

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 CCN: _____	PERIOD : FROM _____ TO _____	WORKSHEET S PARTS I, II & III
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronic filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. If this is an amended report enter the number of times the provider resubmitted this cost report. _____	Date: _____ Time: _____
Contractor use only:	4. <input type="checkbox"/> Cost Report Status <input type="checkbox"/> 1] As Submitted <input type="checkbox"/> 2] Settled without audit <input type="checkbox"/> 3] Settled with audit <input type="checkbox"/> 4] Reopened <input type="checkbox"/> 5] Amended	5. Date Received _____ 6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. If line 4, column 1 is "4": Enter number of times reopened _____ 11. Contractor Vendor Code _____

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE 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 RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS)

I HEREBY CERTIFY that I have read the above *certification* 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 Name(s) and Provider CCN(s)} for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, *and that the services* identified in this cost report were provided in compliance with such laws and regulations.

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-Mentally Retarded					3
4 SNF - BASED HHA					4
5 SNF - BASED RHC					5
6 SNF - BASED FQHC					6
7 SNF - BASED CMHC					7
100 TOTAL					100

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART I
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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 0	Component Name 1	Provider CCN 2	Date Certified 3	Payment System (P, O or N)			
					V 4	XVIII 5	XIX 6	
4	SNF							4
5	Nursing Facility							5
6	ICF - Mentally Retarded							6
7	SNF-Based HHA							7
8	SNF-Based RHC							8
9	SNF-Based FQHC							9
10	SNF-Based CMHC							10
11	SNF-Based OLTC							11
12	SNF-Based HOSPICE							12
13	OTHER (specify)							13
14	Cost Reporting Period (mm/dd/yyyy)	From:	To:					14
15	Type of Control (see instructions)							15

Type of Freestanding Skilled Nursing Facility

		Y / N					
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						17
18	Are there any costs included in Worksheet A <i>that</i> resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.						18

Miscellaneous Cost Reporting Information

19	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.						19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)						19.01

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.

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? (Y?N)						27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)						28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I
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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 HHA				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
36	SNF-Based OLTC				36

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. (Y/N)	Y / N			37
38	Are you legally required to carry malpractice insurance? (Y/N)				38
39	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made," enter 1. If the policy is "occurrence", enter 2.				39

		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 "Y", check box, and submit supporting schedule listing cost centers and amounts.	Y / N				42
43	<i>Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?</i>					43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.					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:	P.O. Box:			46	
47	City:	State:	ZIP Code			47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART II
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General Instruction: For all column 1 responses, enter in column 1, "Y" for Yes or "N" for No
For all dates responses, use the format mm/dd/yyyy.

Completed by All Skilled Nursing Facilities

Provider Organization and Operation		Y/N	Date	
		1	2	
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

		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare Program? If column 1 is "Y", 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		Y/N	Type	Date	
		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, 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		Y/N	Y/N	
		1	2	
6	Column 1: Were costs claimed for nursing school? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)			6
7	Were costs claimed for allied health programs? (Y/N) (see instructions)			7
8	Were approvals and/or renewals obtained during the cost reporting period for nursing school and/or allied health program? (Y/N) (see instructions)			8

Bad Debts		Y/N		
		1		
9	Is the provider seeking reimbursement for bad debts? (Y/N) (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 Report Data		Y/N Part A	Date Part A	Y/N Part B	Date Part B	
		1	2	3	4	
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", were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16
17	If line 13 or 14 is "Y", 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 CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART I
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PART I - STATISTICAL DATA

Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					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-Mentally Retarded														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

Component	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 - Mentally Retarded												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

SNF WAGE INDEX INFORMATION	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PARTS II & III
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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	Home office personnel					4
5	Sum of lines 2 through 4					5
6	Revised wages (line 1 minus line 5)					6
7	Other Long Term Care					7
8	Home Health Agency					8
9	CMHC					9
10	Hospice					10
11	Other excluded areas					11
12	Subtotal excluded salary (sum of lines 7 through 11)					12
13	Total adjusted salaries (line 6 minus line 12)					13
OTHER WAGES AND RELATED COSTS						
14	Contract Labor: Patient Related & Mgmt					14
15	Contract Labor: Physician services-Part A					15
16	Home office salaries & wage related costs					16
WAGE RELATED COSTS						
17	Wage related costs core (see Pt. IV)					17
18	Wage related costs other (see Pt. IV)					18
19	Wage related costs (excluded units)					19
20	Physicians Part A - WRC					20
21	Physicians Part B - WRC					21
22	Total adjusted wage related cost (see instructions)					22

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	Nursing and Allied Health Ed. Act.					12
13	Other General Service (specify _____)					13
14	Total (sum lines 1 through 13)					14

SNF WAGE RELATED COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART IV
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PART IV - Wage Related Cost

Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
PLAN ADMINISTRATIVE COSTS (Paid to External Organizations)			
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
HEALTH AND INSURANCE COST			
8	Health Insurance (Purchased or Self Funded)		8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
TAXES			
17	FICA - Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (sum of lines 1 -23)		24
Part B Other than Core Related Cost			
25	Other Wage Related Costs (specify)		25

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART V
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OCCUPATIONAL CATEGORY	Amount Reported 1	Fringe Benefits 2	Adjusted Salaries (col. 1 + col. 2) 3	Paid Hours Related to Salary in col. 3 4	Average Hourly Wage (col. 3 ÷ col. 4) 5
Direct Salaries					
Nursing Occupations					
1 Registered Nurses (RNs)					1
2 Licensed Practical Nurses (LPNs)					2
3 Certified Nursing Assistants/Nursing Assistants/Aides					3
4 Total Nursing (sum of lines 1 through 3)					4
Physical Therapists					
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
13					13
Contract Labor					
Nursing Occupations					
14 Registered Nurses (RNs)					14
15 Licensed Practical Nurses (LPNs)					15
16 Certified Nursing Assistants/Nursing Assistants/Aides					16
17 Total Nursing (sum of lines 14 through 16)					17
Physical Therapists					
18 Physical Therapy Assistants					18
19 Physical Therapy Aides					19
20 Occupational Therapists					20
21 Occupational Therapy Assistants					21
22 Occupational Therapy Aides					22
23 Speech Therapists					23
24 Respiratory Therapists					24
25 Other Medical Staff					25
26					26

