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
GEN	ERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
- 8 - 9	Dietary								8
$\frac{9}{10}$	Nursing Administration								10
11	Central Services and Supply Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14									14
15									15
	TIENT ROUTINE SERVICE COST CENTERS								115
	Skilled Nursing Facility								30
31						+	+		31
32	Intermediate Care Facility - Mentally Retarded								32
33	Other Long Term Care			+		+			33
	ILLARY SERVICE COST CENTERS								+
	Radiology								40
41	Laboratory					+			41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy					1	1		43
44	Physical Therapy					1	†		44
45	Occupational Therapy					1			45
46	Speech Pathology			1		1	1		46
47	Electro cardiology						1		47
48	Medical Supplies Charged to Patients								48

49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost Center				52

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120)

41-327 Rev. 1

4190	(Cont.)	FORM CMS-2540-10							
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B		
	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	1
OUT	PATIENT SERVICE COST CENTERS					,			
60	Clinic								60
61	Rural Health Clinic (RHC)								61
	FQHC								62
	Other Outpatient Service Cost								63
	ER REIMBURSABLE COST CENTERS								
	Home Health Agency Cost								70
71	Ambulance								71
72	Nursing and Allied Health Education Activities								72
73	C.M.H.C.								73
74	Other Reimbursable Cost								74
SPEC	TAL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON	REIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients Laundry								94
95	Other Non Reimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total						 		100

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120)

4190 (Cont.)	FORM CMS-2540-10							
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM TO		WORKSH			
	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)		
		0	1	2	3	4 A	4		
GENE	RAL SERVICE COST CENTERS							1	
1	Capital-Related Costs - Building & Fixture							1	
2	Capital-Related Costs - Moveable Equipment							2	
3	Employee Benefits							3	
4	Administrative and General							4	
5	Plant Operation, Maintenance and Repairs							5	
6	Laundry and Linen Service							6	
7	Housekeeping							7	
8	Dietary							8	
9	Nursing Administration							9	
10	Central Services and Supply							10	
11	Pharmacy							11	
12	Medical Records and Library							12	
13	Social Service							13	
14	Nursing and Allied Health Education Activities							14	
15	Other General Service Cost							15	
INPA	TIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility							30	
31	Nursing Facility							31	
32	Intermediate Care Facility - Mentally Retarded							32	
33	Other Long Term care							33	
	LLARY SERVICE COST CENTERS								
40	Radiology							40	
41	Laboratory							41	
42	Intravenous Therapy							42	
43	Oxygen (Inhalation) Therapy							43	
44	Physical Therapy							44	
45	Occupational Therapy							45	
46	Speech Pathology							46	
47	Electro cardiology					1		47	
48	Medical Supplies Charged to Patients					1		48	
49	Drugs Charged to Patients							49	
50	Dental Care - Title XIX only							50	
51	Support Surfaces							51	
52	Other Ancillary Service Cost Center							52	
	Other parentary out vice dost denter					I			

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B-1		
	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	
OLITED A	TIPME CERVICE COCE CEMPERC	0	1	2	3	4 A	4	
60 60	ATIENT SERVICE COST CENTERS Clinic							60
61	Rural Health Clinic (RHC)							61
62	FQHC							62
63	Other Outpatient Service Cost							63
	R REIMBURSABLE COST CENTERS							
70	Home Health Agency Cost							70
71	Ambulance							71
72	Nursing and Allied Health Education Activities							72
73	C.M.H <mark>.</mark> C.							73
74	Other Reimbursable Cost							74
SPECIA	AL PURPOSE COST CENTERS							
83	Hospice							83
84	Other Special Purpose Cost							84
89	Subtotals							89
	EIMBURSABLE COST CENTERS							
90	Gift, Flower, Coffee Shops and Canteen							90
91	Barber and Beauty Shop							91
92	Physicians' Private Offices							92
93	Nonpaid Workers							93
94	Patients Laundry							94
95	Other Non Reimbursable Cost							95
98	Cross Foot Adjustment							98
99	Negative Cost Center							99
102	Cost to Be Allocated (Per Worksheet B, Part I)							102
103	Unit Cost Multiplier (Worksheet B, Part I)							103
104	Cost to Be Allocated (Per Worksheet B, Part II)							104
105	Unit Cost Multiplier (Worksheet B, Part II)							105

FORM CMS-2540-10 4190 (Cont.) 2/11 PROVIDER NO.: PERIOD: COST ALLOCATION - GENERAL SERVICE COSTS FROM **WORKSHEET B-1** TO PLANT OPER. LAUNDRY HOUSE DIETARY NURSING CENTRAL PHARMACY MAINTENANCE & LINEN KEEPING ADMINIS-**SERVICES** COST CENTER & REPAIRS SERVICE TRATION & SUPPLY (Omit Cents) (Square (Pounds of (Hours of (Meals (Direct (Costed (Costed Feet) Laundry) Service) Served) Nrsing Hrs.) Requisitions) Requisitions) 5 6 8 10 11 GENERAL SERVICE COST CENTERS Captial-Related Costs - Building & Fixture Capital-Related Costs - Moveable Equipment Employee Benefits Administrative and General Plant Operation, Maintenance and Repairs 5 Laundry and Linen Service Housekeeping 8 Dietary Nursing Administration 10 Central Services and Supply 10 11 Pharmacy 11 12 Medical Records and Library 12 13 Social Service 13 Nursing and Allied Health Education Activities 14 14 Other General Service Cost 15 INPATIENT ROUTINE SERVICE COST CENTERS Skilled Nursing Facility 30 31 Nursing Facility 31 Intermediate Care Facility - Mentally Retarded 32 32 Other Long Term care 33 ANCILLARY SERVICE COST CENTERS Radiology 40 41 Laboratory 41 42 Intravenous Therapy 42 43 43 Oxygen (Inhalation) Therapy Physical Therapy 44 44 45 45 Occupational Therapy 46 Speech Pathology 46 47 47 Electro cardiology 48 48 Medical Supplies Charged to Patients Drugs Charged to Patients 49 49 50 Dental Care - Title XIX only 50 51 Support Surfaces 51

52

52

Other Ancillary Service Cost Center

Rev. 1

2/11 FORM CMS-2540-10 4190 (Cont.)

2/11	2/11		FORM CMS-2540-10					4190 (Cont.)		
	COST ALLOCATION - GENERAL SERVICE	E COSTS	PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B-1			
		PLANT OPER.	LAUNDRY	HOUSE	DIETARY	NURSING	CENTRAL	PHARMACY		
		MAINTENANCE	& LINEN	KEEPING		ADMINIS-	SERVICES			
	COST CENTER	& REPAIRS	SERVICE			TRATION	& SUPPLY			
	(Omit Cents)	(Square	(Pounds of	(Hours of	(Meals	(Direct	(Costed	(Costed		
		Feet)	Laundry)	Service)	Served)	Nrsing Hrs.)	Requisitions)	Requisitions)		
		5	6	7	8	9	10	11		
OUTP	ATIENT SERVICE COST CENTERS									
60	Clinic								60	
61	Rural Health Clinic (RHC)								61	
62	FQHC								62	
63	Other Outpatient Service Cost								63	
	R REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70	
71	Ambulance								71	
72	Nursing and Allied Health Education Activities								72	
73	C.M.H.C.								73	
74	Other Reimbursable Cost								74	
	AL PURPOSE COST CENTERS									
83	Hospice								83	
84	Other Special Purpose Cost								84	
89	Subtotals								89	
NON F	REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90	
91	Barber and Beauty Shop								91	
92	Physicians' Private Offices								92	
93	Nonpaid Workers								93	
94	Patients Laundry								94	
95	Other Non Reimbursable Cost								95	
98	Cross Foot Adjustment								98	
99	Negative Cost Center								99	
102	Cost to Be Allocated (Per Worksheet B, Part I)								102	
103	Unit Cost Multiplier (Worksheet B, Part I)								103	
104	Cost to Be Allocated (Per Worksheet B, Part II)								104	
105	Unit Cost Multiplier (Worksheet B, Part II)								105	

4190 (Cont.) FORM CMS-2540-10 2/11

7150 (Cont.)		PDOMINI CIVIS		DEDIAD.				2/11
	COST ALLOCATION - GENERAL SERVICE	COSTS	PROVIDE	LR NO.:	PERIOD: FROM TO		WORKSHE	ET B-1	
		MEDICAL	SOCIAL	NURSING &	OTHER		POST		
	COST CENTER	RECORDS	SERVICE	ALLIED	GENERAL	SUBTOTAL	STEP-DOWN	TOTAL	
	(Omit Cents)	& LIBRARY		HEALTH EDUCA	SERVICE		ADJUSTMENTS		
		(Time	(Time	(Assigned	COST				
		Spent)	Spent)	Time)					
		12	13	14	15	16	17	18	
GENE	RAL SERVICE COST CENTERS								
1	Captial-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education Activities								14
15	Other General Service Cost								15
INPA	TIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	Intermediate Care Facility - Mentally Retarded								32
33	Other Long Term care								33
	LLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45

46	Speech Pathology				46
47	Electro cardiology				47
48	Medical Supplies Charged to Patients				48
50	Dental Care - Title XIX only				50
52	Other Ancillary Service Cost Center				52

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120)

Rev. 1

41-333 Rev. 1

2/11			FORM CMS-	4190 (Cont.)					
COST	ALLOCATION - GENERAL SERVICE COST	TS .	PROVIDE	R NO.:	PERIOD: FROM TO		WORKSHE	ET B-1	
	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDU (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
OLUED	TYPINT GERMANE COOK CENTERS	12	13	14	15	16	17	18	
	ATIENT SERVICE COST CENTERS			_					
60	Clinic								60
61 62	Rural Health Clinic (RHC)								61
63	FQHC Other Outpatient Service Cost								63
	R REIMBURSABLE COST CENTERS								0.5
70	Home Health Agency Cost			1					70
$\frac{70}{71}$	Ambulance								70
72	Nursing and Allied Health Education Activities								72
73	C.M.H.C.								73
74	Other Reimbursable Cost								74
	AL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON R	EIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients Laundry								94
95	Other Non Reimbursable Cost								95
98	Cross Foot Adjustment								98
99	Negative Cost Center								99
102	Cost to Be Allocated (Per Worksheet B, Part I)								102
103	Unit Cost Multiplier (Worksheet B, Part I)								103
104	Cost to Be Allocated (Per Worksheet B, Part II)								104

105	Unit Cost Multiplier (Workshee	B, Part II	[)				105

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4120) Rev. 1

41-334

4190 ((Cont.)		FURM CMS						2/11
	ALLOCATION OF CAPITAL - RELATED	COSTS	PROVIDE		PERIOD: FROM _ TO		PAI	KSHEET B RT II	
	COST CENTER	DIRECTLY ASSIGNED CAPITAL	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
	(Omit Cents)	RELATED COST	1	2	2 A	3	4	5	
GENE	ERAL SERVICE COST CENTERS	Ŭ	1		211		-	3	
1	Capital-Related Costs - Building & Fixture								1
	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education Activities								14
15	Other General Service Cost								15
	TIENT ROUTINE SERVICE COST CENTER	RS		•			•		
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	Intermediate Care Facility - Mentally Retarded								32
33	Other Long Term care								33
	LLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electro cardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost Center								52
		-			•	•	•		

2/11 FORM CMS-2540-10 4190 (Cont.)

2/11			4190 (Cont.)						
	ALLOCATION OF CAPITAL - RELATEI	COSTS	PROVIDE	ER NO.:	PERIOD: FROM_ TO		-1	KSHEET B RT II	
		DIDECELL	CAP DEL	CAP DEL	10 —	EL (DI OVEE			
		DIRECTLY	CAP. REL.	CAP. REL.		EMPLOYEE	ADMINIS-	PLANT OPER.	
		ASSIGNED	BUILDINGS	MOVABLE	SUBTOTAL	BENEFITS	TRATIVE	MAINTENANCE	
	COST CENTER	CAPITAL	& FIXTURES	EQUIPMENT			& GENERAL	& REPAIRS	
	(Omit Cents)	RELATED COST	\$						
		0	1	2	2 A	3	4	5	
OUTP	ATIENT SERVICE COST CENTERS								
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHE	R REIMBURSABLE COST CENTERS								
70	Home Health Agency Cost								70
71	Ambulance								71
72	Nursing and Allied Health Education Activities								72
73	C.M.H.C.								73
74	Other Reimbursable Cost								74
SPECI	AL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON I	REIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients Laundry								94
95	Other Non Reimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100
				•	1				

4190 (Cont.) FORM CMS-2540-10 2/11 PROVIDER NO.: PERIOD:

4190 ((Cont.)	FURM CMS						2/11
	ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDE	PERIOD: FROM TO		WORKSHEET B PART II			
	COST CENTER (Omit Cents)	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
Z I NII		6	7	8	9	10	11	
	ERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - Movable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education Activities							14
15	Other General Service Cost							15
	TIENT ROUTINE SERVICE COST CENTERS							
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	Intermediate Care Facility - Mentally Retarded							32
33	Other Long Term care							33
	LLARY SERVICE COST CENTERS							
40	Radiology							40
41	Laboratory							41
42	Intravenous Therapy							42
43	Oxygen (Inhalation) Therapy							43
44	Physical Therapy							44
45	Occupational Therapy							45
46	Speech Pathology							46
47	Electro cardiology							47
48	Medical Supplies Charged to Patients							48
49	Drugs Charged to Patients							49
50	Dental Care - Title XIX only							50
51	Support Surfaces							51
52	Other Ancillary Service Cost Center							52
			-	-		_		

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4121)

41-337 Rev. 1

2/11 FORM CMS-2540-10 4190 (Cont.)

