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

FORM APPROVED
OMB NO. 0938-0463

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S PARTS I II & III

PART I - COST REPORT STATUS

Provider use only	[ ] Electronic filed cost report	Date:_____	Time:_____
	[ ] Manually submitted cost report		
Contractor use only:	[ ] Cost Report Status	If # 3 or 4:	Date Received _____
	[1] As Submitted:	[ ] Desk Reviewed	Contractor No. _____
	[2] Amended:	[ ] Audited	[ ] First Cost Report Processed by Contractor
	[3] Settled:		
	[4] Reopened: If number 4, Enter Number of times reopened [ ]		[ ] Last Cost Report to be Processed by Contractor

PART II - CERTIFICATION

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 I

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS)

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

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name _____ Signed_____

Title _____ Date _____

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F / M R					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.)

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.:	PERIOD FROM_____ TO_____	WORKSHEET S - 2 Part I

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	P.O. Box:		1
2	City:	State:	Zip Code:	2
3	County:	CBSA Code:	Urban / Rural:	3

SNF and SNF-Based Component Identification:

	Component	Component Name	Provider No.	Date Certified	Payment System (P, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
4	S N F							4
5	Nursing Facility							5
6	I C F / M R							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/yyyy)	From:	To:	13
14	Type of Control (See Instructions)			14

	Type of Freestanding Skilled Nursing Facility	Y / N	
15	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?		15
16	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?		16
17	Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10? If yes, complete Worksheet A-8-1.		17
	Miscellaneous Cost Reporting information		
18	If this is a low or no Medicare utilization cost report, enter "L" for low Medicare Utilization, or enter "N" for No Medicare Utilization.		18
19	Other		19

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 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	If depreciation is funded, enter the balance as of the end of the period.			24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)			25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)			26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies			27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports			28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.:	PERIOD FROM TO	WORKSHEET S - 2 Part I (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	
29	Skilled Nursing Facility				29
30	Nursing Facility				30
31	I C F / M R				31
32	SNF-Based H.H.A.				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
	SNF-Based OLTC				36
				Y / N	
37	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
38	Are you legally-required to carry malpractice insurance?				38
39	Is the malpractice a "claims-made:", or "occurence" policy? If the policy is "claims-maid" enter 1. If policy is "occurence", enter 2.				39
40	What is the liability limit for the malpractice policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.				40

		Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:				41

42	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	Y / N	42
43	Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10?		43
44	If yes, and there are costs, for the home office, enter the applicable provider number	Provider #	44

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	45
46	Street:			PO Box	46
47	City		State	Zip	47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO.:	PERIOD: FROM TO	WORKSHEET S-2 Part II

General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No
For all the dates responses the format will be (mm/dd/yyyy)

Completed by All Skilled Nursing Facilities

	Provider Organization and Operation	1 Y/N	2 Date		
1	Has the Provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)				1

		1 Y/N	2 Date	3 V/I	
2	Has the provider terminated participation in the Medicare Program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

Financial Data and Reports

		1 Y/N	2 Type	3 Date	
4	Were the financial statements prepared by a Certified Public Accountant? If column 1 is "Y" enter "A" for Audited, "C" for Compiled, or "R" for Reviewed in column 2. Submit a complete copy or enter date available in column 3. (see instructions) If column 1 is "N" see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If column 1 is "Y", submit reconciliation.				5

Approved Educational Activities		1 Y/N	2 Legal Oper.	
6	Were costs claimed for Nursing School? If column 1 is "Y", enter "Y" or "N" in column 2 to indicate whether the provider is the legal operator of the program			6
7	Were costs claimed for Allied Health Programs? If "Y" see instructions.			7
8	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? If "Y", see instructions.			8

Bad Debts

		1 Y/N	
9	Is the provider seeking reimbursement for bad debts? If "Y", see instructions.		9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		10
11	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

PS&R Data		1 Y/N Part A	2 Date Part A	3 Y/N Part B	4 Date Part B	
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4 .(see Instructions.)					13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.					14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.					15
16	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R information? If "Y", see Instructions.					16
17	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments: _____					17
18	Was the cost report prepared only using the provider's records? If "Y" see Instructions.					18

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

	Component	Number of Beds	Bed Days Available	Inpatient Days					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Facility													1
2	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

		Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2	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.

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

PART II DIRECT SALARIES		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		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	CMHC						10
11	Hospice						11
12	Non-reimbursable						12
13	Total Excluded salary (Sum of lines 8 through 12)						13
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

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

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

SNF WAGE RELATED COSTS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHE S-3 PART IV

PART IV - Wage Related Cost

Part A - Core List

		Amount Reported
	RETIREMENT COST	
1	401K Employer Contributions	
2	Tax Sheltered Annuity (TSA) Employer Contribution	
3	Qualified and Non-Qualified Pension Plan Cost	
4	Prior Year Pension Service Cost	
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):	
5	401K/TSA Plan Administration fees	
6	Legal/Accounting/Management Fees-Pension Plan	
7	Employee Managed Care Program Administration Fees	
	HEALTH AND INSURANCE COST	
8	Health Insurance (Purchased or Self Funded)	
9	Prescription Drug Plan	
10	Dental, Hearing and Vision Plan	
11	Life Insurance (If employee is owner or beneficiary)	
12	Accidental Insurance (If employee is owner or beneficiary)	
13	Disability Insurance (If employee is owner or beneficiary)	
14	Long-Term Care Insurance (If employee is owner or beneficiary)	
15	Workers' Compensation Insurance	
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)	
	TAXES	
17	FICA-Employers Portion Only	
18	Medicare Taxes - Employers Portion Only	
19	Unemployment Insurance	
20	State or Federal Unemployment Taxes	
	OTHER	
21	Executive Deferred Compensation	
22	Day Care Cost and Allowances	
23	Tuition Reimbursement	
24	Total Wage Related cost (Sum of lines 1 -23)	