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SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CCN: HHA <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET S-4
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HOME HEALTH AGENCY STATISTICAL DATA

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)		Staff 1	Contract 2	Total 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 in column 1 the number of CBSAs where you provided services during the cost reporting period.		21
22	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 contains the first code).		22

PPS ACTIVITY DATA	Full Episodes		LUPA Episodes 3	PEP only Episodes 4	Total (cols. 1 through 4) 5	
	Without Outliers 1	With Outliers 2				
23	Skilled Nursing Visits					23
24	Skilled Nursing Visit Charges					24
25	Physical Therapy Visits					25
26	Physical Therapy Visit Charges					26
27	Occupational Therapy Visits					27
28	Occupational Therapy Visit Charges					28
29	Speech Pathology Visits					29
30	Speech Pathology Visit Charges					30
31	Medical Social Service Visits					31
32	Medical Social Service Visit Charges					32
33	Home Health Aide Visits					33
34	Home Health Aide Visit Charges					34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)					35
36	Other Charges					36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)					37
38	Total Number of Episodes (standard/non outlier)					38
39	Total Number of Outlier Episodes					39
40	Total Non-Routine Medical Supply Charges					40

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER CCN: COMPONENT <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET S-5
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Check applicable box: RHC FQHC

Clinic Address and Identification:

1	Street:	County:	1
2	City:	State:	Zip Code:
3	Designation (for FQHC's only) - "U" for urban or "R" for rural		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? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.	1	2	10
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Facility hours of operations (1)

Type of Operation	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) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). 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?	1	2	12
13 Is this a consolidated cost report in accordance with IOM CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14 Provider Name:	CCN Number:		14

SKILLED NURSING FACILITY BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-6
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Check applicable box: CMHC CORF OPT OOT OSP

Enter the number of hours in your normal workweek _____

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

		Staff	Contract	Total (col. 1 + col. 2)
		1	2	3
1	Administrator and Assistant Administrator(s)			1
2	Director(s) and Assistant Director(s)			2
3	Other Administrative Personnel			3
4	Direct Nursing Service			4
5	Nursing Supervisor			5
6	Physical Therapy Service			6
7	Physical Therapy Supervisor			7
8	Occupational Therapy Service			8
9	Occupational Therapy Supervisor			9
10	Speech Pathology Service			10
11	Speech Pathology Supervisor			11
12	Medical Social Service			12
13	Medical Social Service Supervisor			13
14	Respiratory Therapy Service			14
15	Respiratory Therapy Supervisor			15
16	Psychiatric/Psychological Service			16
17	Psychiatric/Psychological Service Supervisor			17
18	Other (specify)			18
19	Other (specify)			19

PROSPECTIVE PAYMENT FOR SNF STATOSTOCA; DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-7
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	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 CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-7
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	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

A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I line 1 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. (If column 2 is zero, enter N/A in column 3) (see instructions)

	Expenses	Percentage	Y/N	
101	Staffing			101
102	Recruitment			102
103	Retention of employees			103
104	Training			104
105	Other (Specify)			105
106	Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)			106

HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD :	WORKSHEET S - 8
	HOSPICE <i>CCN</i> :	FROM _____ TO _____	

PART I - ENROLLMENT DAYS

	Unduplicated Days						
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col. 1, 2 & 5)	
	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	All Other	Total (sum of col. 1, 2 & 5)	
	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 (line 5 / line 6)						8
9	Unduplicated census count						9

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET A		
Cost Center Description			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)
A	B	C	1	2	3	4	5	6	7
GENERAL SERVICE COST CENTERS									
1	0100	Capital-Related Costs - Buildings & Fixtures							1
2	0200	Capital-Related Costs - Moveable Equipment							2
3	0300	Employee Benefits							3
4	0400	Administrative and General							4
5	0500	Plant Operation, Maintenance and Repairs							5
6	0600	Laundry and Linen Service							6
7	0700	Housekeeping							7
8	0800	Dietary							8
9	0900	Nursing Administration							9
10	1000	Central Services and Supply							10
11	1100	Pharmacy							11
12	1200	Medical Records and Library							12
13	1300	Social Service							13
14	1400	Nursing and Allied Health Education							14
15		Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS									
30	3000	Skilled Nursing Facility							30
31	3100	Nursing Facility							31
32	3200	ICF - Mentally Retarded							32
33	3300	Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS									
40	4000	Radiology							40
41	4100	Laboratory							41
42	4200	Intravenous Therapy							42
43	4300	Oxygen (Inhalation) Therapy							43
44	4400	Physical Therapy							44
45	4500	Occupational Therapy							45
46	4600	Speech Pathology							46
47	4700	Electrocardiology							47

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET A (Cont.)		
Cost Center Description			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase /Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)
A	B	C	1	2	3	4	5	6	7
48	4800	Medical Supplies Charged to Patients							48
49	4900	Drugs Charged to Patients							49
50	5000	Dental Care - Title XIX only							50
51	5100	Support Surfaces							51
52		Other Ancillary Service Cost							52
OUTPATIENT SERVICE COST CENTERS									
60	6000	Clinic							60
61	6100	Rural Health Clinic (RHC)							61
62	6200	FQHC							62
63		Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS									
70	7000	Home Health Agency Cost							70
71	7100	Ambulance							71
72		Outpatient Rehabilitation (specify)							72
73	7300	CMHC							73
74		Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS									
80	8000	Malpractice Premiums & Paid Losses							-0-
81	8100	Interest Expense							- 0 -
82	8200	Utilization Review							- 0 -
83	8300	Hospice							83
84		Other Special Purpose Cost							84
89		SUBTOTALS (sum of lines 1 through 84)							89
NON REIMBURSABLE COST CENTERS									
90	9000	Gift, Flower, Coffee Shops and Canteen							90
91	9100	Barber and Beauty Shop							91
92	9200	Physicians' Private Offices							92
93	9300	Nonpaid Workers							93
94	9400	Patients' Laundry							94
95		Other Nonreimbursable Cost							95
100		TOTAL							100