2/11	ALLOCATION OF CAPITAL - RELATED COSTS	COSTS PROVIDER NO.: LAUNDRY HOUSE				WORKSHEET B PART II		
	COST CENTER (Omit Cents)	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
OUTD	ATIENT SERVICE COST CENTERS	6	7	8	9	10	11	
60	Clinic							60
61	Rural Health Clinic (RHC)							61
62	FQHC							62
63	Other Outpatient Service Cost							63
	CR REIMBURSABLE COST CENTERS							- 05
	Home Health Agency Cost							70
71	Ambulance							71
72	Nursing and Allied Health Education Activities							72
73	C.M.H.C.							73
74	Other Reimbursable Cost							74
SPEC	IAL PURPOSE COST CENTERS							
83	Hospice							83
84	Other Special Purpose Cost							84
89	Subtotals							89
NON I	REIMBURSABLE COST CENTERS							
90	Gift, Flower, Coffee Shops and Canteen							90
91	Barber and Beauty Shop							91
92	Physicians' Private Offices							92
93	Nonpaid Workers							93
94	Patients Laundry							94
95	Other Non Reimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

Rev. 1

2/11			FORM CMS					4190	(Cont.)
	ALLOCATION OF CAPITAL - RELATED C	OSTS	PROVID	ER NO.:	PERIOD: FROM _ TO _		WORKS	HEET B	
		MEDICAL	SOCIAL	NURSING &	OTHER	1	POST		
	COST CENTER (Omit Cents)	RECORDS & LIBRARY	SERVICE	ALLIED HEALTH EDUCATION	GENERAL SERVICE COST	SUBTOTAL	STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
GENI	ERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education Activities								14
15	Other General Service Cost								15
	TIENT ROUTINE SERVICE COST CENTER	5							
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	Intermediate Care Facility - Mentally Retarded								32
33	Other Long Term care								33
	LLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electro cardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49

50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost Center				52

41-339 Rev. 1

2/11 FORM CMS-2540-10 4190 (Cont.)

	ALLOCATION OF CAPITAL - RELATED O		PROVIDI		PERIOD: FROM _ TO		PAR	БНЕЕТ В Г II	
		MEDICAL	SOCIAL	NURSING &	OTHER		POST		
		RECORDS	SERVICE	ALLIED	GENERAL	SUBTOTAL	STEP-DOWN	TOTAL	
	COST CENTER	& LIBRARY		HEALTH	SERVICE		ADJUSTMENTS		
	(Omit Cents)			EDUCATION	COST				
		12	13	14	15	16	17	18	
	ATIENT SERVICE COST CENTERS								
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHE	R REIMBURSABLE COST CENTERS								
70	Home Health Agency Cost								70
71	Ambulance								71
72	Nursing and Allied Health Education Activities								72
73	C.M.H.C.								73
74	Other Reimbursable Cost								74
SPECI	AL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON I	REIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients Laundry								94
95	Other Non Reimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

#REF!

POST	T STEP DOWN ADJUSTMENTS	PROVIDER NO.: PERIOD FROMTO			WORKSHEET B-2	
	DESCRIPTION		WORKSI DART NO	HEET B -	AMOUNT	
-	DESCRIPTION 1		PART NO.	3	AWOUNT 4	
$\frac{}{1}$					7	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9 10						9
11						11
12			1			12
13			+			13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24 25						24 25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38 39			1			38 39
40						40
41			+			41
42			1			42
43						43
44			1			44
45						45
46						46
47						47
48						48
49						49
50	CMC 2540 10 (12/10) (INSTRICTIO					50

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 4122)

41-341 Rev. 1

RATIO OF COST TO CHARGES
FOR ANCILLARY AND OUTPATIENT
COST CENTERS

PROVIDER NO. | PERIOD :
| FROM ______
| TO ______

WORKSHEET C

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges 2	Ratio (col. 1 divided by col. 2) 3	
ANCI	LLARY SERVICE COST CENTERS				
40	Radiology				40
41	Laboratory				41
42	Intravenous Therapy				42
43	Oxygen (Inhalation) Therapy				43
44	Physical Therapy				44
45	Occupational Therapy				45
46	Speech Pathology				46
47	Electro cardiology				47
48	Medical Supplies Charged				48
49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost				52
OUTP	ATIENT SERVICE COST CENTERS				
60	Clinic				60
61	RHC				61
62	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

4190 (Cont.)				FORM CMS-2540-10				
APPORTIONMENT OF ANCILLARY AND		PROVIDER NO. :	PERIOD:	WORKSHEET D				
	OUTPATIE	ENT COST			FROM	PART I		
					_ ТО			
PART	I - CALCULATION	OF ANCILLAR	RY AND OUTPATIENT	COST	<u>'</u>	<u>'</u>		
Check	[] Title V	(1)	Check One: [] S	NF [] NF [] ICF/	MR [] C	Other		
One:	[] Title XVIII		[] P	PS - Must also complete Part II				
	[] Title XIX	(1)						
		RATIO OF		HEALTH CARE		HEALTH CARE		
		COST TO	PRO	OGRAM CHARGES	1	PROGRAM COST		
Cost	Center	CHARGES						
		(Fr. Wkst. C	Part A	Part B	Part A	Part B		
		Column 3)			(Col. 1 X Col. 2)	(Col. 1 X Col. 3)		
		1	2	3	4	5		
	LARY SERVICE COST	CENTERS	T		1			
40	Radiology						40	
41	Laboratory						41	
42	Intravenous Therapy						42	
43	Oxygen (Inhalation)						43	
	Therapy							
44	Physical Therapy						44	
45	Occupational Therapy						45	
46	Speech Pathology						46	
47	Electro cardiology						47	
48	Medical Supplies						48	
	Charged To Patients							
49	Drugs Charged to Patients						49	
50	Dental Care - Title XIX						50	
51	Support Surfaces						51	
52	Other Ancillary Services						52	
	ATIENT COST CENT	TERS		l .		l .		
60	Clinic						60	
61	R H C						61	
62	FQHC						62	
63	Other Outpatient Services						63	
71	Ambulance (2)						71	
100	Total (Sum of lines 40 - 71)						100	
100	1 0 tai (Suiii 01 11ftes 40 - /1)						100	

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

FORM CMS- 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 4124)

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⁽²⁾ Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

2/11	1 FORM CMS-2540-10					4190 (Cor			
	APPORTIONMENT OF ANCILLARY AND	PROVIDER NO. :	PERIOD:			WOI	RKSHEET D		
	OUTPATIENT COST		FROM			PAI	RTS II & III		
			<u>TO</u>						
Check	One: [] SNF	[] NF	[]	ICF/MR					
	PART II - APPORTIONMENT OF VACCINE COST								
1]	Drugs charged to patients - ratio of cost to charges (Fron	1 Worksheet C, column 3, line 49)						1	
2 Program vaccine charges (From your records, or the P S & R.)								2	
3	Program costs (Line 1 X line 2) (Title XVIII, PPS pro	viders,						3	
	transfer this amount to Worksheet E, Part I, line 24)								

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

-		Total Cost	Nursing &	Ratio of Nursing	Program	Part A	Program	Part B	
		(From	Allied Health	& Allied Health	Part A Cost	Nursing & Allied	Part B Cost	Nursing & Allied	
	Cost Centers	Worksheet B,	(From Wkst. B,	Costs To Total	(From Wkst. D.	Health Costs for	(From Wkst. D.	Health Costs for	
		Part I, Col 18)	Part I, Column 14)	Costs - Part A	Part 1, Col. 4)	Pass Through	Part 1, Col. 5)	Pass Through	
				(Col. 2 / Col 1)		(Col. 3 X Col. 4)		(Col. 3 X Col. 6)	
		1	2	3	4	5	6	7	
ANC	ILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electro cardiology								47
48	Medical Supplies								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Costs								52
100	Total (Sum of lines 40 - 52)								100

4130 (C	0111.,		C1V10-2040-1			2/11
		PROVIDER NO.	PERIOD:			
COMP	PUTATION OF INPATIENT		FROM _		WORKSHEET D-	-1
R	OUTINE COSTS		то		PARTS I & II	
Chec	k One: [] Title V	[] Title XVIII	[] Title	XIX		
Chec	k One: [] SNF	[] NF	[] ICF/M	1R		
PART 1	I CALCULATION OF INPATIE	NT ROUTINE COS	STS			
	INPATIENT DAYS					
1	Inpatient days including private roor	n days				1
2	Private room days					2
3	Inpatient days including private roor					3
4	Medically necessary private room da		rogram			4
5	Total general inpatient routine service					5
	PRIVATE ROOM DIFFERENTI	AL ADJUSTMENT	•			-
6	General inpatient routine service cha					6
7	General inpatient routine service cos		divided by li	ine 6)		7
8	Enter private room charges from you					8
9	Average private room per diem char		ges			9
	line 8 divided by private room days					
10	Enter semi-private room charges from					10
11	Average semi-private room per diem		e room charg	es		11
	line 10, divided by semi-private roo					
12	Average per diem private room char					12
13	Average per diem private room cost					13
14						
15	General inpatient routine service cos	t net of private room	cost different	ıal		15
	(Line 5 minus line 14)					
	PROGRAM INPATIENT ROUT		STS			1
16	Adjusted general inpatient service co	ost per diem				16
	(Line 15 divided by line 1)	D. I. (6)				
17	Program routine service cost (Line		(1: 4::	1. 45.)		17
18	Medically necessary private room co					18
19	Total program general inpatient rout					19
20	Capital related cost allocated to inpa					20
21	Part II column 18, - line 30 for SN			F/MR)		71
21	Per diem capital related costs (Line Program capital related cost (Line 3)			21
23	Inpatient routine service cost (Line					23
24	Aggregate charges to beneficiaries for		n provider red	corde)		24
25	Total program routine service costs					25
25	(Line 23 minus line 24)	for companison to the	cost minitatio	11		23
26	Enter the per diem limitation (1)					26
27	Inpatientroutine service cost limitation	on (Line 3 times the n	er diem limita	ation line 26) (1)		27
28	Reimbursable inpatient routine se				line 27)	28
_0	(Transfer to Worksheet E, Part II,			501 01 IIIIC 2 5 01 1	c = , ,	-0
	(1) Lines 26 and 27 are not applicable			or title V and or t	itle XIX	
	· · · · · · · · · · · · · · · · · · ·	,	J			
PART 1	II CALCULATION OF INPATIE	NT NURSING & AL	LIED HEAI	LTH COSTS FO	R PPS PASS-THROUG	GH
1	Total inpatient days				1	1
2	Program inpatient days. (From Work	sheet S-3, Part I. col	s. 3. or 5. lir	ne 1 as applicable	, 	2
3	Total Nursing & Allied Health costs.				<u></u>	3
4	Nursing & Allied Health ratio. (Line	•	- ure 1, corum	1 1, 11110 17)		4
5	Program Nursing & Allied Health co	<u> </u>	(Line 3 times	line 4)		5
	CMS-25/0-10 (12/10) (INSTRUC				SHED IN	

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4125)