Part B Other than Core Related Cost

25	**Other Wage Related Costs (specify)**_____	

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:105)

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-3 PART V

	Occupational Category	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
	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

S.N.F. -BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: HHA NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

1	County						1
	DESCRIPTION	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	
2	Home Health Aide Hours						2
3	Unduplicated Census Count (see instructions)						3

HOME 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

HOME HEALTH AGENCY CBSA CODES

21	Enter the number of hours in your normal work week		21
22	How many CBSAs in column 1 did you provide services to during this cost reporting period.		22
23	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		23

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

		Full Episodes		LUPA	PEP	TOTAL	
		Without Outliers	With Outliers	Episodes	only 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 CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER NO: _____ COMPONENT NO: _____	PERIOD: FROM_____ TO_____	WORKSHEET S - 5

Check applicable box: [ ] RHC [ ] FQHC

PART I - STATISTICAL DATA

1	Street:	County:		1
2	City:	State:	Zip Code:	2
3	Designation (for FQHC's only) - Enter "R" for rural or "U" for urban			3

Source of Federal funds:		Grant Award	Date	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look - Alikes			8
9	Other (specify)			9

10	Does the facility operate as other than an RHC or FQHC? If yes, indicate the number of other operations in column 2. (Enter in subscripts of line 10 the type of other operation(s) and the operating hours.) NOTE: Line 11 (Clinic) is to be completed regardless of the response to line 10.	1	2	10

Facility hours of operations (1)

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

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

12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report in accordance with CMS Pub 27, section 508D. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers on subscripted lines below.			13
14	Provider Name	NPI Number		14
15	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.			15

SKILLED NURSING FACILITY BASED C.M.H.C. STATISTICAL DATA	PROVIDER NO.: C.M.H.C. NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-6

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

	Employment Category: Enter the number of hours in your normal work week ( ).	Staff	Contract	Total	
		1	2	3	
1	Administrator and Assistant Administrators				1
2	Directors and Assistant Directors				2
3	Other Administrative Personnel				3
4	Directing Nursing Service				4
5	Nursing Supervisor				5
6	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
16	Psychological Service				16
17	Psychological Service Supervisor				17
18					18
19					19

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

	GROUP	Days	
	1	2	
1	RUX		1
2	RUL		2
3	RVX		3
4	RVL		4
5	RHX		5
6	RHL		6
7	RMX		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
24	ES3		24
25	ES2		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		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

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

	GROUP	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		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
102	Recruitment				102
103	Retention of employees				103
104	Training				104
105	Other (Specify)				105

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

PART I Enrollment Days Based on Level of Care

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

PART II Census Data

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

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

		COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)	
A	B	D	1	2	3	4	5	6	7	A
GENERAL SERVICE COST CENTERS										
1	00100	Capital-Related Costs - Building & Fixture								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 Education Activities								14
15		Other General Service Cost								15
DIRECT CARE EXPENDITURES			***LINES 16 THROUGH 29 ARE RESERVED FOR FUTURE USE***							
INPATIENT ROUTINE SERVICE COST CENTERS										
30	03000	Skilled Nursing Facility								30
31	03100	Nursing Facility								31
32	03200	Intermediate Care Facility - Mentally Challenged								32
33		Other Long Term Care								33
ANCILLARY 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

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

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

		COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSI-FICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase /Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)	
A	B	D	1	2	3	4	5	6	7	
48	04800	Medical Supplies Charged to Patients								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										
60	06000	Clinic								60
61	06100	Rural Health Clinic (RHC)								61
62	6200	FQHC								62
63	6300	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS										
70	07000	Home Health Agency Cost								70
71	07100	Ambulance								71
72	07200	Nursing and Allied Health Education Activities								72
73	07300	C.M.H.C.								73
74	07400	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS										
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										
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

RECLASSIFICATIONS | **PROVIDER NO:** | **PERIOD: FROM _____ TO _____** | **WORKSHEET A-6**

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

RECONCILIATION OF CAPITAL COSTS CENTERS	**PROVIDER NO.:** _____	**PERIOD:** FROM _____ TO _____	WORKSHEET A-7

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 6 minus line 8)								9

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

	(1) DESCRIPTION	(2) BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A, TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED\ COST CENTER	LINE NO.	
	1	2	3	4	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 (Chapter 21)					6
7	Parking lot (chapter 21)					7
8	Remuneration applicable to provider-based physician adjustment	**Worksheet A-8-2**				8
9	Home office costs (chapter 21)					9
10	Sale of scrap, waste, etc. (Chapter23)					10
11	Nonallowable costs related to certain Capital expenditures (chapter 24)					11
12	Adjustment resulting from transactions with related organizations (chapter 10)	**Worksheet A-8-1**				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Depreciation--buildings and fixtures			**Capital Related Cost- Building**	**1**	22
23	Depreciation--movable equipment			**Capital Related Cost-Movable Equipment**	**2**	23
24	Other Adjustment					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	PROVIDER NO:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-1

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

Line No.		Cost Center	Expense Items	Amount	Amount Allowable In Cost	Adjustments (Col 4 minus Col 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
100	TOTALS (Sum of lines 1-9) Transfer column 6, line 100 to Worksheet A-8, column 3, line 12)						100

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.

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator or key person of provider and related organization.