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	I N C R E A S E				D E C R E A S E				
		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
100	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2))									100

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

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-7
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	Description	Beginning Balances 1	Acquisitions			Disposals and Retirements 5	Ending Balance 6	Fully Depreciated Assets 7	
			Purchases 2	Donation 3	Total 4				
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 7 minus line 8)								9

ADJUSTMENTS TO EXPENSES		PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-8	
Description (1)	Basis for Adjustment (2)	Amount	Expense Classification on Wkst. A to/from which the amount is to be adjusted		
			Cost Center	Line No.	
0	1	2	3	4	
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. (Chapter 23)					10
11 Nonallowable costs related to certain Capital expenditures (Chapter 24)					11
12 Adjustment resulting from transactions with related organizations (Chapter 10)	Worksheet A-8-1				12
13 Laundry and Linen service					13
14 Revenue - Employee meals					14
15 Cost of meals - Guests					15
16 Sale of medical supplies to other than patients					16
17 Sale of drugs to other than patients					17
18 Sale of medical records and abstracts					18
19 Vending machines					19
20 Income from imposition of interest, finance or penalty charges (Chapter 21)					20
21 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22 Utilization review--physicians' compensation (Chapter 21)			Utilization Review- SNF	82	22
23 Depreciation--buildings and fixtures			Capital Related Cost- Building	1	23
24 Depreciation--movable equipment			Capital Related Cost-Movable	2	24
25 Other Adjustment					25
100 TOTAL (sum of lines 1 through 99) (transfer to Wkst. A, col. 6, line 100)					100

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-8-1
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PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A., col. 5	Adjustments (col. 4 minus col. 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS (sum of lines 1-9) (Transfer column 6, line 10 to Wkst. A-8, col. 3, line 12)						10

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND / OR HOME OFFICE

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

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

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

(1) Use the followings 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 organization.
- E. Individual is director, officer, administrator or key person of provider and related organization.
- F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify _____

PROVIDER - BASED PHYSICIANS ADJUSTMENTS	PROVIDER CCN: _____	PERIOD : FROM _____ TO _____	WORKSHEET A-8-2
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	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
	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 Col. 14	Adjusted R C E Limit	R C E Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	100	TOTAL								100

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS- TRATIVE & GENERAL	
	0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							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							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - 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 Electrocardiology							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							52

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 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	Outpatient Rehabilitation (specify)						72
73	CMHC						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 Nonreimbursable Cost						95
98	Cross Foot Adjustments						98
99	Negative Cost Center						99
100	Total						100

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS 5	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9	CENTRAL SERVICES & SUPPLY 10	PHARMACY 11	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures							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							14
15	Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF - 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	Electrocardiology							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							52

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS 5	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9	CENTRAL SERVICES & SUPPLY 10	PHARMACY 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	Outpatient Rehabilitation (specify)							72
73	CMHC							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 Nonreimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 18	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								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								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF - 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 Electrocardiology								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								52

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 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	Outpatient Rehabilitation (specify)							72
73	CMHC							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 Nonreimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	0	CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCILIATION 4 A	ADMINISTRATIVE & GENERAL (Accumulated Cost)	4
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							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							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - 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 Electrocardiology							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							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	0	CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accumulated Cost)	
		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 Outpatient Rehabilitation (specify)							72
73 CMHC							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 Nonreimbursable Cost							95
98 Cross Foot Adjustment							98
99 Negative Cost Center							99
102 Cost to be allocated (Per Wkst. B, Pt I.)							102
103 Unit Cost Multiplier (Wkst. B, Pt I.)							103
104 Cost to be allocated (Per Wkst. B, Pt. II)							104
105 Unit Cost Multiplier (Wkst B, Pt. II)							105

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures							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							14
15	Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF - 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	Electrocardiology							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							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	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	Outpatient Rehabilitation (specify)							72
73	CMHC							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 Nonreimbursable Cost							95
98	Cross Foot Adjustment							98
99	Negative Cost Center							99
102	Cost to be allocated (Per Wkst. B, Pt I.)							102
103	Unit Cost Multiplier (Wkst. B, Pt I.)							103
104	Cost to be allocated (Per Wkst. B, Pt. II)							104
105	Unit Cost Multiplier (Wkst B, Pt. II)							105

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent) 12	SOCIAL SERVICE (Time Spent) 13	NURSING & ALLIED HEALTH EDUCATION (Assigned Time) 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 18	
GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures							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							14
15	Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF - 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	Electrocardiology							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							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent) 12	SOCIAL SERVICE (Time Spent) 13	NURSING & ALLIED HEALTH EDU EDUCATION (Assigned Time) 14	GENERAL SERVICE COST COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 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	Outpatient Rehabilitation (specify)							72
73	CMHC							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 Nonreimbursable Cost							95
98	Cross Foot Adjustment							98
99	Negative Cost Center							99
102	Cost to be allocated (Per Wkst. B, Pt I.)							102
103	Unit Cost Multiplier (Wkst. B, Pt I.)							103
104	Cost to be allocated (Per Wkst. B, Pt. II)							104
105	Unit Cost Multiplier (Wkst B, Pt. II)							105

ALLOCATION OF CAPITAL - RELATED COSTS				PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET B PART II	
Cost Center Description	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 - Buildings & Fixtures							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							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - 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 Electrocardiology							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							52