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	CALCIJI ATION OF	PROVIDER NO.:	DEDIOD:	413	o (Cont.)
	CALCULATION OF	PROVIDER NO.:	PERIOD:	WORKSHEET E	
	REIMBURSEMENT SETTLEMENT		FROM	I	
	TITLE XVIII		ТО	_ PART I	
PART	A - INPATIENT SERVICE PPS PROVIDER C	OMPLITATION OF REI	MRIIRSEMENT LESSEE	OF COST OR CHARGES	
1	Inpatient ancillary services - Part A - (See Instructi		WIDEROEMENT EESSET		1
	Nursing and Allied Health Education Activitie				2
3	Total cost (Sum of lines 1 and 2)				3
4	Inpatient PPS amount (see instructions)				4
	Primary payor amounts				5
6	Coinsurance				6
7	Reimbursable bad debts (From your records)				7
8	Reimbursable bad debts for dual eligible beneficiarie	s (See instructions)			8
9	Adjusted reimbursable bad debts for periods ending of	•	e instructions)		9
10	Recovery of bad debts - for statistical records only	`	·		10
11	Utilization review				11
12	Subtotal (See instructions)				12
13	Interim payments (See instructions)				13
14	Tentative adjustment				14
15	OTHER adjustment (See instructions)				15
16	Balance due provider/program (Line 12 minus line 1	3 and 14, plus or minus line	e 15)		16
	(Indicate overpayment in brackets) (See Instructions))			
17	Protested amounts (Nonallowable cost report items in	n accordance with CMS Pub	o. 15-II, section 115.2)		17
				•	•
	B - ANCILLARY SERVICES COMPUTATION	OF REIMBURSEMENT	T LESSER OF COST OR	CHARGES - TITLE XVIII ONLY	
18	Ancillary services Part B				18
19	Vaccine cost (From Wkst D, Part II, line 3)				19
20	Nursing & Allied Health Education Activities (from	Wkst D, part III, col. 7, line	100)		20
21	Total reasonable costs (Sum of lines 18, 19, and 20)				21
22	Medicare Part B ancillary charges (See instructions)				22
23	Cost of covered services (Lesser of line 21 or line 22)			23
24	Primary payor amounts				24
25	Coinsurance and deductibles				25
26	Reimbursable bad debts (From your records)				26
27	Other Adjustments (See instructions) Specify				27
28	Subtotal (Sum of lines 23 and 26, minus lines 24 and	25, plus or minus line 27)			28
29	Interim payments (See instructions)				29
30	Tentative adjustment				30
31	OTHER adjustments (See instructions)				31
32	Balance due provider/program (Line 28 minus line 2	·			32
	(Indicate overpayments in brackets) (See Instructions	<u>s)</u>			
33	Protested amounts (Nonallowable cost report items)	in accordance with CMS Pu	b.15-II. section 115.2		33

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB.15-II SECTION 4130)

	CALCULATION OF	PROVIDER NO.:	PE	RIOD:		
	REIMBURSEMENT SETTLEMENT		FR	ОМ	_ WORKSHEET E	
	FOR TITLE V and TITLE XIX ONLY		ТО		PART II	
Check	one:	Title V	<u> </u>] Title XIX		
Check		NF	Ť	ICF/MR		
	COMPUTATION OF NET COST OF CO	OVERED SERVICES				
1	Inpatient ancillary services (See Instructions					1 1
2	Intern and Resident Cost (From Worksheet	D-2)				2
3	Outpatient services	·				3
4	Inpatient routine services (See instructions)					4
5	Utilization reviewphysicians' compensation	n (From provider record	ls)			5
6	Cost of covered services (Sum of lines 1 - 5))				6
7	Differential in charges between semiprivate	accommodations and le	SS			7
	than semiprivate accommodations					
8	SUBTOTAL (Line 6 minus line 7)					8
9	Primary payor amounts					9
10	Total Reasonable Cost (Line 8 minus line 9)					10
	REASONABLE CHARGES					•
11	Inpatient ancillary service charges					11
12	Intern and Resident Charges (From Provider	Records)				12
13	Outpatient service charges					13
14	Inpatient routine service charges					14
15	Differential in charges between semiprivate	accommodations and le	SS			15
	than semiprivate accommodations					
16	Total reasonable charges					16
	CUSTOMARY CHARGES					•
17	Aggregate amount actually collected from p	atients liable for payme	nt for	•		17
	services on a charge basis					
18	Amounts that would have been realized from					18
	on a charge basis had such payment been ma	ade in accordance with 4	42 CI	FR 413.13(e)		
19	Ratio of line 17 to line 18 (not to exceed 1.0	00000)				19
20	Total customary charges (See instructions)					20
	COMPUTATION OF REIMBURSEMEN	Γ SETTLEMENT				
21	Cost of covered services (See Instructions)					21
22	Deductibles					22
23	Subtotal (Line 21 minus line 22)					23
24	Coinsurance					24
25	Subtotal (Line 23 minus line 24)					25
26	Reimbursable bad debts (From your records	5)				26
27	Subtotal (Sum of lines 25 and 26)		11 .			27
28	Unrefunded charges to beneficiaries for exce	ess costs erroneously co	Hecte	ed		28
	based on correction of cost limit	.1				20
29	Recovery of excess depreciation resulting fr	om provider terminatioi	n or a	decrease		29
- 20	in program utilization	C				1 20
30	Other Adjustments (See instructions) Speci			tion of		30
31	Amounts applicable to prior cost reporting p		sposi	HOU OI		31
	depreciable assets (If minus, enter amount i		1 20°			1 22
32	Subtotal (Line 27 plus or minus lines 30, an	iu 31, minus lines 28 an	u 29)			32
33	Interim payments	1: 22)				33
34	Balance due provider/program (Line 32 min (Indicate overpayments in brackets) (See Ins					34
	remuicate overbavinents in brackets) (See Ins	SU UCHOUS I				1

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4130.2)

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

Date: (mm/dd/yyyy)

Signature of Authorized Person

				PRO	OVIDER NO.					
BALANCE SHEET				FROM	1	WOI	RKSHEET	G		
(If you are nonproprietary and do not maintain fund-type				TO						
<u>acco</u>	unting records, complete the "General Fur	<u>ıd" cc</u>	lumn only)							
					Specific					
	Assets		General		Purpose	End	lowment		Plant	
	(Omit cents)		Fund		Fund]	Fund		Fund	
			1		2		3		4	
	CURRENT ASSETS									
1	Cash on hand and in banks									1
	Temporary investments									2
	Notes receivable									3
4	Accounts receivable									4
5	Other receivables									5
6	Less: allowances for uncollectible notes	()	()	()	()	6
	and accounts receivable									
7	Inventory									7
8	Prepaid expenses									8
9	Other current assets									9
10	Due from other funds									10
11	TOTAL CURRENT ASSETS									11
	(Sum of lines 1 - 10)									
	FIXED ASSETS									
12	Land									12
13	Land improvements									13
14	Less: Accumulated depreciation	()	()	()	()	14
15	Buildings									15
16	Less Accumulated depreciation	()	()	()	()	16
17	Leasehold improvements									17
18	Less: Accumulated Amortization	()	()	()	()	18
	Fixed equipment									19
	Less: Accumulated depreciation	()	()	()	()	20
21	Automobiles and trucks									21
22	Less: Accumulated depreciation	()	()	()	()	22
	Major movable equipment									23
	Less: Accumulated depreciation	()	()	()	()	24
25	Minor equipment - Depreeciable									25
	Minor equipment nondepreciable									26
	Other fixed assets									27
28	TOTAL FIXED ASSETS									28
	(Sum of lines 12 - 27)									
	OTHER ASSETS									
29	Investments									29
	Deposits on leases									30
	Due from owners/officers									31
	Other assets									32
33	TOTAL OTHER ASSETS									33
	(Sum of lines 29 - 34)									
34	TOTAL ASSETS									34
	(Sum of lines 11, 28 and 33)									

) = contra amount

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2/11		PROVIDER N	4130 (Cont.)				
BALANCE SHEET			PROVIDER N	FROM	WORKSHEET G		
(If you are nonproprietary and do not maintain fund-type			TO	_ (Cont.)	1 G		
	ate nonproprietary and do not maintain the				_ (Cont.)		
uccoun	Liabilities and Fund		Specific				
	Balances	General	Purpose	Endowment	Plant		
	(Omit cents)	Fund	Fund	Fund	Fund		
	(Office Cents)	1	2	3	4		
	CURRENT LIABILITIES		_		·		
35	Accounts payable					35	
	Salaries, wages & fees payable					36	
	Payroll taxes payable					37	
	Notes & loans payable (Short term)					38	
	Deferred income					39	
40	Accelerated payments					40	
	Due to other funds					41	
42	Other current liabilities					42	
43	TOTAL CURRENT LIABILITIES					43	
	(Sum of lines 35 - 42)						
	LONG TERM LIABILITIES						
44	Mortgage payable					44	
45	Notes payable					45	
46	Unsecured loans					46	
	Loans from owners:					47	
48	Other long term liabilities					48	
49						49	
50	TOTAL LONG TERM LIABILITIES					50	
	(Sum of lines 44 - 49)						
51	TOTAL LIABILITIES					51	
	(Sum of lines 43 and 50)						
	CAPITAL ACCOUNTS						
	General fund balance					52	
	Specific purpose fund					53	
54	Donor created - endowment fund					54	
	balance - restricted						
55	Donor created - endowment fund					55	
	balance - unrestricted						
56	Governing body created - endowment					56	
	fund balance						
	Plant fund balance - invested in plant					57	
58	Plant fund balance - reserve for					58	
	plant improvement, replacement and						
	expansion						
59	TOTAL FUND BALANCES					59	
	(Sum of lines 50 thru 56)						
60	TOTAL LIABILITIES AND					60	
	FUND BALANCES						
	(Sum of lines 51 and 59)						

(Sum of lines 51 and 59) () = contra amount

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4140)

4150 (Cont.)	1 01017 0110 2040 10		4/11
	PROVIDER NO:	PERIOD:	
STATEMENT OF CHANGES IN FUND BALANCES		FROM	WORKSHEET G-1
		<u>TO</u>	

	GENERA	L FUND	SPECIFIC PUR	POSE FUND	ENDOWMI	ENT FUND	PLAI	NT FUND	
	1	2	3	4	5	6	7	8	T
1 Fund balances at beginning of									1
period]							\top
2 Net income (loss)			7						2
(From Wkst. G-3, line 32)									
3 Total (Sum of line 1 and line 2)			7						3
4 Additions (Credit adjustments)			7						4
5]]					5
6]]					6
7				1					7
8]]					8
9]							9
10 Total additions (Sum of lines 4 - 9)									10
11 Subtotal (Line 3 plus line 10)									11
12 Deductions (Debit adjustments)									12
13]							13
14]							14
15									15
16									16
17									17
18 Total deductions									18
(Sum of lines 12 - 17)									
19 Fund balance at end of period per									19
balance sheet (Line 11 - line 18)									

		PROVIDER NO:	PERIOD:		
	STATEMENT OF PATIENT REVENUES		FROM	WORKSHEET (G - 2
	AND OPERATING EXPENSES		TO	PARTS I & II	
	PART I - PATIENT REVENUES	•	•	•	
	Revenue Center	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVI	CES			
	Skilled Nursing Facility				1
2	Nursing facility				2
	ICF/MR				3
	Other long term care				4
5	Total general inpatient care services				5
	(Sum of lines 1 - 4)			L	<u></u>
	All Other Care Service		T	1	
	Ancillary services				6
	Clinic Home Health Agency				7 8
	Ambulance				9
	RHC				10
	FQHC & CMHC				11
	SNF Based Hospice				12
	Total Patient Revenues (Sum of lines 5 - 12)				13
<u> 10</u>	(Transfer column 3 to Worksheet G-3, Line 1)				==
	PART II - OPERATING EXPENSES				
1	Operating Expenses (Per Worksheet A, Col. 3, Line	100)			1
	Add (Caralla)				<u> </u>
2	Add (Specify)				2
3					3
4					4
					<u> </u>
5					5
6					6
7					7
	Track Additions (Compatibility 2017)				<u> </u>
8	Total Additions (Sum of lines 2 - 7)				8
9	Deduct (Specify)				9
	(- <u>-</u>				
10					10
					11
11					11
12					12
13					13
	Tatal Dadagiana (Consulting O. 42)				1,
14	Total Deductions (Sum of lines 9 - 13)				14
15	Total Operating Expenses (Sum of lines 1 and 8, mi	nus line 14)			15
_3	(Transfer to Worksheet G-3 Line 4)	- ',			

[(Transfer to Worksheet G-3, Line 4)

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4140)

4190) (Cont.)	FURM CM5-2540-	10	2/11	
	STATEMENT OF REVENUES	PROVIDER NO:	PERIOD:		
	AND EXPENSES		FROM	WORKSHEET G	ì - 3
			_TO	_	
			•	<u> </u>	
1	Total patient revenues (From Wkst. G - 2, Part I, col. 3				1
2		accounts			2
3	Net patient revenues (Line 1 minus line 2)				3
4		Part II, line 15)			4
5	1 \				5
6					6
7	Contributions, donations, bequests, etc				7
8					8
9	\ I	ernet service)			9
10					10
11	Purchase discounts				11
12	Rebates and refunds of expenses				12
13	1				13
14	<u> </u>				14
15	1 0 0				15
16	9.1				16
17		to other than patients			17
18	5 1				18
19					19
20					20
21	Revenue from gifts, flower, coffee shops, canteen				21
22					22
23	O I				23
24	11 1				24
25	\1 0/				25
26	·				26
27	Total (Line 5 plus line 26)				27
28	Other expenses (specify)				28
29					29
30					30
31	Total other expenses (Sum of lines 28 - 30)				31
32	Net income (or loss) for the period (Line 27 minus line	e 31)			32