F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial or non-financial) specify _____

_____

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

PROVIDER-BASED PHYSICIANS ADJUSTMENTS | **PROVIDER NO:** _____ | **PERIOD: FROM** _____ **TO** _____ | **WORKSHEET A-8-2**

	Wkst A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

	Wkst A Line No.	Cost Center / Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of Col 12	Physician Cost of Malpractice Insurance	Provider Component Share of Column 14	Adjusted R C E Limit	R C E Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

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

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B PART I		
COST CENTER (Omit Cents)		NET EXPENSES FOR COST ALLOCATION Fr. Wkst A, Col 7	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (Sum of Columns 0 - 3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - 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
INPATIENT 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
ANCILLARY 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

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B PART I		
COST CENTER (Omit Cents)		NET EXPENSES FOR COST ALLOCATION Fr. Wkst A, Col 7	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (Sum of Columns 0 - 3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3 A	4	
OUTPATIENT SERVICE COST CENTERS								
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	
GENERAL SERVICE COST CENTERS									
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
INPATIENT 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
ANCILLARY 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

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

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
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)	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	
GENERAL SERVICE COST CENTERS									
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
INPATIENT 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
ANCILLARY 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)

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)		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	
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

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

	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		0	1	2	3	4 A	4	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - 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
INPATIENT 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
ANCILLARY 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**

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

	COST CENTER (Omit Cents)		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		0	1	2	3	4 A	4	
OUTPATIENT SERVICE COST CENTERS								
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 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**

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

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS									
1	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
INPATIENT 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
ANCILLARY 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

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

	COST CENTER (Omit Cents)	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
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 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**

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

	COST CENTER (Omit Cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCAT (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
GENERAL 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
INPATIENT 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
ANCILLARY 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

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

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

COST CENTER (Omit Cents)		MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDU (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
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 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

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

	COST CENTER (Omit Cents)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
GENERAL SERVICE COST CENTERS									
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
INPATIENT 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
ANCILLARY 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.)

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

	COST CENTER (Omit Cents)	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL. BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
OUTPATIENT SERVICE COST CENTERS									
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

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER NO.:	PERIOD: FROM TO	WORKSHEET B PART II				
	COST CENTER (Omit Cents)	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Building & Fixture							1
2	Capital-Related Costs - Movable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education Activities							14
15	Other General Service Cost							15
INPATIENT 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
ANCILLARY 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)

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

ALLOCATION OF CAPITAL - RELATED COSTS		**PROVIDER NO.:**		**PERIOD: FROM TO**		**WORKSHEET B PART II**		
COST CENTER (Omit Cents)		LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS								
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

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

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

	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	
GENERAL SERVICE COST CENTERS									
1	Capital-Related Costs - Building & Fixture								1
2	Capital-Related Costs - Movable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education Activities								14
15	Other General Service Cost								15
INPATIENT 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
ANCILLARY 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

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

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

	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	
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

POST STEP DOWN ADJUSTMENTS	PROVIDER NO.:	PERIOD FROM_____ TO_____	WORKSHEET B-2

	DESCRIPTION	WORKSHEET B - PART NO.	LINE NO.	AMOUNT	
	1	2	3	4	
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					36
37					37
38					**38**
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50

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

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

	Cost Center	TOTAL (From Wkst B, Pt. I, Col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1	2	3	
ANCILLARY SERVICE COST CENTERS					
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
OUTPATIENT SERVICE COST CENTERS					
60	Clinic				60
61	R H C				61
62	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

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

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

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

Check One: [ ] SNF [ ] NF [ ] ICF/MR [ ] Other _____ [ ] PPS - Must also complete Part II

Cost Center		RATIO OF COST TO CHARGES (Fr. Wkst. C Column 3)	HEALTH CARE PROGRAM CHARGES Part A	HEALTH CARE PROGRAM CHARGES Part B	HEALTH CARE PROGRAM COST Part A (Col. 1 X Col. 2)	HEALTH CARE PROGRAM COST Part B (Col. 1 X Col. 3)	
		1	2	3	4	5	
ANCILLARY 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						50
51	Support Surfaces						51
52	Other Ancillary Services						52
OUTPATIENT COST CENTERS							
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

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

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

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER NO. :	PERIOD : FROM _____ TO _____	WORKSHEET D PARTS II & III

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

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 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 providers, transfer this amount to Worksheet E, Part I, line 24)				3

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

	Cost Centers	Total Cost (From Worksheet B, Part I, Col 18)	Nursing & Allied Health (From Wkst. B, Part I, Column 14)	Ratio of Nursing & Allied Health Costs To Total Costs - Part A (Col. 2 / Col.. 1)	Program Part A Cost (From Wkst. D. Part 1, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 X Col. 4)	Program Part B Cost (From Wkst. D. Part 1, Col. 5)	Part B Nursing & Allied Health Costs for Pass Through (Col. 3 X Col. 6)	
		1	2	3	4	5	6	7	
ANCILLARY 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

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

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

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

PART I CALCULATION OF INPATIENT ROUTINE COSTS

	INPATIENT DAYS		
1	Inpatient days including private room days		1
2	Private room days		2
3	Inpatient days including private room days applicable to the Program		3
4	Medically necessary private room days applicable to the Program		4
5	Total general inpatient routine service cost		5
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6	General inpatient routine service charges		6
7	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		7
8	Enter private room charges from your records		8
9	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		9
10	Enter semi-private room charges from your records		10
11	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		11
12	Average per diem private room charge differential (Line 9 minus line 11)		12
13	Average per diem private room cost differential (Line 7 times line 12)		13
14	Private room cost differential adjustment (Line 2 times line 13)		14
15	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		15
	PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		16
17	Program routine service cost (Line 3 times line 16)		17
18	Medically necessary private room cost applicable to program (line 4 times line 13)		18
19	Total program general inpatient routine service cost (Line 17 plus line 18)		19
20	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF,or line 32 for ICF/MR)		20
21	Per diem capital related costs (Line 20 divided by line 1)		21
22	Program capital related cost (Line 3 times line 21)		22
23	Inpatient routine service cost (Line 19 minus line 22)		23
24	Aggregate charges to beneficiaries for excess costs (From provider records)		24
25	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		25
26	Enter the per diem limitation (1)		26
27	Inpatientroutine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27
28	**Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27)** (Transfer to Worksheet E, Part II, line 4) (See instructions)		**28**