ALLOCATION OF CAPITAL - RELATED COSTS				PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART II		
Cost Center Description	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 Outpatient Rehabilitation (specify)								72
73 CMHC								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 Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART II
Cost Center Description	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS-TRATION 9	CENTRAL SERVICES & SUPPLY 10	PHARMACY 11	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							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							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - 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 Electrocardiology							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							52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART II
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINISTRATION	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	Outpatient Rehabilitation (specify)						72
73	CMHC						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 Nonreimbursable Cost						95
98	Cross Foot Adjustments						98
99	Negative Cost Center						99
100	Total						100

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART II	
Cost Center Description	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 18	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								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								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF - 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 Electrocardiology								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								52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET B PART II	
Cost Center Description	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE COST 15	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	TOTAL 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	Outpatient Rehabilitation (specify)							72
73	CMHC							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 Nonreimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET B-2
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	Description	Worksheet B		Amount	
		Part No.	Line No.		
	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

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET C
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Cost Center Description	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 Electrocardiology				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				52
OUTPATIENT SERVICE COST CENTERS				
60 Clinic				60
61 Rural Health Clinic (RHC)				61
62 FQHC				62
63 Other Outpatient Service Cost				63
71 Ambulance				71
100 Total				100

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PART I
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Check applicable box:	<input type="checkbox"/> Title V (1)	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX (1)
Check applicable box:	<input type="checkbox"/> SNF	<input type="checkbox"/> NF	<input type="checkbox"/> ICF/MR
	<input type="checkbox"/> Other _____	<input type="checkbox"/> PPS - Must also complete Part II	

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

Cost Center Description	Ratio of Cost to Charges (from Wkst. C, col. 3)	Health Care Program Charges		Healthcare Program Cost	
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)
		1	2	3	4
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 Electrocardiology					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					52
OUTPATIENT COST CENTERS					
60 Clinic					60
61 Rural Health Clinic (RHC)					61
62 FQHC					62
63 Other Outpatient Service Cost					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.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PARTS II & III
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TITLE XVIII ONLY

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)		1
2	Program vaccine charges (From your records or the PS&R report)		2
3	Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E, Pt. I, line 1)		3

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

Cost Center Description	Total Cost (from Wkst. B, Pt. I, col. 18)	Nursing & Allied Health (from Wkst. B, Pt. I, col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (col. 2 / col. 1)	Program Part A Cost (from Wkst. D., Pt. I, col. 4)	Part A Nursing & Allied Health Costs for Pass Through (col. 3 x col. 4)	
	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 Electrocardiology						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						52
100 Total (sum of lines 40 - 52)						100

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D-1 PARTS I & II
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Check applicable box: Title V Title XVIII Title XIX
 Check applicable box: 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 on line 8 divided by private room days on 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 on 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 11)		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, Pt. II, col. 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	Inpatient routine 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 Wkst. E, Pt. II, line 4) (see instructions)		28

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

1	Total inpatient days		1
2	Program inpatient days (from Wkst. S-3, Pt. I, cols. 3, 4 or 5, line 1 or 2 as applicable)		2
3	Total nursing & allied health costs (see instructions)		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

(1) Lines 26, 27 and 28 are not applicable for title XVIII, but may be used for title V and or title XIX

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART I
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PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1	Inpatient PPS amount (see instructions)	1
2	Nursing and Allied Health Education Activities (pass through payments)	2
3	Subtotal (sum of lines 1 and 2)	3
4	Primary payor amounts	4
5	Coinsurance	5
6	Reimbursable bad debts (from your records)	6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	7
8	Adjusted reimbursable bad debts (see instructions)	8
9	Recovery of bad debts - for statistical records only	9
10	Utilization review	10
11	Subtotal (see instructions)	11
12	Interim payments (see instructions)	12
13	Tentative adjustment	13
14	Other adjustment (see instructions)	14
14.99	Sequestration amount (see instructions)	14.99
15	Balance due provider/program (see instructions) (Indicate overpayment in parentheses)	15
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	16

PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17	Ancillary services Part B	17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)	18
19	Total reasonable costs (sum of lines 17 and 18)	19
20	Medicare Part B ancillary charges (see instructions)	20
21	Cost of covered services (lesser of line 19 or line 20)	21
22	Primary payor amounts	22
23	Coinsurance and deductibles	23
24	Reimbursable bad debts (from your records)	24
24.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	24.02
25	Subtotal (sum of lines 21 and 24.02, minus lines 22 and 23)	25
26	Interim payments (see instructions)	26
27	Tentative adjustment	27
28	Other Adjustments (Specify _____) (see instructions)	28
28.99	Sequestration amount (see instructions)	28.99
29	Balance due provider/program (see instructions) (indicate overpayments in parentheses)	29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	30

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART II
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Check applicable box: <input type="checkbox"/> Title V <input type="checkbox"/> Title XIX
Check applicable box: <input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF/MR

COMPUTATION OF NET COST OF COVERED SERVICES

1	Inpatient ancillary services (see instructions)		1
2	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)		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	Outpatient service charges		12
13	Inpatient routine service charges		13
14	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		14
15	Total reasonable charges		15

CUSTOMARY CHARGES

16	Aggregate amount actually collected from patients liable for payment for services on a charge basis		16
17	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)		17
18	Ratio of line 16 to line 17 (not to exceed 1.000000)		18
19	Total customary charges (see instructions)		19

COMPUTATION OF REIMBURSEMENT SETTLEMENT

20	Cost of covered services (see instructions)		20
21	Deductibles		21
22	Subtotal (line 20 minus line 21)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Reimbursable bad debts (from your records)		25
26	Subtotal (sum of lines 24 and 25)		26
27	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		27
28	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		28
29	Other adjustments (Specify _____) (see instructions)		29
30	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		30
31	Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		31
32	Interim payments		32
33	Balance due provider/program (line 31 minus line 32) (indicate overpayments in parentheses) (see instructions)		33

