DRAFT	FORM CMS-2540-10	4190 (Cont.)
This report is required by law (42 USC 139	5g: 42 CER 413 20(b)) Failure to report can result in all interim	EORM APPROVED

-	de since the beginning of the cost reporting period being	-			OMB NO. 0938-0463
SKILLED I	NURSING FACILITY AND SKILLED NURSING HEALTH CARE COMPLEX COST REPORT	PROVIDER CCN:	PERIOD : FROM	WORKSHEET S PARTS I, II & III	OMB 100. 0530-0403
CERTIFICA	ATION AND SETTLEMENT SUMMARY		то		
PART I - 0	COST REPORT STATUS				
Provider	[ ] Electronic filed cost report	Date:	Time:		
use only	2. [ ] Manually submitted cost report				
	<ol><li>If this is an amended report ente</li></ol>	r the number of times the provid	er resubmitted this cost report	_	
Contractor	4. [ ] Cost Report Status		Received		
use only:	[ 1 ] As Submitted:		actor No.		
	[ 2 ] Settled without audit		First Cost Report for this Provider CCN		
	[ 3 ] Settled with audit		Last Cost Report for this Provider CCN	Í	
	[4] Reopened	9. NPR	Date:	. 1	
	[ 5 ] Amended		4, column 1 is "4": Enter number of the actor Vendor Code	mes reopened	
		11. Colid	actor velidor Code		
PART II -	CERTIFICATION				
ADMINIST THROUGH AND/OR IN CERT I HEE and th period prepa regard	SENTATION OR FALSIFICATION OF ANY INFORM RATIVE ACTION, FINE AND/OR IMPRISONMENT I THE PAYMENT DIRECTLY OR INDIRECTLY OF AMPRISONMENT MAY RESULT.  FIFICATION BY OFFICER OR ADMINISTRATOR OF REBY CERTIFY that I have read the above certification is not be Balance Sheet and Statement of Revenue and Expenses to beginning and ending red from the books and records of the provider in accordating the provision of health care services, and that the services OR ADMINISTRATOR OF PROVIDER	UNDER FEDERAL LAW. FUR A KICKBACK OR WERE OTHER F PROVIDERS)  statement and that I have examine as prepared by and that to the best of my leance with applicable instructions vices identified in this cost report	ed the accompanying electronically file [Provider Name(s) and Provider Name(s) and Provider Name(s) and Provider Name(s) and St. except as noted. I further certify that t were provided in compliance with st.	TIFIED IN THIS REPORT WERE PROVITL, AND ADMINISTRATIVE ACTION  and or manually submitted cost report  revoider CCN(s)} for the cost reporting  atement are true, correct, complete and  I am familiar with the laws and regulation  ich laws and regulations.	N, FINES
]	Printed Name		Signed		
	Title		Date		
PART III -	SETTLEMENT SUMMARY				
		THE P. L.	TITLE XVIII	D TIME E TIME	
		TITLE V	A 2	B TITLE XIX 3	4
1 SKII	LLED NURSING FACILITY	1		3	1
	SING FACILITY				2
3 I C F					3
	- BASED HHA				4
5 SNF	- BASED RHC				5

100 TOTAL

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

6 SNF - BASED FQHC 7 SNF - BASED CMHC

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.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Rev. 41-303

	(Cont.)	FORM	и CMS-2540-10					D	
SKILL	ED NURSING FACILITY AND SKILLED NURSING		PROVIDER CC	PROVIDER CCN:		PERIOD:		WORKSHEET S-2	
	ITY HEALTH CARE COMPLEX				FROM		PART I		
IDENT	IFICATION DATA				то				
			•						
Skilled	Nursing Facility and Skilled Nursing Facility Complex Address:								
1	Street:	P.O. Box:							
2	City:	State:	ZIP Code						
	County:	CBSA Code:	Urban / Rural:						
	· ·	-	•						
SNF ar	nd SNF - Based Component Identification:								
							Payment System		
				Provider	Date		(P, O or N)		
	Component	Compoi	nent Name	CCN	Certified	V	XVIII	XIX	
	0	<del>-</del>	1	2	3	4	5	6	
4	SNF								
	Nursing Facility								
	I C F/IID								
	SNF-Based HHA								
	SNF-Based RHC								
	SNF-Based FOHC				1				
	SNF-Based CMHC				1				
	SNF-Based OLTC								
	SNF-Based HOSPICE								
	OTHER (specify)			-	1				
	Cost Reporting Period (mm/dd/yyyy) From:	To:							
	Type of Control (see instructions)	1			<del>                                     </del>				
- 10	Type of control (see moduletons)								
Type o	of Freestanding Skilled Nursing Facility			Y/N					
	Is this a distinct part skilled nursing facility that meets the requirements set forth in	1 42 CFR section 483 5?		- ,					
	Is this a composite distinct part skilled nursing facility that meets the requirements		483 5?						
	Are there any costs included in Worksheet A that resulted from transactions with a								
	organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksh								
	organizations as defined in early 1 and 15 1, enapter 101 in yes, complete woman			ļ					
Miscell	aneous Cost Reporting Information								
	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.								
	If the response to line 19 is "Y", does this cost report meet your contractor's criterion	a for filing a low utilization	cost report? (Y/N)						
13.01	If the response to line 15 is 17, aloes and cost report meet your conductor's criteria	a for fining a low damzadon (	(1/14)						
Denrec	iation - Enter the amount of depreciation reported in this SNF for the method indica	ated on lines 20 - 22							
	Straight Line	aca on mics 20 22.							
	Declining Balance								
	Sum of the Year's Digits			+					
	Sum of line 20 through 22								
	If depreciation is funded, enter the balance as of the end of the period.			+					
	Were there any disposal of capital assets during the cost reporting period? (Y/N)								
	Was accelerated depreciation claimed on any assets in the current or any prior cos	t reporting period2 (V/N)							
	Did you cease to participate in the Medicare program at end of the period to which		?N)						
	Was there a substantial decrease in health insurance proportion of allowable cost f								
20	1 trus arere a substantial accrease in nearth insurance proportion of allowable cost i	rom prior cost reports: (1/1)	' <i>)</i>	1					

41-304

46 Street:

47 City

P.O. Box:

State

11-12 FORM CM			4190		
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX	PROVIDER CCN	FROM		WORKSHEET S- PART I	-2
IDENTIFICATION DATA		TO			
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of			Part	Part	1
costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.			A	В	Other
29 Skilled Nursing Facility					
30 Nursing Facility					
31 I C F/IID					
32 SNF-Based HHA					
33 SNF-Based RHC					
34 SNF-Based FQHC					
35 SNF-Based CMHC					
36 SNF-Based OLTC					
			Y / N		
37 Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given	for Titles V & XIX pati	ients. (Y/N)			
38 Are you legally required to carry malpractice insurance? (Y/N)					
39 Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made," enter 1. If the policy is "oc	ccurrence", enter 2.				
	Prem	niums	Paid Losses	Self in	surance
41 List malpractice premiums and paid losses:					
		Y / N		_	
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.					
43 Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?					
44 If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.					
If this facility is not of a hair region is a single property of the house of the h					
If this facility is part of a chain organization, enter the name and address of the home office on the lines below.	Control at an N		Contracto N	.h	
45 Name:	Contractor Name:		Contractor Num	iber:	

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4190 (Cont.)	FORM CMS-2540-10			11-12
SKILLED NURSING FACILITY AND SKILLED NURSING	PROVIDER CCN:	PERIOD:	WORKSHEET S-2	
FACILITY HEALTH CARE COMPLEX		FROM	PART II	
REIMBURSEMENT QUESTIONNAIRE		то		
		•		
General Instruction: For all column 1 responses, enter in column 1, "Y" for Y	es or "N" for No			
For all dates responses, use the format mm/dd/yyyy.				
			<u> </u>	

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					
			1101	T 5:	_
Provider Organization and Operation			Y/N 1	Date 2	4
Has the provider changed ownership immediately prior to the beginning of the cost reporting	period?		1 1	2	+
If column 1 is "Y", enter the date of the change in column 2. (see instructions)					
		Y/N	Date	V/I	
		1	2	3	+
2 Has the provider terminated participation in the Medicare Program? If column 1 is "Y",			<u> </u>		1
enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involu					
3 Is the provider involved in business transactions, including management contracts, with indiv					
entities (e.g., chain home offices, drug or medical supply companies) that are related to the pr					
its officers, medical staff, management personnel, or members of the board of directors throu	gh				
ownership, control, or family and other similar relationships? (see instructions)		1			
		Y/N	Type	Date	
Financial Data and Reports		1	2	3	1
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 co	mplete copy				
or enter date available in column 3. (see instructions) If no, see instructions.					
5 Are the cost report total expenses and total revenues different from those on the filed financia	l				
statements? If column 1 is "Y", submit reconciliation.					
			Y/N	Y/N	$\neg$
Approved Educational Activities			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)					
7 Were costs claimed for allied health programs? (Y/N) (see instructions)					
8 Were approvals and/or renewals obtained during the cost reporting period for nursing school a	and/or				
allied health program? (Y/N) (see instructions)					
				Y/N	
Bad Debts				1	+-
<ul> <li>9 Is the provider seeking reimbursement for bad debts? (Y/N) (see instructions)</li> <li>10 If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting</li> </ul>	pariod2 If "V" submit copy				+
11 If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.	period: If f, Sublifit copy.				
11 If the 5 to 1 , are putern deductions and of combatance warred. If 1 , see instructions.				ļ.	
Bed Complement					
12 Have total beds available changed from prior cost reporting period? If "Y", see instructions.					
	Y/N	Date	Y/N	Date	1
	Part A	Part A	Part B	Part B	
PS&R Report Data	1	2	3	4	1
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)					
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.  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?			l		
If "Y", see instructions.					
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.					
17 If line 13 or 14 is "Y", were adjustments made to PS&R data for Other?					
Describe the other adjustments:					
18 Was the cost report prepared only using the provider's records? If "Y", see instructions.					