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ANALYSIS OF PROVIDER-BASED						PROVIDER NO	.:	PERIOD:		WORKSHEET	
HOME HEALTH AGENCY COSTS								FROM	_	H	
						HHA NO.:		то	_		
			TRANSPOR-	CONTRACTED/	OTHER	TOTAL	RECLASSIFI-	RECLASSIFIED	ADJUST-	NET	T
	SALARIES	EMPLOYEE	TATION	PURCHASED	COSTS	(sum of cols.	CATIONS	TRIAL BALANCE	MENTS	EXPENSES FOR	
COST CENTER DESCRIPTIONS		BENEFITS	(see	SERVICES		1 thru 5)		(col. 6 + col. 7)		ALLOCATION	
(omit cents)			instructions)							(col. 8 + col. 9)	
	1	2	3	4	5	6	7	8	9	10	1
GENERAL SERVICE COST CENTERS											
1 Capital Related-Bldgs. and Fixtures											1
2 Capital Related-Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General											5
HHA REIMBURSABLE SERVICES											\vdash
6 Skilled Nursing Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech Pathology											9
10 Medical Social Services											10
11 Home Health Aide											11
12 Supplies (see instructions)											12
13 Drugs											13
14 DME											14
15 Telemedicine											15
HHA NONREIMBURSABLE SERVICES											\vdash
16 Home Dialysis Aide Service											16
17 Respiratory Therapy											17
18 Private Duty Nursing											18
19 Clinic											19
20 Health Promotion Activities			<u> </u>					+		1	20
21 Day Care Program											21
22 Home Delivered Meals Program			<u> </u>	 				+		1	22
23 Homemaker Service											23
24 All Others				 				+		1	24
25 Total (sum of lines 1-24)								+ +			25

25 Total (sum of lines 1-24)
Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

СО	ST ALLOCATION - HHA GENERAL SERVICE COST	PROVIDER NO.	:	FROM	PART I					
					HHA NO.:		то			
		NET EXPENSES		PITAL						
		FOR COST	RELATE	D COSTS						
		ALLOCATION			PLANT			ADMINIS-		
		(from Wkst.	BLDGS. &	MOVABLE	OPERATION &	TRANS-	SUBTOTAL	TRATIVE	TOTAL	
		H, col. 10)	FIXTURES	EQUIPMENT	MAINTENANCE	PORTATION	(cols. 0-4)	& GENERAL	(cols. 4a + 5)	
		0	1	2	3	4	4a	5	6	
	NERAL SERVICE COST CENTERS									
	Capital Related-Bldgs. and Fixtures									1
	Capital Related-Movable Equipment									2
	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
НН	A REIMBURSABLE SERVICES									
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies (see instructions)									12
	Drugs									13
14	DME									14
15	Telemedicine									15
НН	A NONREIMBURSABLE SERVICES									Г
	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Totals (sum of lines 1-24)									25

2/11 FORM CMS-2540-10 4190 (Cont.)

COST ALLOCATION - HHA STATISTICAL BASIS				PROVIDER N	O.:	PERIOD: FROM		WORKSHEET H-1, PART II	
COST ALLOCATIO	OST ALLOCATION - HHA STATISTICAL BASIS			LILIA NO .		TO		PARTII	
			CAL	HHA NO.: PITAL	1	10	<u> </u>		_
				D COSTS	PLANT			ADMINIS-	
			BLDGS. &	MOVABLE	OPERATION &			TRATIVE	
			FIXTURES	EQUIPMENT		TRANS-		& GENERAL	
			(SQUARE	(DOLLAR	(SQUARE	PORTATION	RECONCIL-	(ACCUM.	
			FEET)	VALUE)	FEET)	(MILEAGE)	IATION	COST)	
			1	2 VALUE)	3	(MILEAGE)	5a	5	\vdash
GENERAL SERVIC	CE COST CENTERS		1	2	3	4	Ja	- 3	\vdash
	-Bldgs. and Fixtures							1	1
	-Movable Equipment								2
3 Plant Operation	• •								3
4 Transportation								1	4
5 Administrative a									5
HHA REIMBURSA									H
6 Skilled Nursing									6
7 Physical Thera								+	7
8 Occupational T								+	8
9 Speech Patholo									9
10 Medical Social									10
11 Home Health A	ide								11
12 Supplies (see in	nstructions)								12
13 Drugs	•							-	13
14 DME								-	14
15 Telemedicine									15
HHA NONREIMBU	RSABLE SERVICES								\vdash
16 Home Dialysis	Aide Services								16
17 Respiratory The	erapy								17
18 Private Duty Nu	ırsing								18
19 Clinic									19
20 Health Promotion	on Activities								20
21 Day Care Progr									21
22 Home Delivered	d Meals Program								22
23 Homemaker Se	ervice								23
24 All Others									24
25 Total (sum of lin									25
26 Cost To Be Allo									26
27 Unit Cost Multip	olier								27

FORM CMS-2540-10 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4142)

	STS TO HHA COST CENTERS		HHA NO.:	.:		FROMTO	PARTI			
_		From		NEW C	L CAPITAL					
		Wkst	HHA	RELATE	D COSTS					
	HHA COST CENTER	H-1	TRIAL					ADMINIS-		LAUNDRY
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	EMPLOYEE	SUBTOTAL	TRATIVE &	OPERATION	& LINEN
		col. 6,	(1)	FIXTURES	EQUIPMENT	BENEFITS	(cols. 0-3)	GENERAL	OF PLANT	SERVICE
		line	0	1	2	3	3A	4	5	6
1	Administrative and General	5								
2	Skilled Nursing Care	6								
3	Physical Therapy	7								
4	Occupational Therapy	8								
5	Speech Pathology	9								
6	Medical Social Services	10								
7	Home Health Aide	11								
8	Supplies	12								
	Drugs	13								
10	DME	14								
11	Telemedicine	15								
12	Home Dialysis Aide Services	16								
	Respiratory Therapy	17								
14	Private Duty Nursing	18								
15	Clinic	19								
16	Health Promotion Activities	20								
17	Day Care Program	21								
18	Home Delivered Meals Program	22								
19	Homemaker Service	23								
20	All Others	24								
21	Totals (sum of lines 1-20) (2)									
22	Unit Cost Multiplier: column 19, line 1									
	divided by the sum of column 19,									
	line 21, minus column 19, line 1,									
	rounded to 6 decimal places									

⁽¹⁾ Column 0, line 21 must agree with Wkst. A, column 7, line 70.

⁽²⁾ Columns 0 through 20, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

2/11	FORM CMS-2540-10	4190 (C
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I-2,	Α	LLOCATION OF GENERAL SERVICE	PROVIDER NO).:		PERIOD:	WORKSHEET		
	COSTS TO HHA COST CENTERS			HHA NO.:			FROM		PART I (CONT.
							то	· · · · · · · · · · · · · · · · · · ·	
		CORF COST CENTER			NURSING	CENTRAL		MEDICAL	
		(omit cents)	HOUSE KEEPING	DIETARY	ADMINIS- TRATION	SERVICES & SUPPLY	PHARMACY	RECORDS & LIBRARY	SOCIAL SERVICE
			7	8	9	10	11	12	13
		1 Administrative and General							
	2	2 Skilled Nursing Care							
	3	3 Physical Therapy							
		4 Occupational Therapy							
		5 Speech Pathology							
	6	6 Medical Social Services							
	7	7 Home Health Aide							
	8	8 Supplies							
	9	9 Drugs							
	10 1	LO DME							
	11 1	11 Telemedicine							
	12 1	12 Home Dialysis Aide Services							
	13 :	13 Respiratory Therapy							
	14 :	L4 Private Duty Nursing							
	15 :	L5 Clinic							
	16 1	L6 Health Promotion Activities							
	17 :	17 Day Care Program							
		L8 Home Delivered Meals Program							
		19 Homemaker Service							
		20 All Others							
		21 Totals (sum of lines 1-20) (2)		1					
		22 Unit Cost Multiplier: column 19, line 1							
		divided by the sum of column 19,							
		line 21, minus column 19, line 1,							
		rounded to 6 decimal places.							
		produced to a decimal places.							

⁽²⁾ Columns 0 through 20 line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

ли.,	4130 (Cont.)	rokwi Civis	-2340-10					2/11		
1 -2,	ALLOCATION OF GENERAL SERVICE		PROVIDER NO	.:		PERIOD:		WORKSHEET H-2,		
)	COSTS TO HHA COST CENTERS		HHA NO.:			FROM		PART I (CONT.)		
						то				
						INTERN &				
						RESIDENT		ALLOCATED		
	HHA COST CENTER	INTERNS &	RESIDENTS	OTHER	SUBTOTAL	COST & POST		ННА		
	(omit cents)	SALARY AND	PROGRAM	GENERAL	(sum of cols.	STEPDOWN	SUBTOTAL	A&G (see	TOTAL	
		FRINGES	COSTS	SERVICE	3a-16)	ADJUSTMENTS	(cols. 17 ± 18)	Part II)	HHA COSTS	
		14	15	16	17	18	19	20	21	
1	1 Administrative and General									
2	2 Skilled Nursing Care									
3	3 Physical Therapy									
4	4 Occupational Therapy									
5	5 Speech Pathology									
6	6 Medical Social Services									
7	7 Home Health Aide									
8	8 Supplies									
9	9 Drugs									
10	10 DME									
11	11 Telemedicine									
12	12 Home Dialysis Aide Services									
13	13 Respiratory Therapy									
14	14 Private Duty Nursing									
15	15 Clinic									
16	16 Health Promotion Activities									
17	17 Day Care Program									
18	18 Home Delivered Meals Program									
19	19 Homemaker Service									
20	20 All Others									
21	21 Totals (sum of lines 1-20) (2)									
22	22 Unit Cost Multiplier: column 19, line 1									
	divided by the sum of column 19,									
	line 21, minus column 19, line 1,									
	rounded to 6 decimal places.									

⁽²⁾ Columns 0 through 20, line 21 must agree with the corresponding columns of Wkst. B, Part I, line 70.

4	190 (Cont.)								
AL	LOCATION OF GENERAL SERVICE	PROVIDER NO.:		PERIOD:			WORKSHEET	Γ H-2,	
CC	OSTS TO HHA COST CENTERS	HHA NO.:		FROM		_	PART II		
ST	ATISTICAL BASIS			то					
		!	CAF	PITAL					
			RELATE	ED COST			ADMINIS-		l
			BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	OPERATION	l
	HHA COST CENTER		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	OF PLANT	l
			(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	l
			FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	l
			1	2	3	3A	4	5	
1	Administrative and General								1
	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
	Medical Social Services								6
7	Home Health Aide								7
	Supplies								8
	Drugs								9
	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
	Home Delivered Meals Program								18
	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
	Total cost to be allocated		1						22

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4143)

23 Unit Cost Multiplier

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23

2/11 FORM CMS-2540-10 4190 (Cont.)