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E-1	
Description	Inpatient 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, enter zero.					2	
2 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	.02			3.01	
		.03			3.02	
		.04			3.03	
		.05			3.04	
		.50			3.05	
	Provider to Program	.51				3.51
		.52				3.52
		.53				3.53
		.54				3.54
		.99				3.99
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)						
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99) (Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)					4	
TO BE COMPLETED BY 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
		.99				5.99
SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)						
6 Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01	
	Provider to Program	.02			6.02	
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7	
8 Name of Contractor	Contractor Number				8	

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G
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	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
Assets					
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 - Depreciable					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 - 32)					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 CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G
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	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Liabilities and Fund Balances	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 Other (specify)					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 52 thru 58)					59
60 TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)					60

() = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G - 1
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	General Fund		Special 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 31)									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 5 - 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 13 - 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 CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G - 2 PARTS I & II
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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-Mentally Retarded			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/FQHC			10
11	CMHC			11
12	SNF based hospice			12
13	Other (specify)			13
14	Total patient revenues (sum of lines 5 - 13) (transfer to Wkst. G-3, col. 3, line 1)			14

PART II - OPERATING EXPENSES

1	Operating Expenses (per Wkst. 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)			15

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

ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS						PROVIDER CCN: HHA <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET H		
COST CENTER DESCRIPTIONS	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	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 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

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 CCN:

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 through 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									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

COST ALLOCATION - HHA STATISTICAL BASIS					PROVIDER CCN:	PERIOD :	WORKSHEET H-1,		
					HHA <i>CCN</i> :	FROM _____	PART II		
						TO _____			
	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE (Square Feet)	TRANS- PORTATION (Mileage)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						0
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								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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN:

HHA *CCN*:

PERIOD:
FROM _____
TO _____

WORKSHEET H-2,
PART I

	From Wkst. H-1, Pt. I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
HHA COST CENTER		0	1	2	3	3A	4	5	6	
1 Administrative and General	5									1
2 Skilled Nursing Care	6									2
3 Physical Therapy	7									3
4 Occupational Therapy	8									4
5 Speech Pathology	9									5
6 Medical Social Services	10									6
7 Home Health Aide	11									7
8 Supplies	12									8
9 Drugs	13									9
10 DME	14									10
11 Telemedicine	15									11
12 Home Dialysis Aide Services	16									12
13 Respiratory Therapy	17									13
14 Private Duty Nursing	18									14
15 Clinic	19									15
16 Health Promotion Activities	20									16
17 Day Care Program	21									17
18 Home Delivered Meals Program	22									18
19 Homemaker Service	23									19
20 All Others	24									20
21 Totals (sum of lines 1-20) (2)										21
22 Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.										22

- (1) Column 0, line 21 must agree with Wkst. A, col. 7, line 70.
- (2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN:

HHA *CCN*:

PERIOD:

FROM _____
TO _____

WORKSHEET H-2,
PART I

		HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		7	8	9	10	11	12	13	
<i>HHA</i> COST CENTER									
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) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN:

HHA CCN:

PERIOD :

FROM _____

TO _____

WORKSHEET H-2, PART I

HHA COST CENTER		NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
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) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II	
HHA COST CENTER	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (Gross Salaries)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accumulated Cost)	OPERATION OF PLANT (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	
	BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						
	1	2	3	4A	4	5	6	
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 CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II		
HHA COST CENTER			HOUSE-KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)
			7	8	9	10	11	12	13
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	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 CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II	
HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (SPECIFY)	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
	14	15	16	17	18	19	20	
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 CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-3, Parts I & II
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Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation	From, Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Costs (col. 1 + col. 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			Cost of Services			Total Program Cost (sum of cols. 9-10)	
							Part A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
Patient Services														
	1	2	3	4	5	6	7	8	9	10	11	12		
1 Skilled Nursing Care	2													1
2 Physical Therapy	3													2
3 Occupational Therapy	4													3
4 Speech Pathology	5													4
5 Medical Social Services	6													5
6 Home Health Aide	7													6
7 Total (sum of lines 1-6)														7

Patient Services by CBSA						CBSA No. (1)	Program Visits				
							Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
						1	2	3	4		
8 Skilled Nursing Care											8
9 Physical Therapy											9
10 Occupational Therapy											10
11 Speech Pathology											11
12 Medical Social Services											12
13 Home Health Aide											13
14 Total (sum of lines 8-13)											14

Supplies and Drugs Cost Computations	From Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Cost (cols. 1 + 2)	Total Charges (from HHA records)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services				
							Part A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
Other Patient Services														
	8	1	2	3	4	5	6	7	8	9	10	11		
15 Cost of Medical Supplies	8													15
16 Cost of Drugs	9													16

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	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Pt. 1 -
		1	2	3	4
1 Physical Therapy	44				col. 2, line 2
2 Occupational Therapy	45				col. 2, line 3
3 Speech Pathology	46				col. 2, line 4
4 Cost of Medical Supplies	48				col. 2, line 15
5 Cost of Drugs	49				col. 2, line 16

(1) The CBSA numbers flow from Wkst. S-4, line 22, and subscripts as indicated should be replicated on lines 8-13.