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SKILLED NURSING FACILITY AND	PROVIDER CCN:	PERIOD:	WORKSHEET S-3
SKILLED NURSING FACILITY HEALTH CARE COMPLEX		FROM	PART I
STATISTICAL DATA		то	

	Number	Bed		Inpatient Days / Visits				Discharges				
	of	Days	Title	Title	Title			Title	Title	Title		
Component	Beds	Available	V	XVIII	XIX	Other	Total	V	XVIII	XIX	Other	Total
	1	2	3	4	5	6	7	8	9	10	11	12
1 Skilled Nursing Facility												
2 Nursing Facility												
3 ICF / IID												
4 Home Health Agency												
5 Other Long Term Care												
6 SNF-Based CMHC												
7 Hospice												
8 Total (sum of lines 1-7)												

										Full	Time
		Average Length of Stay					Admissions			Equivalent	
	Title	Title	Title		Title	Title	Title			Employees	Nonpaid
Component	V	XVIII	XIX	Total	V	XVIII	XIX	Other	Total	on Payroll	Workers
	13	14	15	16	17	18	19	20	21	22	23
1 Skilled Nursing Facility											
2 Nursing Facility											
3 ICF / IID											
4 Home Health Agency											
5 Other Long Term Care											
6 SNF-Based CMHC											

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4190 (Cont.)	FORM	CMS-2540-10			DR	AFT
SNF WAGE INDEX INFORMATION	PROVIDER CCN:		PERIOD: FROM TO	WORKSHEET S-3 PARTS II & III		
PART II - DIRECT SALARIES						
	Amount	Reclass. of Salaries from Wkst.	Adjusted Salaries ( col. 1 ±	Paid Hours Related to Salary	Average Hourly Wage ( col. 3 ÷	

			Reclass.	Adjusted	Paid Hours	Average	
			of Salaries	Salaries	Related	Hourly Wage	
		Amount	from Wkst.	( col. 1 ±	to Salary	( col. 3 ÷	
		Reported	A-6	col. 2 )	in col. 3	col. 4 )	
		1	2	3	4	5	1
SALA	ARIES						
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	СМНС						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
OTHE	ER 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
WAG	E 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	S
--	---

			Reclass.	Adjusted	Paid Hours	Average	I
			of Salaries	Salaries	Related	Hourly Wage	
		Amount	from	( col. 1 ±	to Salary	( col. 3 ÷	
		Reported	Wkst. A-6	col. 2 )	in col. 3	col. 4)	
		1	2	3	4	5	1
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

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Part A - Core List			то		
RETIREMENT COST	Part A	- Core List		Amount	
1   401k Employer Contributions				Reported	
2   Tax Sheltered Annuity (TSA) Employer Contribution   2   3   3   4   Pior Year Pension Service Cost   4   4   5   4   4   4   5   4   4   5   5		EMENT COST			
3 Qualified and Non-Qualified Pension Plan Cost   3   4   Prior Year Pension Service Cost   4   4   Prior Year Pension Service Cost   4   4   Prior Year Pension Service Cost   4   4   Prior Year Pension Service Cost   5   4   4   4   4   5   5   5   5   5					1
4   Prior Year Pension Service Cost   4   4	2 7	Γax Sheltered Annuity (TSA) Employer Contribution			
PLAN   ADMINISTRATIVE COSTS (Paid to External Organizations)   5   401K/TSA Plan Administration fees   5   6   Legal/Accounting/Management Fees-Pension Plan   6   6   Common Plan   6   6   6   Common Plan   7   7   7   7   7   7   7   7   7	3 (	Qualified and Non-Qualified Pension Plan Cost			3
5   401K/TSA Plan Administration fees   5   6   Legal/Accounting/Management Fees-Pension Plan   6   7   Employee Managed Care Program Administration Fees   7   7   HEALTH AND INSURANCE COST   7   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)   17   18   Medicare Taxes - Employers Portion Only   18   19   Unemployment Insurance   19   20   State or Federal Unemployment Taxes   19   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   24   Total Wage Related Cost   Amount Reported   24   25   Care Cost and Allowances   26   26   Care Cost and Allowances   27   27   Expected   28   28   Care Cost and Allowances   29   29   Care Cost and Allowances   29   20   Care Cost and Allowances   29   21   Care Cost and Allowances   29   22   Day Care Cost and Allowances   29   23   Tuition Reimbursement   29   24   Total Wage Related Cost   29   25   Care Cost and Allowances   29   26   Care Cost and Allowances   29   27   Care Cost and Allowances   29   28   Care Cost and Allowances   29   29   Care Cost and Allowances   29   20   Care Cost and Allowances   29   21   Care Cost and Allowances   29   22   Care Cost and Allowances   29   23   Tuition Reimbursement   29   24   Total Wage Related Cost (sum of lines 1-23)   29	4 F	Prior Year Pension Service Cost			4
Egal/Accounting/Management Fees-Pension Plan   6     7   Employee Managed Care Program Administration Fees   7     REALTH 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     Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)   17     17   FICA - 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   Amount Reported   18     Part B Other than Core Related Cost   18     10   Part B Other than Core Related Cost   18     7   Employees   19     8   Part B Other than Core Related Cost   18     9   Part B Other than Core Related Cost   18     9   Part B Other than Core Related Cost   18     9   Part B Other than Core Related Cost   18     9   Part B Other than Core Related Cost   18     10   Part B Other than Core Related Cost   18     11   Part B Other than Core Related Cost   18     12   Part B Other than Core Related Cost   18     15   Part B Other than Core Related Cost   18     16   Part B Other than Core Related Cost   18     17   Part B Other than Core Related Cost   18     18   Part B Other than Core Related Cost   18     10   Part B Other than Core Related Cost   18     10   Part B Other than Core Related Cost   18     11   Part B Other than Core Related Cost   18     12   Part B Other than Core Related Cost	PLAN	ADMINISTRATIVE COSTS (Paid to External Organizations)			
7   Employee Managed Care Program Administration Fees   7	5 4	401K/TSA Plan Administration fees			
HEALTH AND INSURANCE COST   8   Health Insurance (Purchased or Self Funded)   8   8   9   Prescription Drug Plan   9   9   9   10   Dental, Hearing and Vision Plan   10   11   Life Insurance (If employee is owner or beneficiary)   11   Accidental Insurance (If employee is owner or beneficiary)   12   Accidental Insurance (If employee is owner or beneficiary)   13   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   15   Worker's Compensation Insurance (If employee is owner or beneficiary)   16   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)   17   18   Medicare Taxes - Employers Portion Only   18   19   Unemployment Insurance   19   19   19   19   19   19   19   1				6	
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)       13         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         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)       Amount Reported					7
9 Prescription Drug Plan 10 Dental, Hearing and Vision Plan 11 Life Insurance (If employee is owner or beneficiary) 11 Accidental Insurance (If employee is owner or beneficiary) 11 Accidental Insurance (If employee is owner or beneficiary) 12 Accidental Insurance (If employee is owner or beneficiary) 13 Disability Insurance (If employee is owner or beneficiary) 14 Long-Term Care Insurance (If employee is owner or beneficiary) 15 Workers' Compensation Insurance 16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)  TAXES 17 FICA - Employers Portion Only 18 Medicare Taxes - Employers Portion Only 19 Unemployment Insurance 19 Unemployment Insurance 20 State or Federal Unemployment Taxes 20 OTHER 21 Executive Deferred Compensation 21 Executive Deferred Compensation 22 Day Care Cost and Allowances 23 Tuition Reimbursement 24 Total Wage Related Cost 24 Part B Other than Core Related Cost 24 Amount Reported					
10   Dental, Hearing and Vision Plan   10   11   Life Insurance (If employee is owner or beneficiary)   11   Life Insurance (If employee is owner or beneficiary)   12   Accidental Insurance (If employee is owner or beneficiary)   12   13   Disability Insurance (If employee is owner or beneficiary)   13   13   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   Long-Term Care Insurance (If employee is owner or beneficiary)   14   15   Workers' Compensation Insurance   15   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)   16   16   17   17   FICA - Employers Portion Only   18   Medicare Taxes - Employers Portion Only   18   Medicare Taxes - Employers Portion Only   19   19   19   19   19   19   19   1		,			
11   Life Insurance (If employee is owner or beneficiary)   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   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   16   17   18   Medicare Taxes - Employers Portion Only   18   Medicare Taxes - Employers Portion Only   18   19   Unemployment Insurance   19   20   State or Federal Unemployment Taxes   20   20   State or Federal Unemployment Taxes   21   Executive Deferred Compensation   21   22   Day Care Cost and Allowances   22   23   Tuition Reimbursement   23   23   24   Total Wage Related cost (sum of lines 1-23)   24   Part B Other than Core Related Cost   Amount Reported   Reported   Reported   25   26   27   27   28   28   28   29   29   20   20   20   20   20   20	9 F	Prescription Drug Plan		9	
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   Workers' Compensation Insurance   15   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)   16   accrual required by FASB 106 Non cumulative portion)   17   18   Medicare Taxes - 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   Amount Reported   Retail Institute   Reta	10 I	Dental, Hearing and Vision Plan		10	
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   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106   Non cumulative portion)   16   16   17   18   17   18   18   19   19   19   19   19   19					
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       20         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       Amount Reported					
15   Workers' Compensation Insurance   15		3 ( 1 3 3)			
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         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       Amount Reported					
Carrual required by FASB 106 Non cumulative portion		1			
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         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       Amount Reported	16 F	Retirement Health Care Cost (Only current year, not the extraordinary			16
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       Amount Reported					
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       Amount Reported					
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       Amount Reported		1 3 3			
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       Amount Reported					
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         Amount Reported	-	1 3			
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       Amount Reported					20
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         Amount Reported					
23     Tuition Reimbursement     23       24     Total Wage Related cost (sum of lines 1 -23)     24       Part B Other than Core Related Cost     Amount Reported					
24     Total Wage Related cost (sum of lines 1 - 23)     24       Part B Other than Core Related Cost     Amount Reported					
Part B Other than Core Related Cost  Amount Reported					
Reported					24
	Part B	Other than Core Related Cost		Amount	
25 Other Wage Related Costs (specify) 25				Reported	
	25 (	Other Wage Related Costs (specify)	 <u> </u>		25

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4130	(Cont.)	FURIVI	CMS-2540-10							
SNF R	EPORTING OF DIRECT CARE	PROVIDER CCN:		PERIOD:		WORKSHEET S-3				
EXPE	NDITURES			FROM		PART V				
				то						
				Adjusted	Paid Hours	Average	T			
				Salaries	Related	Hourly Wage				
		Amount	Fringe	( col. 1 +	to Salary	( col. 3 ÷				
		Reported	Benefits	col. 2)	in col. 3	col. 4)				
	OCCUPATIONAL CATEGORY	1	2	3	4	5	+-			
Direc	t 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			
5	Physical Therapists						5			
6	Physical Therapy Assistants						6			
7	Physical Therapy Aides						7			
8	Occupational Therapists						8			
9							9			
	Occupational Therapy Aides						10			
	Speech Therapists						11			
	Respiratory Therapists						12			
	Other Medical Staff						13			
Contr	act Labor									
	Nursing Occupations									
	Registered Nurses (RNs)						14			
	Licensed Practical Nurses (LPNs)						15			
	Certified Nursing Assistants/Nursing Assistants/Aides						16			
17	81 9 7						17			
	Physical Therapists						18			
	Physical Therapy Assistants						19			
	Physical Therapy Aides						20			
21							21			
22	1 13						22			
	Occupational Therapy Aides						23			
	Speech Therapists						24			
	Respiratory Therapists						25			
26	Other Medical Staff						26			

FORM CMS-2540-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4105.5)

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4190 (Cont.)	FORM CMS-2540-10	11-12

SNF-BASED HOME HEALTH AGENCY	PROVIDER CCN:	PERIOD:	WORKSHEET S-4	
STATISTICAL DATA		FROM		
	HHA CCN:	то		
HOME HEALTH AGENCY STATISTICAL DATA				
1 County				