2/11			FURIVI CIVIS-2540-10 4190 (C				
ALLOCATION OF GENERAL SERVICE	PROVIDER N	O.:	PERIOD:		WORKSHEET	H-2,	
COSTS TO HHA COST CENTERS	HHA NO.:		FROM		PART II (CON	T.)	
STATISTICAL BASIS			то				
	LAUNDRY			NURSING	CENTRAL		
	& LINEN	HOUSE-		ADMINIS-	SERVICES &		
HHA COST CENTER	SERVICE	KEEPING	DIETARY	TRATION	SUPPLY	PHARMACY	
HHA COST CENTER		(HOURS OF		(DIRECT	(COSTED	(COSTED	
	(POUNDS OF LAUNDRY)	SERVICE)	SERVED)	NURS. HRS)	1 '	REQUIS.)	
	6	3ERVICE)	SERVED)	9	10	11	
1 Administrative and Conevel	Ь В	/	Ö	9	10	11	<u> </u>
1 Administrative and General							1
2 Skilled Nursing Care							2
3 Physical Therapy							3
4 Occupational Therapy							4
5 Speech Pathology							5
6 Medical Social Services							6
7 Home Health Aide							7
8 Supplies							8
9 Drugs							9
10 DME							10
11 Telemedicine							11
12 Home Dialysis Aide Services							12
13 Respiratory Therapy							13
14 Private Duty Nursing							14
15 Clinic							15
16 Health Promotion Activities							16
17 Day Care Program							17
18 Home Delivered Meals Program							18
19 Homemaker Service							19
20 All Others							20
21 Totals (sum of lines 1-20)							21
22 Total cost to be allocated							22
23 Unit Cost Multiplier							23

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4143)

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ALL	OCATION OF GENERAL SERVICE	PROVIDER N	10.:	PERIOD:		WORKSHEET	H-2,	
COS	STS TO HHA COST CENTERS	HHA NO.:		FROM		PART II (CON	T.)	
STA	TISTICAL BASIS			то				
		•						
			MEDICAL			RESIDENTS		
			RECORDS &		SALARY &	PROGRAM	OTHER	
	HHA COST CENTER		LIBRARY	SERVICE	FRINGES	COSTS	GENERAL	
			(TIME	(TIME	(ASSIGNED	(ASSIGNED	SERVICE	
			SPENT)	SPENT)	TIME)	TIME)	(SPECIFY)	
			12	13	14	15	16	
	Administrative and General							1
	Skilled Nursing Care							2
	Physical Therapy							3
	Occupational Therapy							4
	Speech Pathology							5
	Medical Social Services							6
	Home Health Aide							7
8	Supplies							8
	Drugs							9
	DME							10
	Telemedicine							11
	Home Dialysis Aide Services							12
	Respiratory Therapy							13
	Private Duty Nursing							14
15	Clinic							15
16	Health Promotion Activities							16
	Day Care Program							17
	Home Delivered Meals Program							18
19	Homemaker Service							19
	All Others							20
	Totals (sum of lines 1-20)							21
22	Total cost to be allocated							22
23	Unit Cost Multiplier							23

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2/11					FORM C	CMS-2540-10							4190 (0
						PROVIDER	NO.:		PERIOD:			WORKSHI	EET H-3,
APPORTIONMENT OF PATI	IENT SEI	RVICE COST	S						FROM			Parts I & II	
						HHA NO.:			то				
Check applicable box		[] Title V	[] Title XVIII	[] Title XIX									
PART I - COMPUTATION O	F LESSE	ER OF AGGR	EGATE PRO	GRAM COS	T, AGGREGA	ATE OF THE	PROGRAM	1 LIMITATIO	N COST, OR	BENEFICIARY	COST LIMIT	ATION	
Cost Per Visit Computation	From,	Facility	Shared			Average		Program Vis	its		Cost of Services		
	Wkst.	Costs	Ancillary			Cost			Part B			Part B	Total
	H-2,	(From	Costs	Total HHA		Per Visit		Not Subject	Subject		Not Subject	Subject	rogram Cos
Patient Services	Part I,	Wkst. H-2,	(From	Costs	Total	(col. 3		to Deductibles	Deductibles	t	p Deductibles		(sum of
	col. 21,	Part I)	Part II)	(cols. 1 + 2)	Visits	÷ col. 4)	Part A	Coinsuranc	Coinsuranc	Part A	Coinsurance	Coinsurance	cols. 9-10)
	line -	1	2	3	4	5	6	7	8	9	10	11	12
1 Skilled Nursing Care	2												
2 Physical Therapy	3												
3 Occupational Therapy	4												
4 Speech Pathology	5												
5 Medical Social Service	6												
6 Home Health Aide	7												
7 Total (sum of lines 1-6)													
								•					
Supplies and Drugs Cost								Progran	n Covered Ch	arges		Cost of Servi	ices
Computations		From	Facility	Shared		Total				Part B			Part B
		Wkst. H-2,	Costs	Ancillary	Total	Charges			Not Subject	Subject		Not Subject	Subject
Other Patient Services		Part I,	(From	Costs	HHA	(from	Ratio		to	to		to	to
			Wkst. H-2,	(From	Cost	HHA	(col. 3		Deductibles	Deductibles		Deductibles	Deductibles
		col. 21,	Part I)	Part II)	(cols. 1 + 2)	Record)	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	Coinsurance	Coinsurance
		line -	1	2	3	4	5	6	7	8	9	10	11
8 Cost of Medical Supplie	es	8											

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED SKILLED NURSING FACILITY DEPARTMENTS

9 Cost of Drugs

			Total		
			HHA Charge	HHA Shared	Transfer to
	From Wkst. C,	Cost to Charge	(From Provider	Ancillary Cost	Part I
	col. 3	Ratio	records)	(Col.1 X Col 2)	as indicated
	line -	1	2	3	4
1 Physical Therapy	44				col. 2, line 2
2 Occupational Therapy	45				col. 2, line 3
3 Speech Pathology	46				col. 2, line 4
4 Cost of Medical Supplies	48				col. 2, line 8
5 Cost of Drugs	49				col. 2, line 9

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4144

Cont.)

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4190 ((Cont.)	FORM CMS-2	540-10			2/11
			PROVIDER NO.:	PERIOD:	WORKSHEET H-4,	
	CULATION OF HHA			FROM	Parts I & II	
REIN	IBURSEMENT SETTLEMENT		HHA NO.:	TO	+	
Chec	k Applicable Box	[] Title V		 [] Title XIX		
	T I - COMPUTATION OF THE LESS					
				Р	art B	Т
				Not Subject to	Subject to	1
				Deductibles	Deductibles	
			Part A	& Coinsurance	& Coinsurance	
	Description	•	1	2	3	
	Reasonable Cost of Part A & Part	B Services				
	Reasonable cost of services (see in	structions)				1
2	Total charges					2
	Customary Charges					
3	Amount actually collected from patie					3
	for services on a charge basis (from	<u> </u>				₩.
4	Amount that would have been realize	•				4
	for payment for services on a charg					
	payment been made in accordance					├
	Ratio of line 3 to line 4 (not to excee					5
	Total customary charges (see instru	-				6
7	Excess of total customary charges of cost (complete only if line 6 exceeds					7
0	Excess of reasonable cost over cus					8
0	(complete only if line 1 exceeds line					°
9	Primary payer amounts	- 0)				9
	T II - COMPUTATION OF HHA RE	IMBURSEMENT SETTI	LEMENT			
				Part A Services	Part B Services	Т
	Description			1	2	†
10	Total reasonable cost (see instruction	ons)				10
	Total PPS Reimbursement - Full Ep	-				11
12	Total PPS Reimbursement - Full Ep	isodes with Outliers				12
13	Total PPS Reimbursement - LUPA	Episodes				13
14	Total PPS Reimbursement - PEP E	pisodes				14
15	Total PPS Outlier Reimbursement -	Full Episodes with Outlie	ers			15
16	Total PPS Outlier Reimbursement -	PEP Episodes				16
	Total Other Payments					17
	DME Payments					18
	Oxygen Payments					19
	Prosthetic and Orthotic Payments					20
	Part B deductibles billed to Medicar		surance)			21
	Subtotal (sum of lines 10 thru 20 mi					22
	Excess reasonable cost (from line	e 8)				23
	Subtotal (line 22 minus line 23)	nto (from vour ropordo)				24
	Coinsurance billed to program patie	nts (nom your records)				25 26
	Net cost (line 24 minus line 25) Reimbursable bad debts (from your	rocorde)				27
	Reimbursable bad debts for dual eli	-	nstructions)			28
	Total costs - current cost reporting p					29
	Other adjustments (see instructions	<u> </u>	,			30
	Subtotal (line 29 plus/minus line 30)					31
	Interim payments (see instructions)					32
	Tentative settlement (for fiscal interior	mediary use only)				33
	Balance due provider/program (line		3)	1		34
	Protested amounts (nonallowable of				†	35

Pub. 15-II, section 115.2

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2/11	1 01011 01110 2040 10		4150 (Cont.
ANALYSIS OF PAYMENTS TO PROVIDER-	PROVIDER NO.:	PERIOD:	WORKSHEET H-5
BASED HHAS FOR SERVICES		FROM	
RENDERED TO PROGRAM BENEFICIARIES	HHA NO.:	то	

						1		
	Description			Pai	rt A	Par	t B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	1
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills either sub	mitted or to						2
	be submitted to the intermediary/contractor for services	s rendered						
	in the cost reporting period. If none, write "NONE" or en	nter a zero.						
3	List separately each retroactive lump sum		.01					3.01
	adjustment amount based on subsequent revision		.02					3.02
	of the interim rate for the cost reporting period.	Program	.03					3.03
	Also show date of each payment. If none, write	to	.04					3.04
	"NONE" or enter a zero.(1)	Provider	.05					3.05
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum							
	of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)							4
	(Transfer to Wkst. H-4, Part II, column as appropriate,	line 32)						
	TO BE COMPLE			ITERMED	IARY/CO	NTRACTOR	₹	
5	List separately each tentative settlement payment	Program						5.01
	after desk review. Also show date of each	to	.02					5.02
	payment. If none, write "NONE" or enter	Provider	.03					5.03
	a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum							
	of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)	Program						
	based on the cost report (see instructions)	to	.01					
		Provider						6.01
		Provider						
		to	.02					
		Program						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				<u> </u>			7
	(see instructions)							
8	Name of Intermediary/Contractor				Intermedia	ry Number		8
	1							

Signature of Authorized Person

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Date: (mm/dd/yyyy)

9

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

2/11 FORM CMS-2540-10 4190 (Cont.)

	ANALYSIS OF SNF-BASED RURAL HI CLINIC/FEDERALLY QUALIFIE HEALTH CENTER COSTS		PROVIDER N COMPONEN		PERIOD: FROM TO		WORKSI	HEET I-1	
Chack	Applicable Box:	RHC	[] FQHC	I NO.	10				
CHECK	хррисают вох.	COMPEN- SATION	OTHER COSTS	TOTAL (Col. 1 + Col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (Col. 3 +/- Col. 4)	ADJUSTMENTS	NEW EXPENSES FOR ALLOCATION (Col. 5 +/- Col.6)	
		1	2	3	4	5	6	7	1
FACIL:	TY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (Sum of lines 1 - 9)								10
COSTS	UNDER AGREEMENT								
11	Physician Services Under Agreement								11
	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
	Subtotal (Sum of lines 11 - 13)								14
OTHER	HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation - Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Pass-through cost.								20
21	Subtotal (Sum of lines 15 - 19, less line 20)								21
22	Total Cost of Health Care Services								22
	(Sum of lines 10, 14, and 21)								
COSTS	OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other non reimbursable costs								26
27	Nonallowable GME Pass-through cost								27
28	Total nonreimbursable costs (Sum of lines								28
	23 - 27)								
FACIL	TY OVERHEAD								\vdash
	Facility Costs								29
30	Administrative Costs				1				30
31	Total Facility Overhead (Sum of lines 29-30)		+		+				31
32	Total Facility Costs (Sum of lines 22, 28 and 31)				†				32
	* 'The net expenses for cost allocation on Workshe	eet A for the RHC	FOHC cost center	line must equal the	total facility costs i	in column 7 line 32	of this worksheet	I	Ь

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	PROVIDER NO:	PERIOD:	
ALLOCATION OF OVERHEAD		FROM	WORKSHEET
TO RHC/FQHC SERVICES	COMPONENT NO:		I - 2
		то	
Check Applicable Box:	RHC FQHC		

PART I - VISITS AND PRODUCTIVITY

		Number		Productivity	Minimum	Greater of	
		of FTE	Total	Standard	Visits	Column 2 or	
		Personnel	Visits	(1)	Col. 1 X Col. 3)	Column 4	
		1	2	3	4	5	
1	Physicians						1
_2	Physician Assistants						2
_3	Nurse Practitioners						3
_4	Subtotal (Sum of lines 1 - 3)						4
_5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Total Staff Costs (Sum of lines 4 - 7)						8
9	Physician Services Under Agreements						9

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

	•	
10	Total costs of Health Care Services (From Worksheet I - 1, column 7, line 22)	10
_11	Total nonreimbursable costs (From Worksheet I - 1, column 7, line 28)	11
12	Cost of all services - excluding overhead (Sum of lines 10 and 11)	12
13	Ratio of RHC / FQHC services (Line 10 divided by line 12)	13
14	Total facility overhead (From Worksheet I - 1, column 7, line 31)	14
15	GME Overhead (See instructions)	15
16	Net Facility Overhead	16
17	Parent provider overhead allocated to facility (See instructions)	17
18	Total overhead (Sum of lines 16 and 17)	18
19	Overhead applicable to RHC / FQHC services (Lines 13 X line 18)	19
20	Total allowable cost of RHC / FQHC services (Sum of lines 10 and 19)	20

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

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4149)