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD :	WORKSHEET H-4, Parts I & II
	HHA <i>CCN</i> :	FROM _____ TO _____	

Check applicable box: Title V Title XVIII Title XIX

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

Description	Part A 1	Part B		
		Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 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 through 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
30.99 Sequestration amount (see instructions)			30.99
31 Subtotal (line 29 plus/minus line 30)			31
32 Interim payments (see instructions)			32
33 Tentative settlement (for contractor use only)			33
34 Balance due provider/program (see instructions)			34
35 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER - BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: HHA CCN :	PERIOD : FROM _____ TO _____	WORKSHEET H-5
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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, 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	.02				3.01	
			.03				3.02	
			.04				3.03	
			.05				3.04	
			.50				3.05	
		Provider to Program	.51					3.50
			.52					3.51
			.53					3.52
			.54					3.53
			.99					3.54
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)						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 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 - 5.49 minus sum of lines 5.50 - 5.98)						5.99		
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01				6.01	
		Provider to Program	.02				6.02	
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7		
8	Name of Contractor	Contractor Number				8		

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

ANALYSIS OF SNF - BASED RURAL HEALTH CLINIC / FEDERALLY QUALIFIED HEALTH CENTER COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I-1
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Check applicable box: RHC FQHC

	COMPEN- SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 +/- col.6)
		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
21	Subtotal (sum of lines 15 - 19)						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
28	Total nonreimbursable costs (sum of lines 23 - 26)						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 CCN:	PERIOD :	WORKSHEET I-2
	COMPONENT CCN:	FROM _____ TO _____	

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	Physicians		4200			1
2	Physician Assistants		2100			2
3	Nurse Practitioners		2100			3
4	Subtotal (sum of lines 1 - 3)					4
5	Visiting Nurse					5
6	Clinical Psychologist					6
7	Clinical Social Worker					7
8	Medical Nutrition Therapist (FQHC only)					8
9	Diabetes Self Management Training (FQHC only)					9
10	Total FTEs and visits (sum of lines 4 - 9)					10
11	Physician Services Under Agreements					11

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

12	Total costs of health care services (from Wkst. I-1, col. 7, line 22)		12
13	Total nonreimbursable costs (from Wkst I-1, col 7, line 28)		13
14	Cost of all services - excluding overhead (sum of lines 12 and 13)		14
15	Ratio of RHC / FQHC services (line 12 divided by line 14)		15
16	Total facility overhead (from Wkst. I-1, col. 7, line 31)		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 15 X line 18)		19
20	Total allowable cost of RHC / FQHC services (sum of lines 12 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 CCN:	PERIOD :	WORKSHEET I-3
	COMPONENT CCN:	FROM _____ TO _____	

Check applicable box:	<input type="checkbox"/> Title V	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC	

PART I - DETERMINATION OF RATE FOR RHC / FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. I-2, Pt. II, line 20)		1
2	Cost of vaccines and their administration (from Wkst. I-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total FTEs and visits (from Wkst. I-2, col. 5, line 10)		4
5	Physicians' visits under agreement (from Wkst. I-2, col. 5, line 11)		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.	Prior to January 1	On or after January 1	
Lines 8 through 14: Calendar year providers use column 2 only.	1	2	
8 Rate per visit limit (from your contractor)			8
9 Rate for Program covered visits (see instructions)			9

PART II - CALCULATION OF SETTLEMENT

10	Program covered visits excluding mental health services (from contractor records)		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		11
12	Program covered visits for mental health services (from contractor records)		12
13	Program covered cost for mental health services (line 9 x line 12)		13
14	Limit adjustment for mental health services (see instructions)		14
15	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 and 2)		15
15.01	Total Program charges (see instructions) (from contractor records)		15.01
15.02	Total Program preventive charges (see instructions) (from provider records)		15.02
15.03	Total Program preventive costs ((line 15.02/line 15.01) times line 15)		15.03
15.04	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17) times .80)		15.04
15.05	Total Program cost (see instructions)		15.05
16	Primary payer amounts		16
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17
18	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18
19	Net Program cost excluding vaccines (see instructions)		19
20	Program cost of vaccines and their administration (from Wkst. I-4, line 16)		20
21	Total reimbursable Program cost (line 19 plus 20)		21
22	Reimbursable bad debts		22
22.01	Adjusted reimbursable bad debts (see instructions)		22.01
23	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		23
24	Other adjustments		24
25	Net reimbursable amount (see instructions)		25
25.01	Sequestration amount (see instructions)		25.01
26	Interim payments (from Wkst. I-5, line 4)		26
27	Tentative settlement (for contractor use only)		27
28	Balance due component/Program (see instructions)		28
29	Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2		29

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN:	PERIOD :	WORKSHEET I-4
	<i>COMPONENT CCN:</i>	FROM _____ TO _____	

Check applicable box:	<input type="checkbox"/> Title V	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC	

CALCULATION OF COST		PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 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 Wkst. 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 cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			15
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			16

ANALYSIS OF PAYMENTS TO SNF - BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET I - 5
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Check applicable box: <input type="checkbox"/> RHC <input type="checkbox"/> FQHC
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Description	mm/dd/yyyy		Amount
	1	2	
1 Total interim payments paid to provider			1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/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 - 3.49 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. I-3, line 26)			4

TO BE COMPLETED BY 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 - 5.49 minus sum of lines 5.50 - 5.98)		.99	5.99
6 Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01	6.01
	Provider to Program	.02	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			7
8 Name of Contractor	Contractor Number		8

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

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I
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COMPONENT COST CENTER	NET EXPENSES FOR COST ALLOCATION 0	CAPITAL RELATED COST		EMPLOYEE BENEFITS 3	SUBTOTAL (cols. 0 through 3) 3A	ADMINISTRATIVE & GENERAL 4	
		BUILDS. & FIXTURES 1	MOVABLE EQUIPMENT 2				
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 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 <i>All Other</i>							21
22 Totals (sum of lines 1-21) (1)							22
23 Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, 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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I
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COMPONENT COST CENTER		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 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	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	<i>All Other</i>						21
22	Totals (sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, 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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I
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COMPONENT COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	
	10	11	12	13	14	15	
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 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 <i>All Other</i>							21
22 Totals (sum of lines 1-21) (1)							22
23 Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, 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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I
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COMPONENT COST CENTER	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	SUBTOTAL 18	ALLOCATED A & G (see Pt. II) 19	TOTAL (sum of cols. 18 and 19) 20	
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 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 <i>All Other</i>						21
22 Totals (Sum of lines 1-21) (1)						22
23 Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, 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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II
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COMPONENT COST CENTER		CAPITAL RELATED		EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION 4A	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	
		BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)				
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	<i>All Other</i>						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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II
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COMPONENT COST CENTER		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 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	<i>All Other</i>						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 CMHC	PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II
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COMPONENT COST CENTER		CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE ()	
		10	11	12	13	14	15	
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	<i>All Other</i>							21
22	Totals (sum of lines 1-21)							22
23	Total cost to be allocated							23
24	Unit Cost Multiplier							24