		Title V	Title XVIII	Title XIX	Other	Total	
DESCRIPTION		1	2	3	4	5	1
2 Home Health Ai	le Hours						2
3 Unduplicated Ce	nsus Count (see instructions)						3

		Staff	Contract	Total	
HOM	E HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)	1	2	3	1
4	Enter the number of hours in your normal work week				4
5	Administrator and Assistant Administrator(s)				5
6	Directors and Assistant Director(s)				6
7	Other Administrative Personnel				7
8	Direct Nursing Service				8
9	Nursing Supervisor				9
10	Physical Therapy Service				10
11	Physical Therapy Supervisor				11
12	Occupational Therapy Service				12
13	Occupational Therapy Supervisor				13
14	Speech Pathology Service				14
15	Speech Pathology Supervisor				15
16	Medical Social Service				16
17	Medical Social Service Supervisor				17
18	Home Health Aide				18
19	Home Health Aide Supervisor				19
20	Other (specify)				20
		-	-		
HOM	E HEALTH AGENCY CBSA CODES				
21	Enter in column 1 the number of CDCAs where you provided services during the cost reporting period				21

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

		Full Episodes				Total	
		Without	With	LUPA	PEP only	( cols. 1	
		Outliers	Outliers	Episodes	Episodes	through 4)	
PPS A	CTIVITY DATA	1	2	3	4	5	
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
	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

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DRAFT FORM CMS-2540-10							419				Cont.				
SNF-BASED RHC/FQHC STATISTICAL DATA							PROVIDER	R CCN:		PERIOD:			WORKSHE		
							RHC/FQHC	C CCN:		TO					
Check applicable box: [ ] RHC		[ ] FQHC	2												
Clinic Address and Identification:															
	1 Street:									County:				1	
2 City:	upu ( 1						State:				Zip Code:		-		2
3 Designation (for FQHC's only) - "U" for urban	or "R" for rural														3
Source of Federal funds:											Grant	Award	Da	te	
4 Community Health Center (Section 330(d), PF	IS Act)										Grant	71Waru	Do	ic .	4
5 Migrant Health Center (Section 329(d), PHS A											1		+		5
6 Health Services for the Homeless (Section 340															6
7 Appalachian Regional Commission	(-),														7
8 Look - Alikes															8
9 Other (specify)															9
·															
											1			2	
10 Does <i>this facility</i> operate as other than an RHC		" for yes or "	'N" for no in o	column 1.											10
If yes, indicate the number of other operations	in column 2.														
Encility hours of appartions (1)															
Facility hours of operations (1)	Su	ndav	I Mo	ndav	Tues	eday	Wodr	nesday	Thu	rsdav	Eri	dav	Satu	vdav	1
Type of Operation	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
-	<u>'</u>	•													-
(1) Enter clinic/center hours of operation on line 1:	1 and other type oper	ations on sub	scripts of line	11 (both type	e and hours of	operation).									
List hours of operation based on a 24 hour close	k For example: 9:0	0090 ic 0800	6.30nm ic 18	20 and midn	ight is 2400										

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

	1	2	
12 Have you received an approval for an exception to the productivity standard?			12
13 Is this a consolidated cost report in accordance with CMS Pub. 100-04, Chapter 9, \$30.8? Enter "Y" for yes or "N" for no in column 1.			13
If yes, enter in column 2 the number of <i>RHC/FQHC</i> 's included in this report. List the names of all <i>RHC/FQHC</i> 's and numbers below.			
14 RHC/FQHC Name: CCN Number:		•	14

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SNF-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION FACILITIES STATISTICAL DATA  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 (col. 1 + col. 2)  1 Administrator and Assistant Administrator(s)  2 Director(s) and Assistant Director(s)  3 Other Administrative Personnel  4 Direct Nursing Service  5 Nursing Supervisor  6 Physical Therapy Service  7 Physical Therapy Service  9 Occupational Therapy Supervisor  8 Occupational Therapy Supervisor  9 Occupational Therapy Supervisor  10 Speech Pathology Service  10 Speech Pathology Service  11 Service Descriptions  12 Secretifies	AFT
Component Con:   To     Component Con:   To     Component Con:   To   Component Con:   To   Component Con:   To   Component Con:   Component	
Check applicable box:   [] CMHC   [] CORF   [] OPT   [] OOT   [] OSP	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)   Staff	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)   Staff	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)   Staff	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)   Staff	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)    Staff	
NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)    Staff	
Staff   Contract   (col. 1 + col. 2)	
Staff   Contract   (col. 1 + col. 2)	
Staff   Contract   (col. 1 + col. 2)	
1   2   3   3   1   Administrator and Assistant Administrator(s)	
1 Administrator and Assistant Administrator(s) 2 Director(s) and Assistant Director(s) 3 Other Administrative Personnel 4 Direct Nursing Service 5 Nursing Supervisor 6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	
2 Director(s) and Assistant Director(s) 3 Other Administrative Personnel 4 Direct Nursing Service 5 Nursing Supervisor 6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	
3 Other Administrative Personnel 4 Direct Nursing Service 5 Nursing Supervisor 6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	1
4 Direct Nursing Service 5 Nursing Supervisor 6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	2
5 Nursing Supervisor 6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	3
6 Physical Therapy Service 7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	4
7 Physical Therapy Supervisor 8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	5
8 Occupational Therapy Service 9 Occupational Therapy Supervisor 10 Speech Pathology Service	6
9 Occupational Therapy Supervisor 10 Speech Pathology Service	7
10 Speech Pathology Service	8
	9
11 Chasch Dathology Cynowicay	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

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			(
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	
		TO	

		_
	GROUP	Days
	1	2
1	RUX	
2	RUL	
3	RVX	
4	RVL	
5	RHX	
6	RHL	
7	RMX	
8	RML	
9	RLX	
10	RUC	
11	RUB	
12	RUA	
13	RVC	
14	RVB	
15	RVA	
16	RHC	
17	RHB	
18	RHA	
19	RMC	
20	RMB	
21	RMA	
22	RLB	
23	RLA	
24	ES3	
25	ES2	
26	ES1	
27	HE2	
28	HE1	
29 30	HD2 HD1	
30	HDI	
31	HC2	
32 33	HC1 HB2	
33		
35	HB1	
36	LE2 LE1	
36	LE1 LD2	
38	LD2 LD1	
39	LC2	
40	LC2 LC1	
41	LB2	
42	LB2 LB1	
43	CE2	
44	CE2	
45	CD2	
46	CD2	
47	CC2	
48	CC2	
49	CB2	
50	CB2	
30	CDI	

4190 (Cont.)	FORM CMS-2540-10			
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7	
STATISTICAL DATA		FROM		
		то		

	GROUP	Days
	1	2
51	CA2	
52		
53		
54	SE2	
55		
56		
57	SSB	
58	SSA	
59		
60	IB1	
61	IA2	
62		
63		
64		
65		
66		
67		
68		
69		
70		
71	PC2	
72	PC1	
73		
74		
75		
76	PA1	
99	AAA	
100	Total	

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 column3. 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
	1	2	3
101 Staffing			
102 Recruitment			
103 Retention of employees			
104 Training			
105 Other (Specify)			
106 Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)			

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PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2014

4 *Hospice* General Inpatient Care 5 Total Hospice Days

			Title XVIII	Title XIX		Total	1
			Skilled	Nursing	All	( sum of	
	Title XVIII	Title XIX	Nursing facility	Facility	Other	col. 1, 2 & 5 )	
	1	2	3	4	5	6	1
6 Number of patients receiving hospice care							(
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							1 9

PART III - ENROLLMENT DAYS BASED ON LEVEL OF CARE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2014

	Unduplicated Days				
				Total	
				(sum of	
	Title XVIII	Title XIX	Other	cols. 1 through 3)	
	1	2	3	4	1
10 Hospice Continuous Home Care					10
11 Hospice Routine Home Care					11
12 Hospice Inpatient Respite Care					12
13 Hospice General Inpatient Care					13
14 Total Hospice Days					14

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2014

				Total	
				(sum of	
	Title XVIII	Title XIX	Other	cols. 1 through 3)	
	1	2	3	4	1
15 Hospice Inpatient Respite Care					15
16 Hospice General Inpatient Care					16

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4 .

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RECLA		ATION AND ADJUSTMENT			PROVIDER CCN:		PERIOD:		WORKSHEET A
OF TR	IAL BA	ALANCE OF EXPENSES					FROM		
							TO		
		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	В	С	1	2	3	4	5	6	7
GENER	RAL SE	RVICE COST CENTERS							
1	0100	Capital-Related Costs - Buildings & Fixtures							
2		Capital-Related Costs - Moveable Equipment							
3		Employee Benefits							
4		Administrative and General							
5	0500	Plant Operation, Maintenance and Repairs							
6	0600	Laundry and Linen Service							
7	0700	Housekeeping							
8	0800	Dietary							
9		Nursing Administration							
		Central Services and Supply							
		Pharmacy							
		Medical Records and Library							
		Social Service							
	1400	Nursing and Allied Health Education							
15		Other General Service Cost							
		OUTINE SERVICE COST CENTERS							
		Skilled Nursing Facility							
		Nursing Facility							
		ICF/ <del>IID</del>							
		Other Long Term Care							
		SERVICE COST CENTERS							
		Radiology							
		Laboratory							
		Intravenous Therapy							
		Oxygen (Inhalation) Therapy							
-		Physical Therapy							
$\overline{}$		Occupational Therapy							
		Speech Pathology							
47	4700	Electrocardiology							

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41-316

09-11	L			FORM CMS-2	2540-10				4190 (C
RECL	ASSIFIC	ATION AND ADJUSTMENT			PROVIDER CCN:		PERIOD:		WORKSHEET A (Co
OF TI	RIAL BA	ALANCE OF EXPENSES					FROM		
							то		
						RECLASSI-	RECLASSIFIED	ADJUSTMENTS	NET EXPENSES
						FICATIONS	TRIAL	TO EXPENSES	FOR COST
					TOTAL	Increase/Decrease	BALANCE	Increase /Decrease	ALLOCATION
		Cost Center Description	SALARIES	OTHER	( col. 1 + col. 2 )	( from Wkst. A-6 )	( col. 3 +/- col. 4 )	( from Wkst. A-8 )	( col. 5 +/- col. 6 )
A	В	С	1	2	3	4	5	6	7
48	4800	Medical Supplies Charged to Patients							
49	4900	Drugs Charged to Patients							
50	5000	Dental Care - Title XIX only							
51	5100	Support Surfaces							
52		Other Ancillary Service Cost							
OUTP	ATIENT	SERVICE COST CENTERS							
60	6000	Clinic							
61	6100	Rural Health Clinic (RHC)							
62	6200	FQHC							
63		Other Outpatient Service Cost							
OTHE	R REIM	BURSABLE COST CENTERS							
70	7000	Home Health Agency Cost							
71	7100	Ambulance							
72		Outpatient Rehabilitation (specify)							
73	7300	CMHC							
74		Other Reimbursable Cost							
SPECI	AL PUF	RPOSE COST CENTERS							
80	8000	Malpractice Premiums & Paid Losses							-0-
81		Interest Expense							- 0 -
82	8200	Utilization Review							- 0 -
83	8300	Hospice							
84		Other Special Purpose Cost							
89		SUBTOTALS (sum of lines 1 through 84)							
NON I	REIMBU	RSABLE COST CENTERS							
90	9000	Gift, Flower, Coffee Shops and Canteen							
91	9100	Barber and Beauty Shop							
92	9200	Physicians' Private Offices							
93	9300	Nonpaid Workers							
94	9400	Patients' Laundry							
95		Other Nonreimbursable Cost							
100		TOTAL							
			•	•	•	-	-	•	