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

1	Total inpatient days		1
2	Program inpatient days. (From Worksheet S-3, Part I, cols. 3, or 5, line 1 as applicable)		2
3	Total Nursing & Allied Health costs. (From Worksheet B, Part I, column 14, line 14)		3
4	Nursing & Allied Health ratio. (Line 2 divided by line 1)		4
5	Program Nursing & Allied Health costs for pass-through. (Line 3 times line 4)		5

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

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E PART I

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

1	Inpatient ancillary services - Part A - (See Instructions)		1
2	Nursing and Allied Health Education Activities		2
3	Total cost (Sum of lines 1 and 2)		3
4	Inpatient PPS amount (see instructions)		4
5	Primary payor amounts		5
6	Coinsurance		6
7	Reimbursable bad debts (From your records)		7
8	Reimbursable bad debts for dual eligible beneficiaries (See instructions)		8
9	Adjusted reimbursable bad debts for periods ending on and after 10/01/2005 (See 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 13 and 14, plus or minus line 15) (Indicate overpayment in brackets) (See Instructions)		16
17	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)		17

PART B - ANCILLARY SERVICES COMPUTATION OF REIMBURSEMENT 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 29, 30 and line 31) (Indicate overpayments in brackets) (See Instructions)		32
33	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.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 REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET E PART II

Check one: [ ] Title V [ ] Title XIX

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

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

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

ANALYSIS OF PAYMENTS TO PROVIDERS
FOR SERVICES RENDERED

PROVIDER NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET E - 1

	Description			Inpatient Part A mm/dd/yyyy 1	Inpatient Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.54)		.99					3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) Transfer to Wkst E, Part I line 18 for Part A, and line 35 for Part B. or Transfer to Wkst E, Part II, line 33)							4
	TO BE COMPLETED BY INTERMEDIARY/CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to provider	.01					6.01
		Provider to program	.50					6.50
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)							7
8	Name of Intermediary/Contractor			Intermediary/Contractor Number				8
9	Signature of Authorized Person			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 d

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

PROVIDER NO. _____

PERIOD:
FROM _____
TO _____

WORKSHEET G

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Less: allowances for uncollectible notes and accounts receivable	( )	( )	( )	( )	6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)					11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Less: Accumulated depreciation	( )	( )	( )	( )	14
15	Buildings					15
16	Less Accumulated depreciation	( )	( )	( )	( )	16
17	Leasehold improvements					17
18	Less: Accumulated Amortization	( )	( )	( )	( )	18
19	Fixed equipment					19
20	Less: Accumulated depreciation	( )	( )	( )	( )	20
21	Automobiles and trucks					21
22	Less: Accumulated depreciation	( )	( )	( )	( )	22
23	Major movable equipment					23
24	Less: Accumulated depreciation	( )	( )	( )	( )	24
25	Minor equipment - Depreeciable					25
26	Minor equipment nondepreciable					26
27	Other fixed assets					27
28	TOTAL FIXED ASSETS (Sum of lines 12 - 27)					28
	OTHER ASSETS					
29	Investments					29
30	**Deposits on leases**					**30**
31	Due from owners/officers					31
32	Other assets					32
33	TOTAL OTHER ASSETS (Sum of lines 29 - 34)					33
34	TOTAL ASSETS (Sum of lines 11, 28 and 33)					34

( ) = contra amount

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

PROVIDER NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET G (Cont.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
35	Accounts payable					35
36	Salaries, wages & fees payable					36
37	Payroll taxes payable					37
38	Notes & loans payable (Short term)					38
39	Deferred income					39
40	Accelerated payments					40
41	Due to other funds					41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)					43
	LONG TERM LIABILITIES					
44	Mortgage payable					44
45	Notes payable					45
46	Unsecured loans					46
47	Loans from owners:					47
48	Other long term liabilities					48
49						49
50	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)					50
51	TOTAL LIABILITIES (Sum of lines 43 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement and expansion					58
59	**TOTAL FUND BALANCES** (Sum of lines 50 thru 56)					**59**
60	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)					60

( ) = contra amount

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

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

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

PART I - PATIENT REVENUES

	Revenue Center	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Skilled Nursing Facility				1
2	Nursing facility				2
3	ICF/MR				3
4	Other long term care				4
5	Total general inpatient care services (Sum of lines 1 - 4)				5
	All Other Care Service				
6	Ancillary services				6
7	Clinic				7
8	Home Health Agency				8
9	Ambulance				9
10	RHC				10
11	FQHC & CMHC				11
12	SNF Based Hospice				12
13	Total Patient Revenues (Sum of lines 5 - 12) (Transfer column 3 to Worksheet G-3, Line 1)				13

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			1
2	Add (Specify)			2
3				3
4				4
5				5
6				6
7				7
8	Total Additions (Sum of lines 2 - 7)			8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (Sum of lines 9 - 13)			14
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14) (Transfer to Worksheet G-3, Line 4)			15

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

STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO: _____	PERIOD: FROM _____ TO _____	WORKSHEET G - 3

1	Total patient revenues (From Wkst. G - 2, Part I, col. 3, line 13)		1
2	Less: contractual allowances and discounts on patients accounts		2
3	Net patient revenues (Line 1 minus line 2)		3
4	Less: total operating expenses (From Worksheet G-2, Part II, line 15)		4
5	Net income from service to patients (Line 3 minus 4)		5
6	Other income:		6
7	Contributions, donations, bequests, etc		7
8	Income from investments		8
9	Revenues from communications (Telephone and Internet service)		9
10	Revenue from television and radio service		10
11	Purchase discounts		11
12	Rebates and refunds of expenses		12
13	Parking lot receipts		13
14	Revenue from laundry and linen service		14
15	Revenue from meals sold to employees and guests		15
16	Revenue from rental of living quarters		16
17	Revenue from sale of medical and surgical supplies to other than patients		17
18	Revenue from sale of drugs to other than patients		18
19	Revenue from sale of medical records and abstracts		19
20	Tuition (fees, sale of textbooks, uniforms, etc.)		20
21	Revenue from gifts, flower, coffee shops, canteen		21
22	Rental of vending machines		22
23	Rental of skilled nursing space		23
24	Governmental appropriations		24
25	Other (specify)		25
26	Total other income (Sum of lines 7 - 25)		26
27	Total (Line 5 plus line 26)		27
28	Other expenses (specify)		28
29			29
30			30
31	Total other expenses (Sum of lines 28 - 30)		31
32	Net income (or loss) for the period (Line 27 minus line 31)		32