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN:	PERIOD :	WORKSHEET J - 2 PART I
	<i>COMPONENT CCN:</i>	FROM _____ TO _____	

PART I - APPORTIONMENT OF CMHC COST CENTERS

	Total Costs (from Wkst. J-1, Pt. I, col. 20)	Total Charges	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)		
				1	2	3	4	5	6		7
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	App. Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment - Rented										19
20	Durable Medical Equipment - Sold										20
21	<i>All Other</i>										21
22	Totals (sum of lines 2-21)										22

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART II
	COMPONENT CCN:		

PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED BY SHARED DEPARTMENTS

	Ratio of Costs to Charges 3	Title V		Title XVIII		Title XIX		
		Charges 4	Costs (col. 3 x col. 4) 5	Charges 6	Costs (col. 3 x col. 6) 7	Charges 8	Costs (col. 3 x col. 8) 9	
23	Oxygen (Inhalation) Therapy							23
24	Physical Therapy							24
25	Occupational Therapy							25
26	Speech Pathology							26
27	Medical Supplies Charged to Patients							27
28	Drugs Charged to Patients							28
29	Other Costs Furnished by shared Departments							29
30	Total (sum of lines 23 through 29)							30
31	Total component cost (sum of Pt. I, line 22 and Pt. II, line 30) (Transfer to Wkst. J-3)							31

(1) Part II - From Wkst. C, col. 3, lines as applicable

CALCULATION OF REIMBURSEMENT SETTLEMENT OF COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES	PROVIDER CCN:	PERIOD :	WORKSHEET J-3
	<i>COMPONENT CCN :</i>	FROM _____ TO _____	

Check applicable box: Title V Title XVIII Title XIX

		PROGRAM COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 31)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
CUSTOMARY CHARGES			
6	Total charges for program services		6
7	Excess of customary charges over reasonable cost (see instructions)		7
8	Excess of reasonable cost over customary charges (see instructions)		8
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
9	Total reasonable cost (see instructions)		9
10	Part B deductible billed to program patients		10
11	Part B coinsurance billed to program patients (from provider records)		11
12	Net cost (line 9 minus lines 10 and 11)		12
13	Reimbursable bad debts (from provider records) (see instructions)		13
<i>13.01</i>	<i>Adjusted reimbursable bad debts (see instructions)</i>		<i>13.01</i>
14	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		14
15	Net reimbursable amount (see instructions)		15
16	Other adjustments (see instructions) (specify)		16
17	Total cost (line 15 plus or minus line 16)		17
<i>17.01</i>	<i>Sequestration amount (see instructions)</i>		<i>17.01</i>
18	Interim payments (see instructions)		18
19	Tentative settlement (for contractor use only)		19
20	Balance due component/program (line 17 minus lines 18 and 19)		20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		21

ANALYSIS OF PAYMENTS TO PROVIDER - BASED CMHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		PROVIDER CCN: <i>COMPONENT CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET J - 4
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1	Description	mm/dd/yyyy	Amount		
			1	2	
1	Total interim payments paid to provider			1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/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	
		Provider to Program	.03	3.03	
			.04	3.04	
			.05	3.05	
			.50	3.50	
			.51	3.51	
			.52	3.52	
				.53	3.53
				.54	3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)	.99	3.99		
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. J-3: Pt. I, line 18)		4		

TO BE COMPLETED BY 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
			.99	5.99
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01	6.01
		Provider to Program	.02	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			7
8	Name of Contractor	Contractor Number		8

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

ANALYSIS OF PROVIDER - BASED HOSPICE COSTS						PROVIDER CCN:	PERIOD :	WORKSHEET K		
						<i>HOSPICE CCN :</i>	FROM _____			
							TO _____			
COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see instruc.)	CON- TRACTED SERVICES (from Wkst. K-3)	OTHER	TOTAL (cols. 1 through 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									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 (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 through 38)									39

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN:

PERIOD :

WORKSHEET K-1

HOSPICE CCN:

FROM _____
TO _____

COST CENTER DESCRIPTIONS	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-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										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 (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 through 38)										39

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

HOSPICE COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-2

HOSPICE CCN:

COST CENTER DESCRIPTIONS	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-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										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 (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 through 38)										39

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

HOSPICE COMPENSATION ANALYSIS
 CONTRATED SERVICES / PURCHASED SERVICES

PROVIDER CCN:

PERIOD :
 FROM _____
 TO _____

WORKSHEET K-3

HOSPICE CCN:

COST CENTER DESCRIPTIONS	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-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										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 (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 through 38)										39

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

COST ALLOCATION - HOSPICE
GENERAL SERVICE COST

PROVIDER CCN:

HOSPICE CCN:

PERIOD :

FROM _____
TO _____

WORKSHEET K-4
PART I

COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC. (1) (from Wkst. K, col. 10)	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (cols. 0 through 5)	ADMINIS-TRATIVE & GENERAL	TOTAL
		BUILDS. & FIXTURES	MOVABLE EQUIPMENT						
	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									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									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 (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 through 38)									39

COST ALLOCATION - HOSPICE
STATISTICAL BASIS

PROVIDER CCN:

HOSPICE CCN:

PERIOD :