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4190 (Cont.)	FORM CMS-2540-10			09-11
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1150 (Cont.)	1 0111/1 01/15 25 10 10			00 1.
RECLASSIFICATIONS		PROVIDER CCN:	PERIOD:	WORKSHEET A-6
			FROM	
			TO	

CONTENTED   1			CODE	INCREAS	E		Γ	ECREAS	E		
EXPLANATION OF RECLASSIFICATION(S)  1 2 3 4 5 6 7 8 9  1 1 2						NON SALARY				NON SALARY	
1         1         2         2         2         3         3         4         4         4         4         4         4         5         5         6         6         6         6         6         6         6         6         6         6         6         6         6         6         7         7         7         7         7         7         7         7         7         7         7         7         7         9		EXPLANATION OF RECLASSIFICATION(S)									
3	1	• • • • • • • • • • • • • • • • • • • •									1
3	2										2
4         4           5         5           6         6           7         7           8         8           9         9           10         10           11         11           12         11           13         11           14         14           15         15           16         16           17         16           19         19           20         19           21         21           22         22           23         23           24         24           25         26           27         20           28         29           30         20	3										
6         6           7         8           9         9           10         9           11         9           12         11           13         12           14         14           15         15           16         16           17         17           18         18           19         19           20         118           19         11           20         122           21         20           21         20           21         21           22         23           24         24           25         25           26         27           28         29           30         29           30         29           30         29           31         30	4										4
7         8         8         8         8         8         9         9         10         9         9         10         10         10         11         11         11         11         11         11         11         11         11         11         11         12         12         12         12         12         12         12         12         12         12         12         12         12         12         12         12         13         14         14         14         14         14         15         15         15         15         16         16         16         16         16         16         16         16         16         16         16         17         17         17         17         17         17         18	5										5
8       9       10       10       10       10       11       11       11       11       11       11       11       11       12       12       13       13       13       13       13       13       14       14       14       14       14       14       14       14       14       14       14       14       14       15       15       15       15       15       15       16       16       16       16       17       17       17       17       17       17       17       17       17       19       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12       12 </td <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>6</td>	6										6
9         9           10         11           11         11           12         12           13         13           14         14           15         15           16         16           17         17           18         17           19         19           20         20           21         21           22         22           23         22           24         24           25         25           26         25           27         28           30         29           30         30	7										7
10	8										8
11         12         13         13         13         13         14         14         14         15         16         16         16         16         16         16         17         17         18         18         19         10         10         10         10         10         10         10         10         10         10<											9
12     13       13     14       15     15       16     15       17     16       18     17       19     19       20     19       21     21       22     23       23     23       24     24       25     25       26     27       28     29       30     30       31											10
13       14       13         14       15       15         15       16       15         17       16       17         18       18       18         19       19       19         20       20       20         21       21       21         22       23       22         23       23       24         25       25       25         26       26       27         28       29       29         30       30         31       30											11
14       15       14         15       15       15         16       17       17         18       17       18         19       18       19         20       20       20         21       21       21         22       22       22         23       24       24         25       26       25         26       26       26         27       28       28         29       30       30         31       30											12
15       16       17         17       18       17         18       18       18         19       19       19         20       20       21         21       21       22         23       23       23         24       24       25         26       26       26         27       28       28         29       30       30         31       30											13
17       18       19       20       21       22       23       24       25       26       27       28       29       30       31											14
17       18       19       20       21       22       23       24       25       26       27       28       29       30       31											15
18       19       18         19       19         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         30       31         31       31											16
19     19       20     20       21     21       22     22       23     24       25     25       26     27       28     29       29     29       30     31											
20       20         21       21         22       22         23       23         24       24         25       25         26       26         27       27         28       29         30       31											
21       21       21         22       22         23       23         24       24         25       25         26       27         28       28         29       29         30       31											19
22       23       23         24       24         25       25         26       26         27       27         28       28         29       29         30       31											20
23       23         24       24         25       25         26       26         27       27         28       28         29       29         30       30         31       31	21							1			21
24     24       25     25       26     26       27     27       28     29       29     29       30     29       31     31	22										22
25     26       26     26       27     28       29     29       30     29       31     31											23
28     28       29     29       30     30       31     31	24							-			24
28     28       29     29       30     30       31     31	25							-			25
28     28       29     29       30     30       31     31											26
29     29       30     30       31     31											2/
30 30 31 31	28										28
31 31	29										29
31 32 33 34 34 34 37			_					-			30
32 33 34 34 37			-					+			31
35 34 37			-					+			32
34 34	33		-					+			33
	35			+				+ +			25
100 TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal 100		TOTAL DECLASSIFICATIONS (Sum of columns 4 and	5 must oqual			+					100
sum of columns 8 and 9 (2)			o musi equal								100

<sup>(1)</sup> 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.

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ANALYSIS OF CHANGES IN	PROVIDER CCN:	PERIOD:	WORKSHEET A-7
CAPITAL ASSET BALANCES		FROM	
		то	

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

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ADJUSTMENTS TO EXPENSES		PROVIDER CCN:	PERIOD:	WORKSHEET A-8	
				FROM	
				TO	
		Basis			cation on Wkst. A
		for			nount is to be adjusted
	Description (1)	Adjustment (2)	Amount	Cost Center	Line No.
	0	1	2	3	4
1	Investment income on restricted funds				
	(Chapter 2)				
2	Trade, quantity and time discounts				
	on purchases (Chapter 8)				
3	Refunds and rebates of expenses				
	Chapter 8)				
4	Rental of provider space by suppliers				
	Chapter 8)				
5	Telephone services (pay stations				
	excluded) (Chapter 21)				
6	Television and radio service				
	(Chapter 21)				
7	Parking lot (Chapter 21)				
		Y.Y. 1.1			
8	Remuneration applicable to provider-	Worksheet			
	based physician adjustment	A-8-2			
9	Home office costs (Chapter 21)				
10	Sale of scrap, waste, etc.				
10	(Chapter23)				
11	Nonallowable costs related to certain				
11	Capital expenditures (Chapter 24)				
12	Adjustment resulting from transactions	Worksheet			
12	with related organizations (Chapter 10)	A-8-1			
13	Laundry and Linen service	A-0-1			
13	Laundry and Emen service				
14	Revenue - Employee meals				
	The venue 2 mprojec means				
15	Cost of meals - Guests				
16	Sale of medical supplies to other than patients				
	11 1				
17	Sale of drugs to other than patients				
18	Sale of medical records and abstracts				
19	Vending machines				
20	Income from imposition of interest,				
	finance or penalty charges (Chapter 21)				
21	Interest expense on Medicare overpayments				
	and borrowings to repay Medicare overpayments				
22	Utilization reviewphysicians'			Utilization Review- SNF	82
	compensation (Chapter 21)				
23	Depreciationbuildings and fixtures		_	Capital Related Cost- Buildin	ng 1
24	Depreciationmovable equipment		_	Capital Related Cost-Movable	le 2
25	Other Adjustment				
100	TOTAL (sum of lines 1 through 99)		I		
	Litranetor to Wiket A. col. 6. lino 100)				

<sup>(1)</sup> 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

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DRAFT	FORM CMS-2540-10	4190 (Co	nt.`

STATEMENT OF COSTS OF SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-1
FROM RELATED ORGANIZATIONS AND		FROM	
HOME OFFICE COSTS		TO	

## PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

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

## 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.

					Related Organization(s)		
			Percentage		Percentage		1
	(1)		of		of	Type of	
	Symbol	Name	Ownership	Name	Ownership	Business	
	1	2	3	4	5	6	1
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.
  - $\mbox{C.}$  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 (fina	ncial or non-financ	cial) specify	

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4190 (Cont.)	FORM CMS-2540-10	DR
7130 ( COIII.)	1 01010 2070 10	DI

PROVIDER - BASED PHYSICIAN ADJUSTMENTS	PROVIDER CCN:	PERIOD:	WORKSHEET A-
		FROM	
		TO	

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

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

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<u>AFT</u>

DIALI	TORM CM3-				4130 (Cont.		
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD:		WORKSHEET B PART I	
				FROM			
				то			
	NET EXPENSES						
	FOR COST	CAP. REL	CAP. REL		SUBTOTAL	ADMINIS-	
	ALLOCATION	BUILDINGS	MOVABLE	EMPLOYEE	( sum of	TRATIVE	
	(from Wkst. A, col. 7)	& FIXTURES	EQUIPMENT	BENEFITS	cols. 0 - 3)	& GENERAL	
Cost Center Description	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							
5 Plant Operation, Maintenance and Repairs							- 5
6 Laundry and Linen Service							- (
7 Housekeeping							7
8 Dietary							- {
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/IID							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

4190 (Cont.) FORM CMS-2540-10 DRAFT COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM PART I TO NET EXPENSES FOR COST CAP. REL CAP. REL SUBTOTAL ADMINIS-ALLOCATION BUILDINGS MOVABLE **EMPLOYEE** TRATIVE ( sum of & FIXTURES **EQUIPMENT** BENEFITS & GENERAL (from Wkst. A, col. 7) cols. 0 - 3) Cost Center Description 0 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 74 Other Reimbursable Cost 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 98 Cross Foot Adjustments 99 Negative Cost Center 99

100

100 Total

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DRAFT FORM CMS-2540-10 4190 (Cont.) COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM\_ PART I TO PLANT OPER. LAUNDRY NURSING CENTRAL MAINTENANCE & LINEN HOUSE ADMINIS-**SERVICES** & REPAIRS SERVICE KEEPING DIETARY TRATION & SUPPLY PHARMACY Cost Center Description 9 10 11 6 GENERAL SERVICE COST CENTERS 1 Capital-Related Costs - Buildings & Fixtures 2 Capital-Related Costs - Moveable Equipment 2 3 4 5 3 Employee Benefits 4 Administrative and General 5 Plant Operation, Maintenance and Repairs 6 Laundry and Linen Service 7 8 7 Housekeeping 8 Dietary 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 31 Nursing Facility 32 ICF/IID 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

100 Total

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FORM CMS-2540-10 4190 (Cont.) DRAFT COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM PART I TO PLANT OPER. NURSING CENTRAL LAUNDRY MAINTENANCE & LINEN HOUSE ADMINIS-SERVICES & REPAIRS SERVICE KEEPING DIETARY TRATION & SUPPLY PHARMACY Cost Center Description 6 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

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52 Other Ancillary Service Cost

**DRAFT** FORM CMS-2540-10 4190 (Cont.) COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: PERIOD: WORKSHEET B PART I FROM\_ TO NURSING & OTHER MEDICAL ALLIED GENERAL POST RECORDS STEP-DOWN SOCIAL HEALTH SERVICE & LIBRARY SERVICE EDUCATION COST SUBTOTAL ADJUSTMENTS TOTAL Cost Center Description 12 13 14 15 16 17 18 GENERAL SERVICE COST CENTERS 1 Capital-Related Costs - Buildings & Fixtures 2 Capital-Related Costs - Moveable Equipment 3 Employee Benefits 4 Administrative and General 5 Plant Operation, Maintenance and Repairs 6 Laundry and Linen Service 7 Housekeeping 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/IID 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 51 Support Surfaces

Rev.