ANALYSIS OF PROVIDER-BASED
HOME HEALTH AGENCY COSTS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET
H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS												
1	Capital Related-Bldgs. and Fixtures											1
2	Capital Related-Movable Equipment											2
3	Plant Operation & Maintenance											3
4	Transportation (see instructions)											4
5	Administrative and General											5
HHA REIMBURSABLE SERVICES												
6	Skilled Nursing Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech Pathology											9
10	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
13	Drugs											13
14	DME											14
15	Telemedicine											15
HHA NONREIMBURSABLE SERVICES												
16	Home Dialysis Aide Service											16
17	Respiratory Therapy											17
18	Private Duty Nursing											18
19	Clinic											19
20	Health Promotion Activities											20
21	Day Care Program											21
22	Home Delivered Meals Program											22
23	Homemaker Service											23
24	All Others											24
25	Total (sum of lines 1-24)											25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

___
COST ALLOCATION - HHA GENERAL SERVICE COST

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	TOTAL (cols. 4a + 5)	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4a	5	6	
GENERAL SERVICE COST CENTERS										
1	Capital Related-Bldgs. and Fixtures									1
2	Capital Related-Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies (see instructions)									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	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

COST ALLOCATION - HHA STATISTICAL BASIS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-1, PART II

		CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	(SQUARE FEET)	(MILEAGE)		(ACCUM. COST)	
		1	2	3	4	5a	5	
GENERAL SERVICE COST CENTERS								
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General							5
HHA REIMBURSABLE SERVICES								
6	Skilled Nursing Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech Pathology							9
10	Medical Social Services							10
11	Home Health Aide							11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
15	Telemedicine							15
HHA NONREIMBURSABLE SERVICES								
16	Home Dialysis Aide Services							16
17	Respiratory Therapy							17
18	Private Duty Nursing							18
19	Clinic							19
20	Health Promotion Activities							20
21	Day Care Program							21
22	Home Delivered Meals Program							22
23	Homemaker Service							23
24	All Others							24
25	Total (sum of lines 1-24)							25
26	Cost To Be Allocated							26
27	Unit Cost Multiplier							27

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM_____
TO _____

WORKSHEET H
PART I

	HHA COST CENTER (omit cents)	From Wkst H-1 Part I, col. 6, line	HHA TRIAL BALANCE (1)	NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-3)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT					
			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								
9	Drugs	13								
10	DME	14								
11	Telemedicine	15								
12	Home Dialysis Aide Services	16								
13	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.

I-2, **ALLOCATION OF GENERAL SERVICE** COSTS TO HHA COST CENTERS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM_____
TO _____

WORKSHEET H
PART I (CONT.)

		CORF COST CENTER (omit cents)	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			7	8	9	10	11	12	13
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.

I-2, **ALLOCATION OF GENERAL SERVICE** COSTS TO HHA COST CENTERS | **PROVIDER NO.:** _____ HHA NO.: _____ | **PERIOD:** FROM _____ TO _____ | **WORKSHEET H-2, PART I (CONT.)**

		HHA COST CENTER (omit cents)	INTERNS & RESIDENTS		OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3a-16)	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 17 ± 18)	ALLOCATED HHA A&G (see Part II)	TOTAL HHA COSTS
			SALARY AND FRINGES	PROGRAM 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.

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM_____
TO _____

WORKSHEET H-2, PART II

	HHA COST CENTER	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	3	3A	4	5	
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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART II (CONT.)

	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		6	7	8	9	10	11	
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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-2, PART II (CONT.)

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	OTHER GENERAL SERVICE (SPECIFY)	
		12	13	14	15	16	
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

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H-3, Parts I & II

Check applicable box [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation Patient Services	From, Wkst. H-2, Part I, col. 21, line -	Facility Costs (From Wkst. H-2, Part I) 1	Shared Ancillary Costs (From Part II) 2	Total HHA Costs (cols. 1 + 2) 3	Total Visits 4	Average Cost Per Visit (col. 3 ÷ col. 4) 5	Program Visits: Part A 6	Program Visits: Part B Not Subject to Deductibles & Coinsurance 7	Program Visits: Part B Subject to Deductibles & Coinsurance 8	Cost of Services: Part A 9	Cost of Services: Part B Not Subject to Deductibles & Coinsurance 10	Cost of Services: Part B Subject to Deductibles & Coinsurance 11	Total Program Cost (sum of cols. 9-10) 12
1 Skilled Nursing Care	2												
2 Physical Therapy	3												
3 Occupational Therapy	4												
4 Speech Pathology	5												
5 Medical Social Services	6												
6 Home Health Aide	7												
7 Total (sum of lines 1-6)													

Supplies and Drugs Cost Computations Other Patient Services	From Wkst. H-2, Part I, col. 21, line -	Facility Costs (From Wkst. H-2, Part I) 1	Shared Ancillary Costs (From Part II) 2	Total HHA Cost (cols. 1 + 2) 3	Total Charges (from HHA Record) 4	Ratio (col. 3 ÷ col. 4) 5	Program Covered Charges: Part A 6	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance 7	Program Covered Charges: Part B Subject to Deductibles & Coinsurance 8	Cost of Services: Part A 9	Cost of Services: Part B Not Subject to Deductibles Coinsurance 10	Cost of Services: Part B Subject to Deductibles Coinsurance 11
8 Cost of Medical Supplies	8											
9 Cost of Drugs	9											