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		10101	5015 2540 10		7150 (0	
	CALCULATION OF	PROVIDER NO.:	PERIOD:			
	REIMBURSEMENT	COMPONENTANO	FROM		WORKSHE	ET
т	SETTLEMENT FOR	COMPONENT NO.:	то		I - 3	
Check	RHC/FQHC SERVICES	<u></u> [] Title V	 [Title XIX		
	Applicable Box:	• •	FQHC	[] Title AIA		
	I - DETERMINATION OF					
1	Total Allowable Cost of RHC/	_		20)		1
2	Cost of vaccines and their adn	- ,				2
3	Total Allowable Cost Excludir					3
4	Total FTE's and VISITS (Fron					4
5	Physicians Visits Under Agree	•	- 2, column 5, line 9)			5
6	Total Adjusted Visits (line 4 p					6
7	Adjusted Cost Per Visit (line 3	divided by line 6)			C f	7
CALC	ULATION OF LIMIT	r providore uso columne 1	and 2	Prior to	On or after	
	Lines 8 through 14: Fiscal year Lines 8 through 14: Calendar			January 1	January 1	-
8	Rate per visit limit (From your		2 Only.	1		8
9	Rate for Medicare Covered Vis					9
	II - CALCULATION OF SE	,				
10	Medicare Covered Visits Exclu		ces			10
	(From intermediary/contractor					
11	Medicare Cost Excluding Cost	s for Mental Health Servic	es			11
	(Line 9 x line 10)					
12	Medicare Covered Visits for M		12			
12	(From Intermediary/Contractor	*				12
13	Medicare Covered Cost from M (Line 9 x line 12)	Mental Health Services				13
14	Limit Adjustment for Mental F	Jealth Services				14
1-1	(See instructions)	icultii Scrvices				1
15	, ,	Cost (See instructions)				15
15 16	Allowable GME Pass-through Total Medicare Cost (Sum of 1		s line 14 columns 1 and	2 nluc lina 15		16
17	Primary payer amounts	ine 11 commi 1 and 2, più	3 mic 14 columns 1 unu 2	2, pius inic 15.		17
-	+	for DIIC only (Coolington)	-ti	/		+
18	Less: Beneficiary Deductible			y/contractor records)	18
19	Net Medicare Cost Excluding	,				19
	Reimbursable Cost of RHC/FC					20
21	Program cost of vaccines and t		Worksheet I -4 line 16)			21
22	Total Reimbursable Program (Cost (Line 20 plus 21)				22
23	Reimbursable Bad Debts					23
24	Reimbursable Bad Debts for d	ual eligible beneficiaries (S	See Instructions)			24
25	Other Adjustments					25
26	Net reimbursable amount (Lin	e 22 plus line 23, plus or	minus line 25)			26
27	Interim payments (From Work	sheet I-5, line 4)				27
28	Tentative settlement (for fisc	al intermediary/contracto	or use only)			28
29	Balance due Component/Progr					29
30	Protested amounts (nonallowal CMS Pub. 15-II, section 115.2	ž ,	cordance with			30

CMS Pub. 15-II, section 115.2

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4150)

Rev. 1 41-368

713	o (Cont.)		1011 C1115-25-0-10			2/1	_
		PR	OVIDER NO.:	1	RIOD:		
	OMPUTATION OF PNEUMOCOCCAL			FR	.OM	WORKSHEET	
	AND INFLUENZA VACCINE COST	CO	MPONENT NO.:			I - 4	
		يِا		TO			
	eck one:	Ţ] Title V	<u> </u>] Title XVIII	[] Title XIX	
Cho	eck Applicable Box:	l] RHC	<u>l</u>] FQHC	1	
	CALCULATION OF COST				PNEUMOCOCCAL	INFLUENZA	_
	1				1	2	
1	Health care staff cost (from Worksheet I -1,	colu	mn 7 line 10)				1
2	Ratio of PNEUMOCOCCAL and influenza						2
_	total health care staff time	Lucc	The start time to	1			-
3	PNEUMOCOCCAL and influenza vaccine h	nealt	h care staff cost				3
J	(Line 1 x line 2)		ir care starr cost				
4	Medical supplies cost - PNEUMOCOCCAI	and	l influenza vaccine				4
	(From your records)						
 5	Direct cost of PNEUMOCOCCAL and influ	enza	vaccine				5
	(Sum of lines 3 and 4)						
6	Total direct cost of the facility (From Wkst.	T 1	col 7 line 22)				6
	Total direct cost of the facility (From WKSt.	1 -1,	Coi. 7, Illie 22)				+ 0
7	Total overhead (From Worksheet I - 2, line						7
8	Ratio of PNEUMOCOCCAL and influenza	vacc	ine direct cost to				8
	Total direct cost (Line 5 divided by Line 6)						
9	Overhead cost - PNEUMOCOCCAL and inf	fluer	nza vaccine				9
	(Line 7 x Line 8)						
10		ccine	cost and its (their)				10
	administration (Sum of lines 5 and 9)						
11	Total number of PNEUMOCOCCAL and in	fluei	nza vaccine injections	5			11
	(From your records)						
12	Cost per PNEUMOCOCCAL and influenza	vacc	cine injection				12
	(Line 10 divided by Line 11)						
13	Number of PNEUMOCOCCAL and influent	za va	accine injections				13
	Administered to medicare beneficiaries						
14		ıflue	nza vaccine and				14
	its (their) administration (Line 12 x line 13)						
15			`	,			15
	(Sum of columns 1 and 2, line 10) (Transfer						
16	Total medicare cost of PNEUMOCOCCAL	and	influenza vaccine and	d its	(their) administration		16
	(Sum of columns 1 and 2 line 14) (Transfer	r this	amount to Workshee	t I-3	3 line 21)	1	

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	2/11		OKWI CWI5-2540-1	LU		413	o (Cont.)
	NALYSIS OF PAYMENTS TO	PRO	VIDER NO.:		RIOD:	T	
SNF-BASED RURAL HEALTH				FRO	OM	WORKSHEET	I - 5
•	CLINIC AND FEDERALLY	COM	IPONENT NO.:	то.			
_	UALIFIED HEALTH CENTERS Ek Applicable Box:] R.H.C.	OT] F.Q.H.C.		
Cilec	K Applicable Box.	L	j K.II.C.	L	mm/dd/yyyy	Amount	
	Description				1	2	_
1	Total interim payments paid to provide	er			1		1
$\frac{1}{2}$	Interim payments payable on individua		either submitted or	to			2
_	be submitted to the intermediary/contr						
	the cost reporting period. If none, write						
3	List separately each retroactive lump s		- ,	.01		_	3.01
	adjustment amount based on subsequer	I .		.02			3.02
	revision of the interim rate for the cost	I .	Program to	.03			3.03
	reporting period.		Provider	.04			3.04
				.05			3.05
	Also show date of each payment.			.50		1	3.50
	If none, write "NONE," or enter a zero	0.(1)		.51			3.51
			Provider to	.52			3.52
			Program	.53			3.53
				.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05			.99			3.99
	minus sum of lines 3.50 - 3.55)						
- 1	TOTAL INTERIM PAYMENTS (Sum	of line	es 1, 2 & 3.99)				4
	(Transfer to Worksheet I-3: line 27)						
	TO DE COMPLETED DY INTER	NATEDI	ADV / COMED A C	TOD			
	TO BE COMPLETED BY INTER List separately each tentative settlemen		Program to	10R .01	1		5.01
	payment after desk review.	11	Program to Provider	.02			5.02
	payment after desk review.		riovidei	.03		+	5.03
	Also show date of each payment.	-	Provider to	.50		+	5.50
	If none, write "NONE," or enter a zero	(1)	Program	.51		_	5.51
	ir none, write 1vorve, or enter a zero	,,(±)	110514111	.52		+	5.52
ŀ	SUBTOTAL (Sum of lines 5.01 - 5.03			.99			5.99
	minus sum of lines 5.50 - 5.52)			"			
6	Determined net settlement		Program to	.01			6.01
	amount (balance due) based		Provider	.02		1	6.02
	on the cost report. (1)		Provider to	.50			6.50
			Program	.51			6.51
	TOTAL MEDICARE PROGRAM LIA	BILIT	Y (See Instructions)				7
8	Name of Intermediary/Contractor				Intermediary/Contract	or Number	8
	Cignotomo of Analysis I Barre				Data (mana/33/)		
9	Signature of Authorized Person				Date (mm/dd/yyy)		9

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

Rev. 1 41-373

4150 (Cont.)	1 01011 01110 2040 10				
	PROVIDER NO.:	PERIOD:			
ALLOCATION OF GENERAL SERVICE COSTS		FROM	WORKSHEET J-1		
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART I		

		NET	CAPITAL RE	LATED. COST			ADMINIS-	\top
		EXPENSES			EMPLOYEE	SUBTOTAL	TRATIVE	
	COMPONENT COST CENTER	FOR COST	BUILDS. &	MOVABLE	BENEFITS		&	
	(Omit Cents)	ALLOCATION	FIXTURES	EQUIPMENT		(COLS. 0-3)	GENERAL	
		0	1	2	3	3a	4	T
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	Appr. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	Other General Service Cost							21
22	Totals (Sum of lines 1-21) (1)							22

⁽¹⁾ Columns 0 through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

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Rev. 1 4190 (Cont.) 2/11 FORM CMS-2540-10

2/11	1 OKM GM3-2340-10		4130 (Cont.
	PROVIDER NO.:	PERIOD:	
ALLOCATION OF GENERAL SERVICE COSTS		FROM	WORKSHEET J-1
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART I (CONT.)
	•	•	

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

⁽¹⁾ Columns 0 through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

FORM CMS 2540-10 (12/10)	(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB.	15-II, SECTION 4153)
Rev. 1		

	` ' '		•	
Rev. 1				41-372
4190 (Cont.)		FORM CMS 2540-10		2/11

· · · · · · · · · · · · · · · · · · ·			
	PROVIDER NO.:	PERIOD:	
ALLOCATION OF GENERAL SERVICE COSTS		FROM	WORKSHEET J-1
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART I (CONT.)

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

⁽¹⁾ Columns 0 through 15, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

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2/11	FORM CMS-2540-10	4190 (Cont.)

	2/11	FURNI CN15-2540-10		4130 (Cont.)
		PROVIDER NO.:	PERIOD:	WORKSHEET J-1
	ALLOCATION OF GENERAL SERVICE COSTS		FROM	PART I (CONT.)
	TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	
_		•		

			<u> </u>		1	ı	
COMPONENT COST CENTER (Omit Cents)		SUBTOTAL	POST STEP-DOWN ADJUSTMENTS 17	SUBTOTAL	ALLOCATED A & G (SEE PART II) 19	TOTAL (SUM OF COLS 18 AND 19) 20	
1	Administrative and General						1
2	Skilled Nursing						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	App. Patient Training & Education						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21	Other General Service Cost						21
22	Totals (Sum of lines 1-21)						22
23	Unit Cost Multiplier (See Instructions)						23

4190 (Cont.) FORM CMS-2540-10	2/11
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1150 (Conta)	1 014/1 01/15 =5 10 10			- / - -
	PROVIDER NO.:	PERIOD:		
ALLOCATION OF GENERAL SERVICE COSTS		FROM	WORKSHEET J - 1	
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART II	

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

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Rev. 1 4190 (Cont.) 2/11 FORM CMS-2540-10

	PROVIDER NO.:	PERIOD:	
ALLOCATION OF GENERAL SERVICE COSTS		FROM	WORKSHEET J - 1
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART II (Cont.)

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

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4190 (Cont.)	FORM CMS-2540-10	2/11

1200 (00110)	1 011111 01110 20 10 10			
ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER NO.:	PERIOD:		
		FROM	WORKSHEET J-1	
TO COST CENTERS FOR C.M.H.C.	COMPONENT NO.:	то	PART II (Cont.)	
		-		

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

41-377 Rev. 1

	2/11			FORM CMS-	2540-10					4190 (Cont.)	
	COMPUTATION OF C.	M.H.C.	PROVIDE	R NO.:		PERIOD:					
	REHABILITATION CO	OSTS				FROM			WORKS	HEET J-2	
			COMPONE	ENT NO.:		ТО			PAI	RT I	
PAR	T I - APPORTIONMENT OF REHA	ABILITATION COS	T CENTERS			•					
		TOTAL COSTS		RATIO OF	TIT	LE V	TITLE	XVIII	TITL	E XIX	i
		(FR. WKST. J-1	TOTAL	COSTS TO	CHARGES	COSTS	CHARGES	COSTS	CHARGES	COSTS	i
		PART I, Col. 20)	CHARGES	CHARGES (1)		(Col 3 X Col 4)		(Col 3 X col 6)		(Col. 3 X Col 6)	i
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services						•				8

9

10

11

12

13

14

15

16

17 18

19 20

21

22

9 Individual Therapy

Group Therapy

13 Diagnostic Services

16

17

Family Counseling

Drugs and Biologicals

Medical Supplies

18 Medical Appliances

Individualized Activity Therapy

14 App. Patient Training & Education

Prosthetic and Orthotic Devices

19 Durable Medical Equipment - Rented

(2)

20 Durable Medical Equipment - Sold

Other General Service Cost
Totals (Sum of lines 2-21)

Rev. 1 41-378

419	0 (Cont.)		FORM CMS	-2540-10					2/11	
	COMPUTATION OF C.M.H.C. REHABILITATION COSTS	PROVIDE	R NO.: ENT NO.:		PERIOD: FROM TO			1	HEET J-2	
PΑ	PART II - APPORTIONMENT OF COST OF REHAB SERVICES FURNISHED BY SHARED DEPARTIME									
			RATIO OF		LE V		XVIII		E XIX	
			COSTS TO	CHARGES	COSTS	CHARGES	COSTS	CHARGES	COSTS	
			CHARGES		(Col 3 X Col 4)		(Col 3 X col 6)		(Col. 3 X Col 8)	
			3	4	5	6	7	8	9	
23	Oxygen (Inhalation) Therapy									23
24	Physical Therapy									24
25	1 13									25
	Speech Pathology									26
27	Medical Supplies Charged to Patients									27
28										28
29	J 1									29
30										30
31	Total component cost. Add the amount from Part									31
	22 and the amount from line 30, columns 5, 7, and	d 9.								
	(Transfer Titles V , XVIII, and XIX amounts									
	to Worksheet J-3, columns 1,2 & 3 respectively.)									