100 Total

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4190 (Cont.) FORM CMS-2540-10 DRAFT COST ALLOCATION - GENERAL SERVICE COSTS PROVIDER CCN: WORKSHEET B PERIOD: FROM PART I TO NURSING & OTHER MEDICAL ALLIED GENERAL POST RECORDS SOCIAL HEALTH SERVICE STEP-DOWN & LIBRARY SERVICE **EDUCATION** COST SUBTOTAL ADJUSTMENTS TOTAL 13 14 16 17 18 Cost Center Description 12 15 OUTPATIENT SERVICE COST CENTERS 60 60 Clinic 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 98 Cross Foot Adjustments 99 Negative Cost Center 99

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4120)

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DKAPI	PORIVI CIVIC			T		4130 (Cont	
COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD:		WORKSHEET B - 1	
				FROM			
				то			
		CAP. REL.	CAP. REL.			ADMINIS-	
		BUILDINGS	MOVABLE	EMPLOYEE		TRATIVE	
		& FIXTURES	EQUIPMENT	BENEFITS		& GENERAL	
		( Square	( Dollar Value or	( Gross	RECONCIL-	( Accumulated	
Cost Center Description		Feet )	Square Feet )	Salaries )	IATION	Cost )	
	0	1	2	3	4 A	4	₩
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							- 1
2 Capital-Related Costs - Moveable Equipment							1
3 Employee Benefits							
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							į
6 Laundry and Linen Service							(
7 Housekeeping							1 :
8 Dietary							1 - 8
9 Nursing Administration							- 9
10 Central Services and Supply							10
11 Pharmacy							1:
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							3
32 ICF/IID							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							4:
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							40
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						1	5
52 Other Ancillary Service Cost							52
				1			

4190 (Cont.) FORM CMS-2540-10 DRAFT COST ALLOCATION - STATISTICAL BASIS PROVIDER CCN: PERIOD: WORKSHEET B-1 FROM TO CAP. REL. CAP. REL. ADMINIS-BUILDINGS MOVABLE **EMPLOYEE** TRATIVE & FIXTURES **EQUIPMENT** BENEFITS & GENERAL RECONCIL-( Square ( Dollar Value or ( Gross ( Accumulated Cost Center Description Feet ) Square Feet ) Salaries ) IATION Cost) 0 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 73 CMHC 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 95 Other Nonreimbursable Cost 98 Cross Foot Adjustments 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

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DICAL I		PROVIDER CCN: PERIOD:				WORKSHEET B - 1		
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:			WORKSHEET B-1		
					FROM			
	DI ANTE ODED	LAUNDRY			NURSING CENTRAL			
	PLANT OPER. MAINTENANCE		HOUSE			SERVICES		
	•	& LINEN	HOUSE	DIETARY	ADMINIS-	1	DYLA DYLA GYL	
	& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY	
	( Square	( Pounds of	( Hours of	( Meals	( Direct	( Costed	( Costed	
Cost Center Description	Feet )	Laundry ) 6	Service )	Served ) 8	Nursing Hrs.)	Requisitions )	Requisitions )	-
GENERAL SERVICE COST CENTERS	3	0	/	0	9	10	11	
1 Capital-Related Costs - Buildings & Fixtures								
2 Capital-Related Costs - Moveable Equipment								
3 Employee Benefits								
4 Administrative and General								-
5 Plant Operation, Maintenance and Repairs								-
6 Laundry and Linen Service								-
7 Housekeeping								
8 Dietary								
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								1
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								3:
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								4
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								4
45 Occupational Therapy								45
46 Speech Pathology								40
47 Electrocardiology								4
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								5
52 Other Ancillary Service Cost								52

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4190 (Cont.)	FORM CMS-2540-10		DRAFT
COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN:	PERIOD:	WORKSHEET B - 1
		FROM	

COST ALLOCATION - STATISTICAL BASIS				PROVIDER CCN:		PERIOD:		
					FROM			
					то			
	PLANT OPER.	LAUNDRY			NURSING	CENTRAL		T
	MAINTENANCE	& LINEN	HOUSE		ADMINIS-	SERVICES		
	& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY	
	( Square	( Pounds of	( Hours of	( Meals	( Direct	( Costed	( Costed	
Cost Center Description	Feet )	Laundry )	Service )	Served )	Nursing Hrs.)	Requisitions )	Requisitions )	
	5	6	7	8	9	10	11	7
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
SPEC AL 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
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

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

DRAFI	FORM CMS-2540-10							4190 (Cont.)	
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B - 1		
					FROM				
					то				
	MEDICAL		NURSING &			T		$\neg$	
	RECORDS	SOCIAL	ALLIED	OTHER					
	& LIBRARY	SERVICE	HEALTH	GENERAL		POST			
	( Time	( Time	EDUCATION	SERVICE		STEP-DOWN			
Cost Center Description	Spent )	Spent )	( Assigned Time )	COST	SUBTOTAL	ADJUSTMENTS	TOTAL		
Cost Center Description	12	13	14	15	16	17	18	$\dashv$	
GENERAL SERVICE COST CENTERS	12	15	14	15	10	17	10		
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								13	
30 Skilled Nursing Facility								30	
31 Nursing Facility								31	
32 ICF/IID								32	
33 Other Long Term Care								33	
ANCILLARY SERVICE COST CENTERS								33	
40 Radiology								40	
41 Laboratory								41	
41 Laboratory 42 Intravenous Therapy								42	
43 Oxygen (Inhalation) Therapy								43	
45 Oxygen (middation) Therapy  44 Physical Therapy								43	
45 Occupational Therapy								45	
								45	
46 Speech Pathology 47 Electrocardiology								46	
48 Medical Supplies Charged to Patients								48	
49 Drugs Charged to Patients 50 Dental Care - Title XIX only								49 50	
51 Support Surfaces		1						51	
52 Other Ancillary Service Cost								52	

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4190 (Cont.) FORM CMS-2540-10 DRAFT COST ALLOCATION - STATISTICAL BASIS PROVIDER CCN: WORKSHEET B-1 PERIOD: FROM TO MEDICAL NURSING & RECORDS SOCIAL ALLIED GENERAL & LIBRARY SERVICE HEALTH EDU SERVICE POST ( Time ( Time **EDUCATION** COST STEP-DOWN Cost Center Description ( Assigned Time ) COST SUBTOTAL ADJUSTMENTS TOTAL Spent) Spent) 12 13 14 15 16 17 18 OUTPATIENT SERVICE COST CENTERS 60 Clinic 60 61 Rural Health Clinic (RHC) 61 62 FQHC 62 63 Other Outpatient Service Cost 63 OTHER REIMBURSABLE COST CENTERS 70 Home Health Agency Cost 70 71 Ambulance 71 72 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 94 Patients' Laundry 95 Other Nonreimbursable Cost 95 98 Cross Foot Adjustments 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

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DIALI		PORMI CIVIS-2340-10						WORKSHEET B	
ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:			PERIOD : FROM				
							PART II		
					то				
	DIRECTLY								
	ASSIGNED	CAP. REL	CAP. REL.			ADMINIS-	PLANT OPER.		
	CAPITAL	BUILDINGS	MOVABLE		EMPLOYEE	TRATIVE	MAINTENANCE		
	RELATED COSTS	& FIXTURES	EQUIPMENT	SUBTOTAL	BENEFITS	& GENERAL	& REPAIRS		
Cost Center Description	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									
5 Plant Operation, Maintenance and Repairs									
6 Laundry and Linen Service								(	
7 Housekeeping								7	
8 Dietary								1	
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/IID								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	
51 Support Surfaces 52 Other Ancillary Service Cost			+		+		+	52	
32   Other Arichlary Service Cost			1	1		1			

4190 (Cont.) FORM CMS-2540-10 DRAFT ALLOCATION OF CAPITAL - RELATED COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM PART II TO DIRECTLY ASSIGNED CAP. REL CAP. REL. ADMINIS-PLANT OPER. CAPITAL BUILDINGS MOVABLE **EMPLOYEE** TRATIVE MAINTENANCE RELATED COSTS & FIXTURES EQUIPMENT SUBTOTAL BENEFITS & GENERAL & REPAIRS Cost Center Description 0 2 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 74 Other Reimbursable Cost 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 98 Cross Foot Adjustments

99

100

99 Negative Cost Center

100 Total

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DRAFT FORM CMS-2540-10 4190 (Cont.) ALLOCATION OF CAPITAL - RELATED COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM\_ PART II TO LAUNDRY NURSING CENTRAL & LINEN HOUSE ADMINIS-**SERVICES** SERVICE KEEPING DIETARY TRATION & SUPPLY PHARMACY Cost Center Description 6 9 10 11 GENERAL SERVICE COST CENTERS 1 Capital-Related Costs - Buildings & Fixtures 2 Capital-Related Costs - Moveable Equipment 2 3 4 5 3 Employee Benefits 4 Administrative and General 5 Plant Operation, Maintenance and Repairs 6 Laundry and Linen Service 7 8 7 Housekeeping 8 Dietary 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 31 Nursing Facility 32 ICF/IID 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

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4190 (Cont.) FORM CMS-2540-10 DRAFT ALLOCATION OF CAPITAL - RELATED COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM PART II TO NURSING CENTRAL LAUNDRY & LINEN HOUSE ADMINIS-SERVICES SERVICE KEEPING DIETARY TRATION & SUPPLY PHARMACY Cost Center Description 6 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

41-338

52 Other Ancillary Service Cost

**DRAFT** FORM CMS-2540-10 4190 (Cont.) ALLOCATION OF CAPITAL - RELATED COSTS PROVIDER CCN: PERIOD: WORKSHEET B FROM\_ PART II TO NURSING & OTHER MEDICAL ALLIED GENERAL POST STEP-DOWN RECORDS SOCIAL HEALTH SERVICE & LIBRARY SERVICE EDUCATION COST SUBTOTAL ADJUSTMENTS TOTAL Cost Center Description 12 13 14 15 16 17 18 GENERAL SERVICE COST CENTERS 1 Capital-Related Costs - Buildings & Fixtures 2 Capital-Related Costs - Moveable Equipment 3 Employee Benefits 4 Administrative and General 5 Plant Operation, Maintenance and Repairs 6 Laundry and Linen Service 7 Housekeeping 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/IID 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 51 Support Surfaces