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

	From Wkst. C, col. 3 line -	Cost to Charge Ratio 1	Total HHA Charge (From Provider records) 2	HHA Shared Ancillary Cost (Col.1 X Col 2) 3	Transfer to Part I as indicated 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

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET H-4, Parts I & II

Check Applicable Box [ ] Title V [ ] Title XVIII [ ] Title XIX

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	**Excess reasonable cost (from line 8)**			**23**
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
31	Subtotal (line 29 plus/minus line 30)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for fiscal intermediary use only)			33
34	Balance due provider/program (line 31 minus lines 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER- BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: HHA NO.:	PERIOD: FROM TO	WORKSHEET H-5

	Description			Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero.(1)		.01					3.01
			.02					3.02
		Program	.03					3.03
		to	.04					3.04
		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) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)							4
	TO BE COMPLETED BY INTERMEDIARY/CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program	.01					5.01
		to	.02					5.02
		Provider	.03					5.03
		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) based on the cost report (see instructions)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	**TOTAL MEDICARE PROGRAM LIABILITY** (see instructions)							**7**
8	Name of Intermediary/Contractor				Intermediary Number			8
9	Signature of Authorized Person				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.

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

Check Applicable Box: [ ] RHC [ ] FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (Col. 1 + Col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (Col. 3 +/- Col. 4)	ADJUSTMENTS	NEW EXPENSES FOR ALLOCATION (Col. 5 +/- Col.6)	
		1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS									
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (Sum of lines 1 - 9)								10
COSTS UNDER AGREEMENT									
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (Sum of lines 11 - 13)								14
OTHER HEALTH CARE COSTS									
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation - Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Pass-through cost.								20
21	Subtotal (Sum of lines 15 - 19, less line 20)								21
22	Total Cost of Health Care Services (Sum of lines 10, 14, and 21)								22
COSTS OTHER THAN RHC/FQHC SERVICES									
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other non reimbursable costs								26
27	Nonallowable GME Pass-through cost								27
28	Total nonreimbursable costs (Sum of lines 23 - 27)								28
FACILITY OVERHEAD									
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (Sum of lines 29-30)								31
32	Total Facility Costs (Sum of lines 22, 28 and 31)								32

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

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

Check Applicable Box: [ ] RHC [ ] FQHC

PART I - VISITS AND PRODUCTIVITY

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

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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET I - 3

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

Check Applicable Box: [ ] RHC [ ] FQHC

PART I - DETERMINATION OF RATE FOR RHC / FQHC SERVICES				
1	Total Allowable Cost of RHC/FQHC Services (From Worksheet I - 2, Part II, line 20)			1
2	Cost of vaccines and their administration (From Worksheet I-4, line 15)			2
3	Total Allowable Cost Excluding Vaccine (Line 1 minus line 2)			3
4	Total FTE's and VISITS (From Worksheet I-2, column 5, line 8)			4
5	Physicians Visits Under Agreement (From Worksheet I - 2, column 5, line 9)			5
6	Total Adjusted Visits (line 4 plus line 5)			6
7	Adjusted Cost Per Visit (line 3 divided by line 6)			7
CALCULATION OF LIMIT	Lines 8 through 14: Fiscal year providers use columns 1 and 2. Lines 8 through 14: Calendar year providers use column 2 only.	Prior to January 1 1	On or after January 1 2	
8	Rate per visit limit (From your intermediary/contractor)			8
9	Rate for Medicare Covered Visits (See instructions)			9
PART II - CALCULATION OF SETTLEMENT				
10	Medicare Covered Visits Excluding Mental Health Services (From intermediary/contractor Records)			10
11	Medicare Cost Excluding Costs for Mental Health Services (Line 9 x line 10)			11
12	Medicare Covered Visits for Mental Health Services (From Intermediary/Contractor Records)			12
13	Medicare Covered Cost from Mental Health Services (Line 9 x line 12)			13
14	Limit Adjustment for Mental Health Services (See instructions)			14
15	Allowable GME Pass-through Cost (See instructions)			15
16	Total Medicare Cost (Sum of line 11 column 1 and 2, plus line 14 columns 1 and 2, plus line 15.			16
17	Primary payer amounts			17
18	Less: Beneficiary Deductible for RHC only. (See instructions)(From intermediary/contractor records)			18
19	Net Medicare Cost Excluding Vaccines (Line 16 minus sum of lines 17 and 18)			19
20	Reimbursable Cost of RHC/FQHC Services, Excluding Vaccine (80% of line 19)			20
21	Program cost of vaccines and their administration (From 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 dual eligible beneficiaries (See Instructions)			24
25	Other Adjustments			25
26	Net reimbursable amount (Line 22 plus line 23, plus or minus line 25)			26
27	Interim payments (From Worksheet I-5, line 4)			27
28	**Tentative settlement (for fiscal intermediary/contractor use only)**			**28**
29	Balance due Component/Program (line 26 minus lines 27 and 28)			29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			30