FORM CMS 2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4154)

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

⁽²⁾ Charges for Part II, col. 2 are obtained from provider records

	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.:	PERIOD: FROM	WORKSHEET J	_ 3
	OF C.M.H.C. SERVICES	COMPONENT NO.:	TO	- WORKSHEET J	- 3
	OF C.M.H.C. SERVICES	COMPONENT NO	10		
		Title V	Title XVIII	Title XIX	
		PROGRAM	PROGRAM	PROGRAM	
		COST	COST	COST	
		1	2	3	
1	Cost of REHAB services (From Wkst. J-2,	_	_	1	1
	Part II, line. 31: Title V - col. 5; Title		-		
	XVIII 'col 7; Title XIX - column 9)		-		
2	Amounts paid and payable by Worker's				2
	Compensation and other primary payers				
3	Subtotal (Line 1 minus line 2)				3
	,				
4	Part B deductible billed to Program				4
	patients (Exclude coinsurance amounts)				
5	Net Cost (Line 3 minus line 4)				5
6	80% of Part B cost (80% X line 5)				6
7	Actual coinsurance billed to Program				7
	patients (From provider records)				
8	Net cost less actual billed coinsurance				8
	(Line 5 minus line 7)				
9	Reimbursable bad debts (See Instructions)				9
10	Reimbursable bad debts for dual eligible				10
	beneficiaries (see instructions)				
11	Net reimbursable amount (See Instructions)				11
12	Amounts applicable to prior cost reporting				12
	periods resulting from disposition of				
	depreciable assets				
13	Recovery of excess depreciation resulting				13
	from facility's termination or a decrease				
	in Program utilization				
14	Other Adjustments				14
15	Total cost - reimbursable to provider				15
	Total cost costs of provider				
16	Interim payments				16
17	Balance due Component/Program				17
	(Line 15 minus line 16)				
	(Indicate overpayments in brackets)				
18	Protested amounts (Non allowable				18
_0	cost report items) in accordance with				
	CMS Pub. 15-II, section 115.2				

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	ANALYSIS OF PAYMENTS TO PROVIDER - BASED C.M.H.C.	PROVIDER NO.:		RIOD: DM	WORKSHEET	I - 1
		COMPONENT NO.:	FIXC)1 V1	WORKSHEET	J - 4
7	TO PROGRAM BENEFICIARIES	COMI ONLINI NO	ТО			
			1-0	mm/dd/yyyy	Amount	
	Description			1	2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual	bills, either submitted or	r to			2
	be submitted to the intermediary, for ser	vices rendered in the cos	t			
	reporting period. If none, write "none',	or enter zero.				
3	List separately each retroactive		.01			3.01
	lump sum adjustment amount		.02			3.02
	based on subsequent revision	Program to	.03			3.03
	of the interim rate for the cost	Provider	.04			3.04
	reporting period.		.05			3.05
			.50			3.50
	Also show date of each payment.		.51			3.51
		Provider to	.52			3.52
	If none, write "NONE," or enter a zero.(.53			3.53
		. /	.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05		.99			3.99
	minus sum of lines 3.50 - 3.55)					
4	TOTAL INTERIM PAYMENTS (Sum of	of lines 1, 2 & 3.99)				4
	(Transfer to Worksheet J-3: Part I line 1					
	<u> </u>	,				
	TO BE COMPLETED BY INTERM	MEDIARY/CONTRACT	ГOR			
5	List separately each tentative	Program to	.01			5.01
	settlement payment after desk review.	Provider	.02			5.02
			.03			5.03
	Also show date of each payment.	Provider to	.50			5.50
	If none, write "NONE," or enter a zero.((1) Program	.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03	I	.99			5.99
	minus sum of lines 5.50 - 5.52)					
6	Determined net settlement	Program to	.01			6.01
	amount (balance due) based	Provider	.02			6.02
	on the cost report. (1)	Provider to	.50			6.50
		Program	.51			6.51
7	TOTAL MEDICARE PROGRAM LIAE)			7
8	Name of Intermediary/Contractor			Intermediary/Contract	or Number	8
9	Signature of Authorized Person			Date (mm/dd/yyyy)		9
						1

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

2/11 FORM CMS-2540-10 4190 (Cont.) PERIOD:

PROVIDER NO.: _

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS						PROVIDER IN	O	FROM		WORKSHEET	ĸ
						HOSPICE NO	.:	то			
COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CON- TRACTED SERVICES (from Wkst. K-3)	OTHER 5	TOTAL (cols. 1-5)	RECLASSI- FICATION 7	SUBTOTAL (col. 6 ± col. 7)	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9)	
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Bldg and Fixt.											1
2 Capital Related Costs-Movable Equip.											2
3 Plant Operation and Maintenance											3
4 Transportation - Staff											4
5 Volunteer Service Coordination	+	<u> </u>				+	+				5
6 Administrative and General											6
INPATIENT CARE SERVICE											
7 Inpatient - General Care											7
8 Inpatient - Respite Care											8
VISITING SERVICES											
9 Physician Services											9
10 Nursing Care											10
11 Nursing Care-Continuous Home Care											11
12 Physical Therapy											12
13 Occupational Therapy											13
14 Speech/ Language Pathology											14
15 Medical Social Services											15
16 Spiritual Counseling											16
17 Dietary Counseling											17
18 Counseling - Other							+				18
19 Home Health Aide and Homemaker											19
20 HH Aide & Homemaker-Cont. Home Care											20
21 Other											21
OTHER HOSPICE SERVICE COSTS											
22 Drugs, Biological and Infusion Therapy											22
23 Analgesics											23
24 Sedatives / Hypnotics											25
25 Other - Specify											25
26 Durable Medical Equipment/Oxygen											26
27 Patient Transportation											27
28 Imaging Services	1					1	1				28
29 Labs and Diagnostics	1					1	1			1	29
30 Medical Supplies	1					1	1			1	30
31 Outpatient Services (including E/R Dept.)	1										31
32 Radiation Therapy	1					1	1				32
33 Chemotherapy	1					1	1				33
34 Other	1					1	1				34
HOSPICE NONREIMBURSABLE SERVICE											
35 Bereavement Program Costs											35
36 Volunteer Program Costs	1					1	1				36
37 Fundraising						1					37
38 Other Program Costs	1					1	1				38
39 Total (sum of lines 1 thru 38)	1					1					39

			PROVIDER	R NO:	HOSPICE	NO:	PERIOD:				
	HOSPICE COMPENSATION ANALY	YSIS					FROM		WORKSE	IEET K-1	
	SALARIES AND WAGES						то				
	COST CENTER DESCRIPTIONS	ADMINIS		SOCIAL	SUPER-		TOTAL				
	(omit cents)	TRATOR	DIRECTOR	SERVICES	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care- Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
15	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedative/Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (incl. E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERV.									1	25
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total		1		1						39

2/11					FORM CMS-254	40-10					4190 (Cont.)
	HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATE	E D)	PROVIDER NO	•	HOSPICE NO:		PERIOD: FROM TO		WORKSI	НЕЕТ К-2	
	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff				+						4
	Volunteer Service Coordination										5
6	Administrative and General				+						6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - General Care Inpatient - Respite Care				+						8
	VISITING SERVICES										0
9											9
10	Physician Services Nursing Care- Continuous Home Care	1	-		1		+		+		10
11	Nursing Care				+		1				11
12	Physical Therapy						+				12
13	Occupational Therapy						+				13
14					+		1		+		14
15	Speech/ Language Pathology				1						15
	Medical Social Services				-						
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs Biological and Infusion Therapy										22
23	Analgesics										23
24 25	Sedative/Hypnotics	1	-		1						24 25
26	Other - Specify	-			+		+		+		26
27	Durable Medical Equipment/ Oxygen	1			1				1		27
28	Patient Transportation	<u> </u>	-		-		+		+		28
	Imaging Services		-								28
29	Labs and Diagnostics	1	-		1						30
30	Medical Supplies										
31	Outpatient Services (incl. E/R Dept.)	1			1						31
32	Radiation Therapy	-			1						32
33	Chemotherapy	1			ļ		1		1		33
34	Other										34
	HOSPICE NONREIMBURSABLE SERV.										
35	Bereavement Program Costs										35

Volunteer Program Costs

Other Program Costs

Fundraising

Total

36

37

38

39

36

37

38

39

	HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES / PURCHASED SERVI	ICES	PROVIDER NO:		HOSPICE NO:		PERIOD: FROM TO		WORKSE	IEET K-3	
	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	OFFICE AL OFFICE COOK OFFICERS	1	2	3	4	5	6	7	8	9	
- 1	GENERAL SERVICE COST CENTERS										1
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
7	INPATIENT CARE SERVICE										7
7	Inpatient - General Care										•
8	Inpatient - Respite Care										8
	VISITING SERVICES										0
9	Physician Services										9
10 11	Nursing Care										10 11
12	Nursing Care- Continuous Home Care										12
13	Physical Therapy										13
14	Occupational Therapy										14
15	Speech/ Language Pathology										15
16	Medical Social Services										16
	Spiritual Counseling										17
17	Dietary Counseling										
18 19	Counseling - Other										18 19
20	Home Health Aide and Homemaker HH Aide & Homaker - Cont. Home Care										20
21	Other										21
	OTHER HOSPICE SERVICE COSTS										21
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedative/Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (incl. E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERV.										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total										39

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2/11		IDDAVIDED.	NO.	FORM CM		DEDIOD.				4190 (Cont.
COST ALLOCATION - HOSP GENERAL SERVICE COST		PROVIDER	NU:	HOSPICE N	U:	PERIOD: FROM TO		WORKSH PAR		
COST CENTER DESCRIPTIONS	FR. WKST. K COL. 10: NET EXPENSES FOR COST ALLOC. (1)	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS PORTATION	VOLUNTEER SERV. COORDI- NATOR	SUBTOTAL (col. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL	
	0	1	2	3	4	5	5A	6	7	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Bldg and Fixt.										1
2 Capital Related Costs-Movable Equip.										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff										4
5 Volunteer Service Coordination										5
6 Administrative and General										6
INPATIENT CARE SERVICE										
7 Inpatient - General Care										7
8 Inpatient - Respite Care										8
VISITING SERVICES										4
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care- Continuous Home Care										11
12 Physical Therapy										12
13 Occupational Therapy										13
14 Speech/ Language Pathology										14
15 Medical Social Services - Direct										15
16 Spiritual Counseling										16
17 Dietary Counseling										17
18 Counseling - Other										18
19 Home Health Aide and Homemakers										19
20 HH Aide & Homaker - Cont. Home Care										20
21 Other										21
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biologicals and Infusion										22
23 Analgesics										23
24 Sedative/Hypnotics										24
25 Other - Specify										25
26 Durable Medical Equipment/Oxygen										26
27 Patient Transportation										27
28 Imaging Services						1				28
29 Labs and Diagnostics										29
30 Medical Supplies										30
31 Outpatient Services (incl. E/R Dept.)						1				31
32 Radiation Therapy						1				32
33 Chemotherapy	1					1				33
34 Other	1					1				34
HOSPICE NONREIMBURSABLE SERV.										
35 Bereavement Program Costs										35
36 Volunteer Program Costs	1					1				36
37 Fundraising						1				37
38 Other Program Costs	1					1				38
39 Total	1					1				39
(1) Column 0, line 29 must agree with Wkst. A, o	column 7, line 83.	l		1	l	-	ı			