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99 Negative Cost Center

100 Total

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4190 (Cont.) FORM CMS-2540-10 DRAFT ALLOCATION OF CAPITAL - RELATED COSTS PROVIDER CCN: WORKSHEET B PERIOD: FROM PART II TO NURSING & OTHER MEDICAL ALLIED GENERAL POST RECORDS SOCIAL HEALTH SERVICE STEP-DOWN & LIBRARY SERVICE **EDUCATION** COST SUBTOTAL ADJUSTMENTS TOTAL 13 14 15 16 17 18 Cost Center Description 12 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 98 Cross Foot Adjustments

99

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4121)

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			(
POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD:	WORKSHEET B-2
		FROM	
		то	

Description		Worksheet B				
1 2 3 4		Description	Part No.	Line No.	Amount	
		1	2	3	4	
2   3   4   4   4   4   5   5   5   6   6   7   7   7   8   8   9   9   9   9   9   9   9   9	1					1
3	2					2
4       4         5       5         6       6         7       8         9       9         10       10         11       11         12       12         13       13         14       14         15       15         16       16         17       17         18       16         19       20         20       20         21       21         22       22         23       22         24       24         25       25         28       25         29       29         30       29         31       31         32       32         33       3         34       34         35       35         36       35         37       37         38       39         39       39         30       35         31       31         32       32         33       33						3
5         6           7         7           8         8           9         9           10         10           11         11           12         11           13         13           14         14           15         15           16         16           17         17           18         19           19         19           20         11           21         20           21         21           22         23           24         22           25         25           27         27           28         22           29         29           30         33           31         31           32         33           33         33           34         34           44         34           44         44           44         44           44         44           44         44           45         45           46         45 <td>4</td> <td></td> <td></td> <td></td> <td></td> <td>4</td>	4					4
6       6         7       8         9       10         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         28       25         29       29         20       20         21       21         22       22         23       23         24       24         25       25         26       25         27       27         28       29         29       29         30       33         31       31         32       33         33       33         34       34         35       35	5					5
7         8         8         8         9         11         11         11         11         11         12         14         15         15         16         16         16         16         16         16         16         16         17         17         18         11         18         11         18         11         18         11         18         12         12         20         20         20         20         20         20         20         20         22         22         22         22         22         22         22         24         24         24         24         24         24         24	6					6
8         9           10         10           11         11           12         12           13         14           15         15           16         16           17         17           18         19           19         19           20         20           21         21           22         22           23         24           24         24           25         26           27         27           28         25           29         29           30         30           31         33           32         33           33         33           34         34           35         35           36         35           37         37           38         33           39         39           40         40           41         41           42         42           43         43           45         45           45 <td< td=""><td>7</td><td></td><td></td><td></td><td></td><td>7</td></td<>	7					7
9						8
10	9					9
11	10					10
112	11					11
13	12					12
14       14       15         16       15       16         17       17       17         18       18       18         19       19       19         20       21       21         21       21       22         23       22       23         24       24       24         25       26       25         26       26       25         27       28       28         29       30       30         31       31         32       32         33       33         34       33         35       35         36       36         37       37         38       38         39       40         40       40         41       44         42       42         43       43         44       44         44       44         45       46         47       48         48       49         49       49         49       49<	13					13
15         15           16         16           17         17           18         19           20         20           21         20           21         22           23         22           24         24           25         26           27         28           29         29           30         28           29         29           30         30           31         31           32         32           33         33           34         33           35         35           36         36           37         36           39         35           39         30           40         40           41         41           42         42           43         43           44         44           45         46           47         46           47         46           47         47           48         49           49         <	14					14
16         16           17         18           19         19           20         20           21         21           22         23           24         223           24         25           26         25           27         28           29         28           29         30           31         30           31         31           32         32           33         32           33         33           34         33           35         35           36         36           37         37           38         33           39         39           40         40           41         41           42         43           43         42           43         44           44         44           45         46           47         48           49         49           49         49           49         49           49	15					15
17	16					16
18       19         20       20         21       22         22       22         23       24         25       25         26       26         27       27         28       29         30       30         31       31         32       32         33       32         33       32         33       33         34       34         35       35         36       36         37       37         38       33         39       39         40       40         41       41         42       42         43       44         44       45         46       46         47       48         49       49         49       49	17					17
19	18					18
20         20           21         21           22         23           24         24           25         25           26         26           27         28           29         28           29         30           31         31           32         33           33         33           34         33           35         35           36         36           37         37           38         38           39         39           40         40           41         41           42         42           43         44           45         45           46         46           47         48           49         49           50         50	19					19
21       21         22       22         23       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       33         39       39         40       40         41       41         42       43         43       43         44       44         45       45         46       46         47       48         49       49         50       50	20					20
22         23         24         25         26         27         28         29         30         31         32         33         34         35         36         37         38         39         40         41         42         43         44         42         43         44         45         46         47         48         49         50	21					21
23       24         24       25         26       26         27       27         28       28         29       29         30       30         31       31         32       33         33       33         34       33         35       35         36       36         37       37         38       33         39       39         40       40         41       41         42       42         43       42         43       42         44       44         45       45         46       47         48       48         49       49         50       50	22					22
24       24         25       26         27       27         28       28         29       30         30       30         31       31         32       32         33       33         34       34         35       35         36       36         37       37         38       33         39       33         39       33         40       40         41       41         42       42         43       44         44       44         45       44         45       45         46       47         48       48         49       49         50       50	23					23
25       25         26       26         27       28         29       29         30       30         31       31         32       32         33       33         34       34         35       35         36       35         37       37         38       33         39       33         40       40         41       41         42       42         43       43         44       44         45       44         45       45         46       46         47       48         49       49         50       50	24					24
26       26         27       28         29       29         30       31         32       32         33       33         34       33         35       35         36       37         37       37         38       33         39       39         40       40         41       41         42       42         43       43         44       44         45       44         44       45         46       46         47       48         49       49         50       50	25					25
27     28       29     28       30     30       31     31       32     32       33     33       34     34       35     35       36     36       37     37       38     33       39     39       40     40       41     41       42     42       43     43       44     44       45     45       47     48       49     48       50     50	26					26
28       28         30       30         31       31         32       32         33       33         34       34         35       35         36       35         37       36         38       33         39       33         40       40         41       40         41       41         42       42         43       43         44       44         45       45         46       46         47       48         49       49         50       50	27					27
29       29         30       30         31       31         32       32         33       33         34       34         35       35         36       36         37       37         38       33         39       40         41       41         42       40         41       41         42       42         43       43         44       44         45       45         46       46         47       46         48       48         49       49         50       50	28					28
30       30         31       31         32       33         34       33         35       35         36       35         37       37         38       33         39       38         40       40         41       41         42       42         43       43         44       44         45       45         46       46         47       46         48       48         49       49         50       50	29					29
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       42         43       43         44       44         45       45         46       46         47       46         47       47         48       48         49       49         50       50	30					30
32       32         33       33         34       34         35       35         36       36         37       38         39       38         40       40         41       41         42       42         43       43         44       44         45       45         46       45         47       47         48       49         50       50	31					31
33       34       33         34       34         35       35         36       36         37       37         38       38         39       39         40       40         41       41         42       42         43       42         43       43         44       44         45       45         46       46         47       47         48       48         49       49         50       50	32					32
34       34         35       35         36       36         37       37         38       38         39       40         41       40         41       41         42       41         43       43         44       44         45       44         46       46         47       47         48       48         49       49         50       50	33					33
35       36       36         37       37       37         38       38       39         40       40       40         41       41       41         42       42       42         43       43       43         44       45       45         46       46       46         47       46       47         48       48       49         50       50       50	34					34
36       36         37       37         38       38         39       40         41       40         42       41         43       42         43       43         44       44         45       45         46       46         47       47         48       49         50       50	35					35
37       38         39       39         40       40         41       41         42       42         43       43         44       44         45       45         46       46         47       47         48       48         49       50	36					36
38       38         39       39         40       40         41       41         42       42         43       43         44       44         45       45         46       46         47       47         48       48         49       50	37					37
39       39         40       40         41       41         42       42         43       43         44       44         45       45         46       46         47       47         48       48         49       50         50       50	38					38
40       40         41       41         42       42         43       43         44       44         45       45         46       46         47       47         48       48         49       50	39					39
41       41         42       42         43       43         44       44         45       45         46       46         47       47         48       48         49       49         50       50	40					40
42       43       43         44       44         45       45         46       46         47       47         48       48         49       49         50       50	41					41
43       43         44       44         45       45         46       46         47       47         48       48         49       49         50       50						42
44       44         45       45         46       46         47       47         48       48         49       49         50       50	43					43
45       45         46       46         47       47         48       48         49       49         50       50	44					44
46       46         47       47         48       48         49       49         50       50	45					45
47     47       48     48       49     49       50     50	46					46
48     48       49     49       50     50	47					47
49     49       50     50	48					48
50 50	49					49
	50					50

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4190 (Cont.)	FORM CMS-2540-10		DRAFT
RATIO OF COST TO CHARGES	PROVIDER CCN:	PERIOD:	WORKSHEET C
FOR ANCILLARY AND OUTPATIENT		FROM	
COST CENTERS		то	

		Total ( from Wkst. B, Pt. I, col. 18 )	Total Charges	Ratio ( col. 1 divided by col. 2 )	
	Cost Center Description	1	2	3	
	LLARY SERVICE COST CENTERS				
	Radiology				40
	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
OUTP	ATIENT SERVICE COST CENTERS				
60	Clinic				60
61	Rural Health Clinic (RHC)				61
	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

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DRAFT	FORM	CMS-2540-10				4190 (0
APPORTIONMENT OF ANCILLARY AND		PROVIDER CCN:		PERIOD:		WORKSHEET D
OUTPATIENT COST				FROM	_	PART I
				TO	_	
Charles-Parks I Train V (1) I Train VVIII	[ ] Tid- VIV (1)					
Check applicable box: [ ] Title V (1) [ ] Title XVIII	[ ] Title XIX (1)	I Other				
Check applicable box: [ ] SNF [ ] NF	[ ] ICF / IID	[ ] Other		[ ] PPS - Must also o	complete Part II	
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST						
		Ratio of				
		Cost to	Healtl	ı Care	Heal	thcare
		Charges	Program	Charges	Progra	m Cost
		( from Wkst. C,			Part A	Part B
		col. 3)	Part A	Part B	( col. 1 x col. 2 )	( col. 1 x col. 3 )
Cost Center Description		1	2	3	4	5
ANCILLARY SERVICE COST CENTERS						
40 Radiology						

40	Radiology			
41	Laboratory			
	Intravenous Therapy			
43	Oxygen (Inhalation) Therapy			
	Physical Therapy			
45	Occupational Therapy			
	Speech Pathology			
47	Electrocardiology			
	Medical Supplies Charged to Patients			
49	Drugs Charged to Patients			
50	Dental Care - Title XIX only			
	Support Surfaces			
	Other Ancillary Service Cost			
OUTF	ATIENT COST CENTERS			
	Clinic			
	Rural Health Clinic (RHC)			
	FQHC			
63	Other Outpatient Service Cost			
	Ambulance (2)			
100	Total (sum of lines 40 - 71)			
		-		

<sup>(1)</sup> For titles V and XIX use columns 1, 2 and 4 only.