FROM _____
TO _____

WORKSHEET K-4
PART II

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		PLANT OPERATION & MAINT. (Square Feet)	TRANS-PORTATION (Mileage)	VOLUNTEER SERVICE COORDINATOR (Hours)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	TOTAL
	BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						
	1	2	3	4	5	6A	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								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								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 (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 Cost to be allocated (per Wkst. K-4, Pt. I)								39
40 Unit Cost Multiplier								40

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS			PROVIDER CCN: <i>HOSPICE CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET K-5, PART I			
HOSPICE COST CENTER (1)	From Wkst. K-4, Pt. I, col. 7, line -	HOSPICE TRIAL BALANCE	CAPITAL RELATED		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINISTRATIVE & GENERAL	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	3A	4	
1	Administrative and General	6						1
2	Inpatient - General Care	7						2
3	Inpatient - Respite Care	8						3
4	Physician Services	9						4
5	Nursing Care	10						5
6	Nursing Care- Continuous Home Care	11						6
7	Physical Therapy	12						7
8	Occupational Therapy	13						8
9	Speech/ Language Pathology	14						9
10	Medical Social Services - Direct	15						10
11	Spiritual Counseling	16						11
12	Dietary Counseling	17						12
13	Counseling - Other	18						13
14	Home Health Aide and Homemakers	19						14
15	HH Aide & Homemaker - Cont. Home Care	20						15
16	Other	21						16
17	Drugs, Biologicals and Infusion	22						17
18	Analgesics	23						18
19	Sedative/Hypnotics	24						19
20	Other - Specify	25						20
21	Durable Medical Equipment/Oxygen	26						21
22	Patient Transportation	27						22
23	Imaging Services	28						23
24	Labs and Diagnostics	29						24
25	Medical Supplies	30						25
26	Outpatient Services (incl. E/R Dept.)	31						26
27	Radiation Therapy	32						27
28	Chemotherapy	33						28
29	Other	34						29
30	Bereavement Program Costs	35						30
31	Volunteer Program Costs	36						31
32	Fundraising	37						32
33	Other Program Costs	38						33
34	Totals (sum of lines 1 through 33)							34
35	Unit Cost Multiplier							35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER CCN: <i>HOSPICE CCN:</i>			PERIOD : FROM _____ TO _____		WORKSHEET K-5 Part I	
HOSPICE COST CENTER (1)		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
		5	6	7	8	9	10	11
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care- Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech/ Language Pathology							9
10	Medical Social Services - Direct							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemakers							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biologicals and Infusion							17
18	Analgesics							18
19	Sedative/Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (incl. E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1 through 33)							34
35	Unit Cost Multiplier							35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		PROVIDER CCN: <i>HOSPICE CCN:</i>			PERIOD : FROM _____ TO _____		WORKSHEET K-5 Part I	
HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE 15	SUBTOTAL (sum of cols. 3A through 15) 16	ALLOCATED HOSPICE A & G (see Pt. II) 17	TOTAL HOSPICE COSTS 18	
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care- Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech/ Language Pathology							9
10	Medical Social Services - Direct							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemakers							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biologicals and Infusion							17
18	Analgesics							18
19	Sedative/Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (incl. E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1 through 33)							34
35	Unit Cost Multiplier							35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: <i>HOSPICE CCN:</i>		PERIOD : FROM _____ TO _____		WORKSHEET K-5, PART II	
HOSPICE COST CENTER (1)		CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION 4A	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	
		1	2	3		4	
1	Administrative and General						1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care						5
6	Nursing Care- Continuous Home Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech/ Language Pathology						9
10	Medical Social Services - Direct						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemakers						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biologicals and Infusion						17
18	Analgesics						18
19	Sedative/Hypnotics						19
20	Other - Specify						20
21	Durable Medical Equipment/Oxygen						21
22	Patient Transportation						22
23	Imaging Services						23
24	Labs and Diagnostics						24
25	Medical Supplies						25
26	Outpatient Services (incl. E/R Dept.)						26
27	Radiation Therapy						27
28	Chemotherapy						28
29	Other						29
30	Bereavement Program Costs						30
31	Volunteer Program Costs						31
32	Fundraising						32
33	Other Program Costs						33
34	Totals (sum of lines 1 through 33)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier						36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: <i>HOSPICE CCN:</i>			PERIOD : FROM _____ TO _____		WORKSHEET K-5 PART II		
HOSPICE COST CENTER (1)		PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: <i>HOSPICE CCN:</i>			PERIOD : FROM _____ TO _____		WORKSHEET K-5 PART II	
HOSPICE COST CENTER (1)		MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (Specify)	SUBTOTAL	ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS
		12	13	14	15	16	17	18
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care- Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech/ Language Pathology							9
10	Medical Social Services - Direct							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemakers							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biologicals and Infusion							17
18	Analgesics							18
19	Sedative/Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (incl. E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1 through 33)							34
35	Total cost to be allocated							35
36	Unit Cost Multiplier							36

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: <i>HOSPICE CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part III
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PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

COST CENTER	Wkst. C, col. 3, line:	Cost to Charge Ratio	Total Hospice Charges (from provider records)	Hospice Shared Ancillary Costs (col. 1 x col. 2)
	0	1	2	3
ANCILLARY SERVICE COST CENTERS				
1 Physical Therapy	44			1
2 Occupational Therapy	45			2
3 Speech/ Language Pathology	46			3
4 Drugs, Biologicals and Infusion	49			4
5 Labs and Diagnostics	41			5
6 Medical Supplies	48			6
7 Radiation Therapy	40			7
8 Other	52			8
9 Total (sum of lines 1-8)				9

CALCULATION OF PER DIEM COST		PROVIDER CCN: <i>HOSPICE CCN:</i>	PERIOD : FROM _____ TO _____	WORKSHEET K-6
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		Title XVIII	Title XIX	Other	Total	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Wkst. S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Wkst. S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Wkst. S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Wkst. S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Wkst. S-8, line 5, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other unduplicated days (Wkst. S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13