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<u>H</u>	COST ALLOCATION - OSPICE STATISTICAL BASIS	PROVIDER N		HOSPICE NO		PERIOD: FROM TO		WORKSHEE PART II	T K-4
	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT \$ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS- PORTATION MILEAGE	VOLUNTEER SERV. COORDI- NATOR (HOURS)	RECONCI- LIATION 6A	ADMINIS- TRATIVE & GENERAL (ACC. COST)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	5	0A	6	
1	Capital Related Costs-Buildings and Fixtures							+	1
2	Capital Related Costs-Movable Equipment								2
3	Plant Operation and Maintenance								3
4	Transportation-staff							_	4
5	Volunteer Service Coordination								5
6	Administrative and General								6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care								1
11	Nursing Care- Continuous Home Care								1
12	Physical Therapy								1
13	Occupational Therapy								1
14	Speech/ Language Pathology								1
15	Medical Social Services - Direct								1
16	Spiritual Counseling								1
17	Dietary Counseling								1
18	Counseling - Other								1
19	Home Health Aide and Homemakers								1
20	HH Aide & Homaker - Cont. Home Care								2
21	Other								2
	OTHER HOSPICE SERVICE COSTS								
22	Drugs, Biologicals and Infusion								2
23	Analgesics								2
24	Sedative/Hypnotics								2
25	Other - Specify								2
26	Durable Medical Equipment/Oxygen								2
27	Patient Transportation								2
28	Imaging Services								2
29	Labs and Diagnostics								2
30	Medical Supplies								3
31	Outpatient Services (incl. E/R Dept.)								3
32	Radiation Therapy								3:
33	Chemotherapy								3
34	Other								3,
	HOSPICE NONREIMBURSABLE SERV.								
35	Bereavement Program Costs								3
36	Volunteer Program Costs								3
37	Fundraising								3
38	Other Program Costs								3
49	Cost To be Allocated (per Wkst K-4, Part I)								4
50	Unit Cost Multiplier								5

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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:		PERIOD FROM: TO:		PA	HEET K-5, RT I	
HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 6,	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED BLDGS. & FIXTURES	CAPITAL RELATED MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-3)	ADMINIS- TRATIVE & GENERAL	
	line -	0	1	2	3	4A	4	1
6 Administrative and General	6							6
7 Inpatient - General Care	7							7
8 Inpatient - Respite Care	8							8
9 Physician Services	9							9
10 Nursing Care	10							10
11 Nursing Care- Continuous Home Care	11							11
12 Physical Therapy	12							12
13 Occupational Therapy	13							13
14 Speech/ Language Pathology	14							14
15 Medical Social Services - Direct	15							15
16 Spiritual Counseling	16							16
17 Dietary Counseling	17							17
18 Counseling - Other	18							18
19 Home Health Aide and Homemakers	19							19
20 HH Aide & Homaker - Cont. Home Care	20							20
21 Other	21							21
22 Drugs, Biologicals and Infusion	22							22
23 Analgesics	23							23
24 Sedative/Hypnotics	24							24
25 Other - Specify	25							25
26 Durable Medical Equipment/Oxygen	26							26
27 Patient Transportation	27							27
28 Imaging Services	28							28
29 Labs and Diagnostics	29							29
30 Medical Supplies	30							30
31 Outpatient Services (incl. E/R Dept.)	31							31
32 Radiation Therapy	32							32
33 Chemotherapy	33							33
34 Other	34							34
35 Bereavement Program Costs	35							35
36 Volunteer Program Costs	36							36
37 Fundraising	37							37
38 Other Program Costs	38							38
39 Totals (sum of lines 1-28)								39
50 Unit Cost Multiplier:		•		•			•	50

Column 16, line 1 divided by the sum of column 16, line 39, minus column 16, line 1, rounded to 6 decimal places.

(2) Columns 0 through 16, line 29 must agree with the corresponding columns of Wkst. B, Part I, line 83.

FORM CMS-2540-10 (12/10) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4162)

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	ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:		PERIOD FROM: TO:			HEET K-5, (Cont.)	
	HOSPICE COST CENTER (omit cents)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	_
6	Administrative and General								_
7	Inpatient - General Care								_
8	Inpatient - Respite Care								_
9	Physician Services								_
10	Nursing Care								_
11	Nursing Care- Continuous Home Care								_
12	Physical Therapy								_
13	Occupational Therapy								_
14	Speech/ Language Pathology								_
15	Medical Social Services - Direct								_
16	Spiritual Counseling								_
17	Dietary Counseling								
18	Counseling - Other								
19	Home Health Aide and Homemakers								
20	HH Aide & Homaker - Cont. Home Care								_
21	Other								
22	Drugs, Biologicals and Infusion								
23	Analgesics								
24	Sedative/Hypnotics								_
25	Other - Specify								
26	Durable Medical Equipment/Oxygen								
27	Patient Transportation								_
28	Imaging Services								
29	Labs and Diagnostics								
30	Medical Supplies								_
31	Outpatient Services (incl. E/R Dept.)								_
32	Radiation Therapy								_
33	Chemotherapy								Т
34	Other								Т
35	Bereavement Program Costs								
36	Volunteer Program Costs								
37	Fundraising								
38	Other Program Costs								
39	Totals (sum of lines 1-28) (2)								_

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			PROVIDER NO.:		PERIOD				
	ALLOCATION OF GENERAL SERVICE				FROM:		WORKSH	EET K-5,	
	COSTS TO HOSPICE COST CENTERS		HOSPICE NO.:		TO:		Part I	(Cont.)	
	HOSPICE COST CENTER (omit cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE	SUBTOTAL (Sum of Columns 4a through 15)	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	+
6	Administrative and General				+				6
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
9	Physician Services								9
10	Nursing Care								10
11	Nursing Care- Continuous Home Care								11
12	Physical Therapy								12
13	Occupational Therapy								13
14	Speech/ Language Pathology								14
15	Medical Social Services - Direct								15
16	Spiritual Counseling								16
17	Dietary Counseling								17
18	Counseling - Other								18
19	Home Health Aide and Homemakers								19
20	HH Aide & Homaker - Cont. Home Care								20
21	Other								21
22	Drugs, Biologicals and Infusion								22
23	Analgesics								23
24	Sedative/Hypnotics								24
25	Other - Specify								25
26	Durable Medical Equipment/Oxygen								26
27	Patient Transportation								27
28	Imaging Services								28
29	Labs and Diagnostics								29
30	Medical Supplies								30
31	Outpatient Services (incl. E/R Dept.)								31
32	Radiation Therapy								32
33	Chemotherapy								33
34	Other								34
35	Bereavement Program Costs								35
36	Volunteer Program Costs								36
37	Fundraising								37
38	Other Program Costs								38
39	Totals (sum of lines 1-28) (2)								39
50	Unit Cost Multiplier:		·						50
	Column 16, line 1 divided by the sum of column 16, line 39,	minus column 16, line 1, r	ounded to 6 decimal pla	ces.					

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4190 (Cont.)		FORM CMS-2	540-10				2/11
	PROVIDER NO.:		PERIOD				
ALLOCATION OF GENERAL SERVICE			FROM:		WORKS	НЕЕТ К-5,	
COSTS TO HOSPICE COST CENTERS	HOSPICE NO.:		то:		PA	RT II	
HOSPICE COST CENTER		CAPITAL RELATED	CAPITAL RELATED	EMPLOYEE BENEFITS	RECONCIL LATION	ADMINIS- TRATIVE &	
(omit cents)		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	(Gross Salaries)		GENERAL (Accum. Cost)	
		1	2	3	4a	4	
6 Administrative and General							6
7 Inpatient - General Care							7
8 Inpatient - Respite Care							8
9 Physician Services							9
10 Nursing Care							10
Nursing Care- Continuous Home Care							11
12 Physical Therapy							12
13 Occupational Therapy							13
14 Speech/ Language Pathology							14
15 Medical Social Services - Direct							15
16 Spiritual Counseling							16
17 Dietary Counseling							17
18 Counseling - Other							18
19 Home Health Aide and Homemakers							19
20 HH Aide & Homaker - Cont. Home Care							20
21 Other							21
22 Drugs, Biologicals and Infusion							22
23 Analgesics							23
24 Sedative/Hypnotics							24
25 Other - Specify							25
26 Durable Medical Equipment/Oxygen							26
27 Patient Transportation							27
28 Imaging Services							28
29 Labs and Diagnostics							29
30 Medical Supplies							30
31 Outpatient Services (incl. E/R Dept.)							31
32 Radiation Therapy							32
33 Chemotherapy							33
34 Other							34
35 Bereavement Program Costs							35
36 Volunteer Program Costs							36
37 Fundraising							37
38 Other Program Costs							38
39 Totals (sum of lines 1-28)							39
50 Unit Cost Multiplier							50
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11			FURINI CIVIS-2	2340-10				4190 ((Cont.
			PROVIDER NO.:		PERIOD				
	ALLOCATION OF GENERAL SERVICE				FROM:		WORKSI	HEET K-5,	
	COSTS TO HOSPICE COST CENTERS		HOSPICE NO.:		то:		Part II	(Cont.)	
		PLANT	LAUNDRY	HOUSE	DIETARY	NURSING	CENTRAL	PHARMACY	
	HOSPICE COST CENTER	OPERATION	& LINEN	KEEPING	(Meals Served)	ADMINIS-	SERVICES &	(Costed	
	(omit cents)	MAINTENANCE	SERVICE	(Hours of		TRATION	SUPPLY	Requisitions)	
		& REPAIRS	(Pounds of	Service)		(Direct Nursing	(Costed		
		(Square Feet)	Laundry)			Hours)	Requisitions)		
		5	6		8	9	10	11	
6	Administrative and General								6
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
9	Physician Services								9
10	Nursing Care								10
11	Nursing Care- Continuous Home Care								11
12	Physical Therapy								12
13	Occupational Therapy								13
14	Speech/ Language Pathology								14
15	Medical Social Services - Direct								15
16	Spiritual Counseling								16
17	Dietary Counseling								17
18	Counseling - Other								18
19	Home Health Aide and Homemakers								19
20	HH Aide & Homaker - Cont. Home Care								20
21	Other								21
22	Drugs, Biologicals and Infusion								22
23	Analgesics								23
24	Sedative/Hypnotics								24
25	Other - Specify								25
26	Durable Medical Equipment/Oxygen								26
27	Patient Transportation								27
28	Imaging Services								28
29	Labs and Diagnostics								29
30	Medical Supplies								30
31	Outpatient Services (incl. E/R Dept.)								31
32	Radiation Therapy								32
33	Chemotherapy								33
34	Other								34
35	Bereavement Program Costs								35
36	Volunteer Program Costs							***************************************	36
37	Fundraising								37
38	Other Program Costs		1					 	38
39	Totals (sum of lines 1-28)							-	39
50	Unit Cost Multiplier		-			-		-	50

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4190	(Cont.)		FURM CM5-2	040-10		1	2/11
				PROVIDER NO.:			
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS			HOSPICE NO.:		FROM:	_ WORKSHEET K-5,	
					то:		
		MEDICAL	SOCIAL	INTERNS &	OTHER		
	HOSPICE COST CENTER	RECORDS &	SERVICE	RESIDENTS	GENERAL		
	(omit cents) LIBRARY		(Time Spent)	(Assigned Time)	SERVICE		
		(Time Spent)			(Specify)		
	T	12	13	14	15		
6	Administrative and General	12	15	14	15		6
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	Physician Services						
9	1 ·						9
10	Nursing Care						10
11	Nursing Care- Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech/ Language Pathology						14
15	Medical Social Services - Direct						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemakers						19
20	HH Aide & Homaker - Cont. Home Care						20
21	Other						21
22	Drugs, Biologicals and Infusion						22
23	Analgesics						23
24	Sedative/Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (incl. E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Totals (sum of lines 1-28)						39
50	Unit Cost Multiplier						50

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APPORTIONMENT OF HOSPICE SHARED SERVICES				I CMS-2540-10	4190(Cont.)		
				IDER NO.: ICE NO.:	PERIOD: From: To:	WORKSHEET K-5 Part III	
PART III - COMPUTATION OF TOTAL I	HOSPIC	E SHARED COSTS	ļ				
Hospice shared cost computation					Total Hospice	Hospice Shared	
COST CENTER		Facility Cost From Worksheet K-5, Part I		st to Charge Ratio	Charges	Ancillary Costs	
				Worksheet C, Col. 3	(From Provider	(col. 4 x col. 5)	
		Amount:	Line:	Ratio	Records)		
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
1 Physical Therapy	12		44				1
2 Occupational Therapy	13		45				2
3 Speech/ Language Pathology	14		46				3
4 Drugs, Biologicals and Infusion	22		49				4
5 Labs and Diagnostics	29		41				5
6 Medical Supplies	30		48				6
7 Radiation Therapy	32		40				7
8 Other	34		52				8
9 Total (sum of lines 1-8)							9

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CALCULATION OF	PROVIDER NO.	PERIOD:	
PER DIEM COST		FROM	WORKSHEET K-6
		<u>TO</u>	

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER 3	TOTAL 4	
1	Total cost (Worksheet K, line 39 less line 38, col. 7)					1
2	Total Unduplicated Days (Worksheet S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Worksheet S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-8, line 5, col. 4)					10
	Average NF cost (line 3 times line 10)					11
	Other Unduplicated days (Worksheet S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13