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

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4190	0 (Cont.)	FORM CMS-2540-10				DF
	ORTIONMENT OF ANCILLARY AND PATIENT COST	PROVIDER CCN:		PERIOD : FROM TO	_	WORKSHEET D PARTS II & III
TITLI	E XVIII ONLY					
PART	T II - APPORTIONMENT OF VACCINE COST					
1	Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)					
	Program vaccine charges ( From your records or the PS&R report)					
3	Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E	, Pt. I, line 1)				
		·				•
PART	T III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED	HEALTH		T D : C37 :		1 5 4
		Total Cost ( from Wkst. B,	Nursing & Allied Health ( from Wkst. B,	Ratio of Nursing & Allied Health Costs to Total Costs - Part A	Program Part A Cost ( from Wkst. D.,	Part A Nursing & Allied Health Costs for Pass Through
		Pt. I, col. 18)	Pt. I, col. 14)	( col. 2 / col. 1 )	Pt. I, col. 4)	( col. 3 x col. 4 )
	Cost Center Description	1	2	3	4	5
ΔNCI	ILLARY SERVICE COST CENTERS	1	2	3	+	,
	Radiology					
	Laboratory					
	Intravenous Therapy					
	Oxygen (Inhalation) Therapy					
	Physical Therapy					
	Occupational Therapy					
46	Speech Pathology					
	Electrocardiology					
48	Medical Supplies Charged to Patients					
	Drugs Charged to Patients					
50	Dental Care - Title XIX only					
	Support Surfaces					
	Other Ancillary Service Cost					
100	Total (sum of lines 40 - 52)					

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COMPUTATION OF INPATIENT	PROVIDER CCN:	PERIOD:	WORKSHEET D-1
ROUTINE COSTS		FROM	PARTS I & II
		TO	
Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title			
Check applicable box: [ ] SNF [ ] NF [ ] ICF/I	TD		
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	5)		7
8 Enter private room charges from your records			8
9 Average private room per diem charge (private room charges on line 8 div	rided 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 o	n line 10 divided by semi-private rooi	n days)	11
12 Average per diem private room charge differential (line 9 minus line 11)			12
13 Average per diem private room cost differential (line 7 times line 12)			13
14 Private room cost differential adjustment (line 2 times line 13)			14
15 General inpatient routine service cost net of private room cost differential	(line 5 minus line 14)		15
PROGRAM INPATIENT ROUTINE SERVICE COSTS			•
16 Adjusted general inpatient service cost per diem (line 15 divided by line 1	1)		16
17 Program routine service cost (line 3 times line 16)			17
18 Medically necessary private room cost applicable to program (line 4 times	line 13)		18
19 Total program general inpatient routine service cost (line 17 plus line 18)			19
20 Capital related cost allocated to inpatient routine service costs (from Wkst	. B, Pt. II, col. 18, line 30 for SNF; li	ne 31 for NF; or	20
line 32 for ICF/IID)			
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	on line 26) (1)		27
28 Reimbursable inpatient routine service costs (line 22 plus the lesser of line	25 or line 27)		28
(Transfer to Wkst. E, Pt. II, line 4) (see instructions)			
PART II - CALCULATION OF INPATIENT NURSING & ALLIED HEALTH	COSTS FOR PPS PASS-THROUGH		
1 Total inpatient days			1
2 Program inpatient days (see instructions)			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	4)		5

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<sup>(1)</sup> Lines 26, 27 and 28 are not applicable for title XVIII, but may be used for title V and or title XIX  $\,$ 

4190	(Cont.)	FORM CMS-2540-10			DRAFT
	ULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E	
	BURSEMENT SETTLEMENT	The vibilities.	FROM		
	TTLE XVIII		TO		
10111		L	1.0		
PART	A - INPATIENT SERVICE PPS PROVIDER COMPUTA	ATION OF REIMBURSEMENT			
1	Inpatient PPS amount (see instructions)				1
2	Nursing and Allied Health Education Activities (pass through	n payments)			2
3	Subtotal (sum of lines 1 and 2)				3
4	Primary payer amounts				4
5	Coinsurance				5
6	Reimbursable bad debts (from your records)				6
7	Reimbursable bad debts for dual eligible beneficiaries (see ir	nstructions)			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
	Tentative adjustment				13
14	Other adjustment (see instructions)				14
14.99	Sequestration amount (see instructions)				14.99
15	Balance due provider/program (see instructions)				15
	(Indicate overpayment in parentheses)				
16	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2, section 115.2			16
DADE	D. ANCH LADY CEDVICE COMPUTATION OF DED	ADJUDGEMENT LEGGED OF COCK OD	CHARGES TITLE VI	THE CAN W	
	B - ANCILLARY SERVICE COMPUTATION OF REIN Ancillary services Part B	MBURSEMENT LESSER OF COST OR	CHARGES - IIILE XV	III ONLY	17
	Vaccine cost (from Wkst. D, Pt. II, line 3)				17 18
	Total reasonable costs (sum of lines 17 and 18)				19
	Medicare Part B ancillary charges (see instructions)				20
	Cost of covered services (lesser of line 19 or line 20)				20
	,				22
	Primary payer amounts  Coinsurance and deductibles				23
	Reimbursable bad debts (from your records)				23
	( ) /				
	Reimbursable bad debts for dual eligible beneficiaries (see in Adjusted reimbursable bad debts (see instructions)	istructions)			24.01
	-3				24.02
	Subtotal (sum of lines 21 and 24.02, minus lines 22 and 23)				25
	F-3				26
27	Tentative adjustment				27

28

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28.99 29

28 Other Adjustments (Specify \_\_\_\_\_

28.99 Sequestration amount (see instructions)
29 Balance due provider/program (see instructions)

\_) (see instructions)

(indicate overpayments in parentheses)

30 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2

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DRA	AFT FORM	CMS-2540-10	4190 (C	
CALC	CULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E
REIM	BURSEMENT SETTLEMENT		FROM	PART II
FOR	TITLE V and TITLE XIX ONLY		то	
			•	•
	Check applicable box: [ ] Title V [ ] Title XIX			
	Check applicable box: [ ] SNF [ ] NF [ ]	ICF / IID		
COM	PUTATION OF NET COST OF COVERED SERVICES			
	Inpatient ancillary services (see instructions)			
	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)			
	Outpatient services			
4	Inpatient routine services (see instructions)			
5	Utilization review - physicians' compensation (from provider records)			
	Cost of covered services (sum of lines 1 - 5)			
7	Differential in charges between semiprivate accommodations and less			
	than semiprivate accommodations			
8	,			
	Primary payer amounts			
	Total reasonable cost (line 8 minus line 9)			
	ONABLE CHARGES Inpatient ancillary service charges			
	Outpatient service charges			
	Inpatient routine service charges			
	Differential in charges between semiprivate accommodations and less			
17	than semiprivate accommodations			
15	Total reasonable charges			
	OMARY CHARGES			
16	Aggregate amount actually collected from patients liable for payment for			
	services on a charge basis			
17	Amounts that would have been realized from patients liable for payment for service	es		
	on a charge basis had such payment been made in accordance with 42 CFR 413.13	(e)		
	Ratio of line 16 to line 17 (not to exceed 1.000000)			
	Total customary charges (see instructions)			
	PUTATION OF REIMBURSEMENT SETTLEMENT			
	Cost of covered services (see instructions)			
21				
22	Subtotal (line 20 minus line 21) Coinsurance			
	Subtotal (line 22 minus line 23)			
	Reimbursable bad debts (from your records)			
	Subtotal (sum of lines 24 and 25)			
27	Unrefunded charges to beneficiaries for excess costs erroneously collected			
	based on correction of cost limit			
28	Recovery of excess depreciation resulting from provider termination or a decrease			
	in program utilization			
29	Other adjustments (Specify) (see instructions)			
30		·		
	depreciable assets (if minus, enter amount in parentheses)			
31	Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)			
	Interim payments			
33	Balance due provider/program (line 31 minus line 32)			
	(indicate overpayments in parentheses) (see instructions)			

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1190 (Cont.) FORM CMS-2540-10	DRAFT
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ANALYSIS OF PAYMENTS TO PROVIDERS				PROVIDER CCN:	PERIOD:	WORKSHEET E-1		
FOR SERVICES RENDERED					FROM	_		
						то	_	
				Inpatie	ent Part A		Part B	
			Ī	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description			1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted							2
	or to be submitted to the intermediary/contractor for services		- 1					
	rendered in the cost reporting period. If none, enter zero.							
2	List separately each retroactive lump sum							3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		to	.52					3.52
		Program	.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 & 3.99)		- 1					4
	(Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)							
	TO BE COMPLETED BY CONTRACTOR	_			-	<del>_</del>		
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6	Determine net settlement amount (balance	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contra	ctor Number				8

<sup>(1)</sup> 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.