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET I - 4

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

Check Applicable Box: [ ] RHC [ ] FQHC

	CALCULATION OF COST	PNEUMOCOCCAL 1	INFLUENZA 2	
1	Health care staff cost (from Worksheet I -1, column 7, line 10)			1
2	Ratio of PNEUMOCOCCAL and influenza vaccine staff time to total health care staff time			2
3	PNEUMOCOCCAL and influenza vaccine health care staff cost (Line 1 x line 2)			3
4	Medical supplies cost - PNEUMOCOCCAL and influenza vaccine (From your records)			4
5	Direct cost of PNEUMOCOCCAL and influenza vaccine (Sum of lines 3 and 4)			5
6	Total direct cost of the facility (From Wkst. I -1, col. 7, line 22)			6
7	Total overhead (From Worksheet I - 2, line 18)			7
8	Ratio of PNEUMOCOCCAL and influenza vaccine direct cost to Total direct cost (Line 5 divided by Line 6)			8
9	Overhead cost - PNEUMOCOCCAL and influenza vaccine (Line 7 x Line 8)			9
10	Total PNEUMOCOCCAL and influenza vaccine cost and its (their) administration (Sum of lines 5 and 9)			10
11	Total number of PNEUMOCOCCAL and influenza vaccine injections (From your records)			11
12	Cost per PNEUMOCOCCAL and influenza vaccine injection (Line 10 divided by Line 11)			12
13	Number of PNEUMOCOCCAL and influenza vaccine injections Administered to medicare beneficiaries			13
14	Medicare cost of PNEUMOCOCCAL and influenza vaccine and its (their) administration (Line 12 x line 13)			14
15	Total Cost of PNEUMOCOCCAL and influenza vaccine and its (their) administration (Sum of columns 1 and 2, line 10) (Transfer this amount to Worksheet I-3, line 2)			15
16	Total medicare cost of PNEUMOCOCCAL and influenza vaccine and its (their) administration (Sum of columns 1 and 2, line 14) (Transfer this amount to Worksheet I-3, line 21)			16

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

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

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor, for services rendered in the cost reporting period. If none, write "none", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.55)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Worksheet I-3: line 27)					4

TO BE COMPLETED BY INTERMEDIARY / CONTRACTOR

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99			5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to Provider	.01			6.01
			.02			6.02
		Provider to Program	.50			6.50
			.51			6.51
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7
8	Name of Intermediary/Contractor			Intermediary/Contractor Number		8
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.

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

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

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

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

	COMPONENT COST CENTER (Omit Cents)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS-TRATION	
		5	6	7	8	9	
1	Administrative and General						1
2	Skilled Nursing						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
	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).

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

	COMPONENT COST CENTER (Omit Cents)	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	INTERNS & RESIDENTS	OTHER GENERAL SERVICE	
		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	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).

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

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

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

	COMPONENT COST CENTER (Omit Cents)	CAPITAL RELATED COST: COST BUILDS. & FIXTURES (Square Feet)	CAPITAL RELATED COST: COST MOVABLE EQUIPMENT (Value or Square Feet	EMPLOYEE BENEFITS (Gross Salaries)	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		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

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR C.M.H.C.

PROVIDER NO.: **COMPONENT NO.: _____**

PERIOD: **FROM _____** **TO _____**

WORKSHEET J - 1 **PART II (Cont.)**

	COMPONENT COST CENTER (Omit Cents)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE - KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS TRATION (Direct Nursing Hours of Service)	
		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

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

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

COMPUTATION OF C.M.H.C. REHABILITATION COSTS	PROVIDER NO.: COMPONENT NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET J - 2 PART I

PART I - APPORTIONMENT OF REHABILITATION COST CENTERS

		TOTAL COSTS (FR. WKST. J-1 PART I, Col. 20)	TOTAL CHARGES	RATIO OF COSTS TO CHARGES (1)	TITLE V		TITLE XVIII		TITLE XIX		
					CHARGES	COSTS (Col 3 X Col 4)	CHARGES	COSTS (Col 3 X col 6)	CHARGES	COSTS (Col. 3 X Col 6)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	App. Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment - Rented										19
20	Durable Medical Equipment - Sold										20
21	Other General Service Cost										21
22	Totals (Sum of lines 2-21) (2)										22

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COMPUTATION OF C.M.H.C. REHABILITATION COSTS	PROVIDER NO.: COMPONENT NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET J - 2 PART II

PART II - APPORTIONMENT OF COST OF REHAB SERVICES FURNISHED BY SHARED DEPARTTMENTS

		RATIO OF COSTS TO CHARGES	TITLE V		TITLE XVIII		TITLE XIX		
			CHARGES	COSTS (Col 3 X Col 4)	CHARGES	COSTS (Col 3 X col 6)	CHARGES	COSTS (Col. 3 X Col 8)	
		3	4	5	6	7	8	9	
23	Oxygen (Inhalation) Therapy								23
24	Physical Therapy								24
25	Occupational Therapy								25
	Speech Pathology								26
27	Medical Supplies Charged to Patients								27
28	Drugs Charged to Patients								28
29	Other Costs Furnished by shared Departments								29
30	Total (Sum of lines 23 through 29)								30
31	Total component cost. Add the amount from Part I, line 22 and the amount from line 30, columns 5, 7, and 9. (Transfer Titles V , XVIII, and XIX amounts to Worksheet J-3, columns 1,2 & 3 respectively.)								31

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT OF C.M.H.C. SERVICES	PROVIDER NO.: / COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET J -

		Title V PROGRAM COST	Title XVIII PROGRAM COST	Title XIX PROGRAM COST
		1	2	3
1	Cost of REHAB services (From Wkst. J-2, Part II, line. 31: Title V - col. 5; Title XVIII 'col 7; Title XIX - column 9)			
2	Amounts paid and payable by Worker's Compensation and other primary payers			
3	Subtotal (Line 1 minus line 2)			
4	Part B deductible billed to Program patients (Exclude coinsurance amounts)			
5	Net Cost (Line 3 minus line 4)			
6	80% of Part B cost (80% X line 5)			
7	Actual coinsurance billed to Program patients (From provider records)			
8	Net cost less actual billed coinsurance (Line 5 minus line 7)			
9	Reimbursable bad debts (See Instructions)			
10	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
11	Net reimbursable amount (See Instructions)			
12	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			
13	Recovery of excess depreciation resulting from facility's termination or a decrease in Program utilization			
14	Other Adjustments			
15	Total cost - reimbursable to provider			
16	Interim payments			
17	**Balance due Component/Program** (Line 15 minus line 16) (Indicate overpayments in brackets)			
18	Protested amounts (Non allowable cost report items) in accordance with 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 4155)

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

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "none", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period.	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
	Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.55)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Worksheet J-3: Part I line 17)					4

TO BE COMPLETED BY INTERMEDIARY/CONTRACTOR

5	List separately each tentative settlement payment after desk review.	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
	Also show date of each payment. If none, write "NONE," or enter a zero.(1)	Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52)		.99			5.99
6	Determined net settlement amount (balance due) based on the cost report. (1)	Program to Provider	.01			6.01
			.02			6.02
		Provider to Program	.50			6.50
			.51			6.51
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7
8	Name of Intermediary/Contractor			Intermediary/Contractor Number		8
9	Signature of Authorized Person			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.

FORM CMS 2540-10 (1210) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4156)

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

PROVIDER NO.: _____ **PERIOD:**
HOSPICE NO.: FROM _____
TO _____

WORKSHEET K

	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	TOTAL (cols. 1-5)	RECLASSI-FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance											3
4	Transportation - Staff											4
5	Volunteer Service Coordination											5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
10	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
12	Physical Therapy											12
13	Occupational Therapy											13
14	Speech/ Language Pathology											14
15	Medical Social Services											15
16	Spiritual Counseling											16
17	Dietary Counseling											17
18	Counseling - Other											18
19	Home Health Aide and Homemaker											19
20	HH Aide & Homemaker-Cont. Home Care											20
21	Other											21
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
23	Analgesics											23
24	Sedatives / Hypnotics											25
25	Other - Specify											25
26	Durable Medical Equipment/Oxygen											26
27	Patient Transportation											27
28	Imaging Services											28
29	Labs and Diagnostics											29
30	Medical Supplies											30
31	**Outpatient Services (including E/R Dept.)**											**31**
32	Radiation Therapy											32
33	Chemotherapy											33
34	Other											34
	HOSPICE NONREIMBURSABLE SERVICE											
35	Bereavement Program Costs											35
36	Volunteer Program Costs											36
37	Fundraising											37
38	Other Program Costs											38
39	Total (sum of lines 1 thru 38)											39

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

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	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.										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total										39

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

HOSPICE COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO: HOSPICE NO: PERIOD: FROM _____ TO _____ WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care- Continuous Home Care										10
11	Nursing 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.										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total										39

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

FORM CMS-2540-10

HOSPICE COMPENSATION ANALYSIS
CONTRACTED SERVICES / PURCHASED SERVICES

PROVIDER NO: _____

HOSPICE NO:

PERIOD:
FROM _____
TO _____

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Moveable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	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.										
35	Bereavement Program Costs										35
36	Volunteer Program Costs										36
37	Fundraising										37
38	Other Program Costs										38
39	Total										39

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

	COST ALLOCATION - HOSPICE GENERAL SERVICE COST	PROVIDER NO:		HOSPICE NO: _____		PERIOD: FROM _____ TO _____		WORKSHEET K-4 PART I		
	COST CENTER DESCRIPTIONS	FR. WKST. K COL. 10: NET EXPENSES FOR COST ALLOC. (1)	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	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										
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										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

(1) Column 0, line 29 must agree with Wkst. A, column 7, line 83.

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

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION MILEAGE	VOLUNTEER SERV. COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-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								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								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
49	Cost To be Allocated (per Wkst K-4, Part I)								49
50	Unit Cost Multiplier								50

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER NO.:

HOSPICE NO.:

PERIOD
FROM:_____
TO: _____

WORKSHEET K-5, PART I

	HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 6, line -	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED BLDGS. & FIXTURES	CAPITAL RELATED MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-3)	ADMINIS-TRATIVE & GENERAL	
			0	1	2	3	4A	4	
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:** Column 16, line 1 divided by the sum of column 16, line 39, minus column 16, line 1, rounded to 6 decimal places.								**50**

(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)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:			PERIOD FROM:_____ TO: _____		WORKSHEET K-5, Part I (Cont.)		
	HOSPICE COST CENTER (omit cents)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
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:** Column 16, line 1 divided by the sum of column 16, line 39, minus column 16, line 1, rounded to 6 decimal places.								**50**

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER NO.:

HOSPICE NO.:

PERIOD
FROM:_____
TO: _____

WORKSHEET K-5, Part I (Cont.)

	HOSPICE COST CENTER (omit cents)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS	OTHER GENERAL SERVICE	SUBTOTAL (Sum of Columns 4a through 15)	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
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:** Column 16, line 1 divided by the sum of column 16, line 39, minus column 16, line 1, rounded to 6 decimal places.								**50**

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER NO.: HOSPICE NO.:		PERIOD FROM:_____ TO: _____		WORKSHEET K-5, PART II		
	HOSPICE COST CENTER (omit cents)		CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL LATION	ADMINIS-TRATIVE & GENERAL (Accum. Cost)	
			1	2	3	4a	4	
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)							39
50	**Unit Cost Multiplier**							**50**

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER NO.:

HOSPICE NO.:

PERIOD
FROM:_____
TO: _____

WORKSHEET K-5, Part II (Cont.)

	HOSPICE COST CENTER (omit cents)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6		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								38
39	Totals (sum of lines 1-28)								39
50	**Unit Cost Multiplier**								**50**

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

	HOSPICE COST CENTER (omit cents)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	INTERNS & RESIDENTS (Assigned Time)	OTHER GENERAL SERVICE (Specify)				
		12	13	14	15				
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)								39
50	**Unit Cost Multiplier**								**50**

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER NO.: HOSPICE NO.:	PERIOD: From: To:	WORKSHEET K-5 Part III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	Hospice shared cost computation	Facility Cost From Worksheet K-5, Part I		Cost to Charge Ratio From Worksheet C, Col. 3		Total Hospice Charges (From Provider Records)	Hospice Shared Ancillary Costs (col. 4 x col. 5)	
	COST CENTER	Line:	Amount:	Line :	Ratio			
		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

CALCULATION OF PER DIEM COST	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET K-(

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

6

1
2
3
4
5
6
7
8
9
10
11
12
13