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BALANCE SHEET	PROVIDER CCN:	PERIOD:	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		FROM	
accounting records, complete the "General Fund" column only.)		то	

Assets	General Fund	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS	-	-			
1 Cash on hand and in banks					1
2 Temporary investments					
3 Notes receivable					3
4 Accounts receivable					4
5 Other receivables					5
6 Less: allowances for uncollectible notes	( )	( )	( )	( )	6
and accounts receivable					
7 Inventory					7
8 Prepaid expenses					8
9 Other current assets					9
10 Due from other funds					10
11 TOTAL CURRENT ASSETS					11
(sum of lines 1 - 10)					
FIXED ASSETS					
12 Land					12
13 Land improvements					13
14 Less: Accumulated depreciation	( )	( )	( )	( )	14
15 Buildings					15
16 Less Accumulated depreciation	( )	( )	( )	( )	16
17 Leasehold improvements					17
18 Less: Accumulated Amortization	( )	( )	( )	( )	18
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					28
(sum of lines 12 - 27)					
OTHER ASSETS					
29 Investments					29
30 Deposits on leases					30
31 Due from owners/officers					31
32 Other assets					32
33 TOTAL OTHER ASSETS					33
(sum of lines 29 - 32)					
34 TOTAL ASSETS					34
(sum of lines 11, 28 and 33)		1		1	

( ) = contra amount

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` '			
BALANCE SHEET	PROVIDER CCN:	PERIOD:	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		FROM	
accounting records, complete the "General Fund" column only.)		то	

			Specific		1	$\overline{}$
		General	Purpose	Endowment	Plant	
	Liabilities and Fund	Fund	Fund	Fund	Fund	
	Balances	1	2	3	4	_
CURE	RENT LIABILITIES	-	_	3		
	Accounts payable					35
	Salaries, wages & fees payable				+	36
37					+	37
	Notes & loans payable (short term)				+	38
					+	39
40	Accelerated payments					40
41						41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES					43
	(sum of lines 35 - 42)					
LONG	G 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					50
	(sum of lines 44 - 49)					
51	TOTAL LIABILITIES					51
	(sum of lines 43 and 50)					
CAPI	TAL ACCOUNTS					
52	General fund balance					52
	Specific purpose fund					53
54	Donor created - endowment fund					54
	balance - restricted					
55	Donor created - endowment fund					55
	balance - unrestricted					
56	Governing body created - endowment					56
	fund balance					
57	Plant fund balance - invested in plant					57
58						58
	plant improvement, replacement and					
	expansion					
59	TOTAL FUND BALANCES					59
	(sum of lines 52 thru 58)					
60	TOTAL LIABILITIES AND					60
	FUND BALANCES					
	(sum of lines 51 and 59)					

( ) = contra amount

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DRAFT	FORM CMS-2540-10	4190 (C
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		(-
STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN: PERIOD :	WORKSHEET C
	FROM	
	то	
	10	

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund	
		1	2	3	4	5	6	7	8
1	Fund balances at beginning of period								
2	Net income (loss) (from Wkst. G-3, line 31)								
3	Total (sum of line 1 and line 2)								
4	Additions (credit adjustments)								
5									
6									
7									
8									
9									
	Total additions (sum of lines 5 - 9)								
	Subtotal (line 3 plus line 10)								
12	Deductions (debit adjustments)								
13									
14									
15									
16									
17									
	Total deductions (sum of lines 13 - 17)								
19	Fund balance at end of period per balance sheet (line 11 - line 18)								_

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4190 (Cont.)	FORM CMS-2540-10			DRAFT
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET G - 2 PARTS I & II	
PART I - PATIENT REVENUES				
	INPATIENT	OUTPATIENT	TOTAL	
Revenue Center	1	2	3	
General Inpatient Routine Care Services  1 Skilled nursing facility				1
2 Nursing facility				1 2
3 ICF / IID				3
4 Other long term care				4
5 Total general inpatient care services				5
(sum of lines 1 - 4)				3
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 Hospice				12
13 Other (specify)				13
14 Total patient revenues (sum of lines 5 - 13)				14
(transfer to Wkst. G-3, col. 3, line 1)				
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

14

15

14 Total Deductions (sum of lines 9 - 13)

15 Total Operating Expenses (sum of lines 1 and 8, minus line 14)

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STATEMENT OF REVENUES		PROVIDER CCN:	PERIOD:	WORKSHEET G-3	
AND EXPENSES			FROM		
			TO		
1 Total patient revenues (from Wkst. G-2, Pt. I, col.	3, line 14)				1
2 Less: contractual allowances and discounts on patie	ents accounts				2
3 Net patient revenues (line 1 minus line 2)					3
4 Less: total operating expenses (form Wkst. G-2, Pt	· ,				4
5 Net income from service to patients (line 3 minus 4	1)				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 gues	ts				14
15 Revenue from rental of living quarters					15
16 Revenue from sale of medical and surgical suppl					16
17 Revenue from sale of drugs to other than patients					17
18 Revenue from sale of medical records and abstra	cts				18
19 Tuition (fees, sale of textbooks, uniforms, etc.)					19
20 Revenue from gifts, flower, coffee shops, canteer	n				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

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4190 (Cont.)	FORM CMS-2540-10	DR
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ANALYSIS OF SNF-BASED							PROVIDER CCN:		PERIOD:		WORKSHEET H
НОМ	E HEALTH AGENCY COSTS								FROM		
							HHA CCN:		то		
				TRANSPOR-							NET
				TATION	CONTRACTED/		TOTAL		RECLASSIFIED		EXPENSES FOR
			EMPLOYEE	( see	PURCHASED	OTHER	( sum of cols.	RECLASSIFI-	TRIAL BALANCE	ADJUST-	ALLOCATION
		SALARIES	BENEFITS	instructions )	SERVICES	COSTS	1 thru 5 )	CATIONS	(col. 6 + col. 7)	MENTS	( col. 8 + col. 9 )
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	10
GEN	ERAL SERVICE COST CENTERS										
1	Capital Related - Bldgs. and Fixtures										
2	Capital Related - Movable Equipment										
3	Plant Operation & Maintenance										
4	Transportation (see instructions)										
5	Administrative and General										
HHA	REIMBURSABLE SERVICES										
6	Skilled Nursing Care										
7	Physical Therapy										
8	Occupational Therapy										
9	Speech Pathology										
10	Medical Social Services										
11	Home Health Aide										
12	Supplies (see instructions)										
13	Drugs										
14	DME										
	Telemedicine										
HHA	NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services										
17	Respiratory Therapy										
	Private Duty Nursing										
19	Clinic										
20	Health Promotion Activities										
21	Day Care Program										
	Home Delivered Meals Program										
23	Homemaker Service										
24	All Others										
25	Total (sum of lines 1-24)										

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

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11-12 FORM (	MS-2540-10 4190 (C
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COS	T ALLOCATION - HHA GENERAL SERVICE COST	GENERAL SERVICE COST		PROVIDER CCN:		PERIOD:	WORKSHEET H-1		
							FROM		PART I
					HHA CCN:		то		
		NET EXPENSES		ITAL					
		FOR COST	RELATE	D COSTS	1				
		ALLOCATION			PLANT			ADMINIS-	
		( from Wkst. H,	BLDGS. &	MOVABLE	OPERATION &	TRANS-	SUBTOTAL	TRATIVE	TOTAL
		col. 10)	FIXTURES	EQUIPMENT	MAINTENANCE	PORTATION	( cols. 0 through 4 )	& GENERAL	( cols. 4A + 5 )
		0	1	2	3	4	4A	5	6
	ERAL SERVICE COST CENTERS								
	Capital Related - Bldgs. and Fixtures								
	Capital Related - Movable Equipment								
	Plant Operation & Maintenance								
	Transportation (see instructions)								
	Administrative and General								
	REIMBURSABLE SERVICES								
	Skilled Nursing Care								
	Physical Therapy								
	Occupational Therapy								
	Speech Pathology								
	Medical Social Services								
11	Home Health Aide								
12	Supplies								
	Drugs								
14	DME								
15	Telemedicine								
HHA	NONREIMBURSABLE SERVICES								
16	Home Dialysis Aide Services								
17	Respiratory Therapy								
18	Private Duty Nursing								
19	Clinic								
20	Health Promotion Activities								
21	Day Care Program								
	Home Delivered Meals Program								
	Homemaker Service								
24	All Others								
25	Total (sum of lines 1-24)								

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4190 (Cont.	FORM CMS-2540-10

COST	COST ALLOCATION - HHA STATISTICAL BASIS			PROVIDER CCN:		PERIOD:	WORKSHEET H-1		
							FROM	PART II	
					HHA CCN:		то		
				ITAL					
				D COSTS	PLANT			ADMINIS-	
			BLDGS. &	MOVABLE	OPERATION &			TRATIVE	
		NET EXPENSES	FIXTURES	EQUIPMENT	MAINTENANCE	TRANS-		& GENERAL	
		FOR COST	( Square	( Dollar Value	( Square	PORTATION	RECONCIL-	( Accumulated	
		ALLOCATION	Feet )	or Square Feet )	Feet )	( Mileage )	IATION	Cost )	TOTAL
		0	1	2	3	4	5A	5	6
	ERAL SERVICE COST CENTERS								
	Capital Related - Bldgs. and Fixtures								
	Capital Related - Movable Equipment								
	Plant Operation & Maintenance								
	Transportation (see instructions)								
	Administrative and General								
	REIMBURSABLE SERVICES								
	Skilled Nursing Care								
7	Physical Therapy								
8	Occupational Therapy								
9	Speech Pathology								
10	Medical Social Services								
11	Home Health Aide								
12	Supplies								
13	Drugs								
14	DME								
15	Telemedicine								
HHA	NONREIMBURSABLE SERVICES								
16	Home Dialysis Aide Services								
17	Respiratory Therapy								
18	Private Duty Nursing								
19	Clinic								
20	Health Promotion Activities								
21	Day Care Program								
22	Home Delivered Meals Program								
23	Homemaker Service								
24	All Others								
25	Total (sum of lines 1-24)								
26	Cost to be allocated								
27	Unit Cost Multiplier								

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1-12

ALLOCATION OF GENERAL SERVICE					PROVIDER CCN:		PERIOD:		WORKSHEET H-	2,
COSTS TO HHA COST CENTERS							FROM		PART I	
					HHA CCN:		то			
	From		1	PITAL						
	Wkst.	HHA	RELATE	ED COSTS						
	H-1,	TRIAL				SUBTOTAL	ADMINIS-		LAUNDRY	
	Pt. I,	BALANCE	BLDGS. &	MOVABLE	EMPLOYEE	( cols. 0	TRATIVE &	OPERATION	& LINEN	
	col. 6,	(1)	FIXTURES	EQUIPMENT	BENEFITS	through 3)	GENERAL	OF PLANT	SERVICE	
HHA COST CENTER	line	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										22
divided by the sum of column 18,										
line 21, minus column 18, line 1,										
rounded to 6 decimal places										

<sup>(1)</sup> Column 0, line 21 must agree with Wkst. A, col. 7, line 70.

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

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1100	3 (Goitt.)	1 011111	C1110 -0 10 1	0				-
	OCATION OF GENERAL SERVICE IS TO HHA COST CENTERS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET H-2, PART I
COS	.5 TO THIA COST CENTERS			HHA CCN:		TO		I AKI I
				IIIII GGIV.				
		*******		NURSING	CENTRAL		MEDICAL	
		HOUSE	DIETADI	ADMINIS-	SERVICES &	DUADMACN	RECORDS &	SOCIAL
	HILA COCT CENTER	KEEPING 7	DIETARY	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE
1	HHA COST CENTER	/	8	9	10	11	12	13
	Administrative and General			+		<del>                                     </del>	<del>                                     </del>	
	Skilled Nursing Care			-			<del>                                     </del>	
	Physical Therapy Occupational Therapy			-			<del>                                     </del>	+
	Speech Pathology					+	<del>                                     </del>	+
	Medical Social Services					+	<del> </del>	+
	Home Health Aide					+	<del>                                     </del>	+
	Supplies			+			<del>                                     </del>	+
	Drugs					+	<del>                                     </del>	_
10	DME					+		+
	Telemedicine					+		+
	Home Dialysis Aide Services					+		+
	Respiratory Therapy					-		+
	Private Duty Nursing					-		-
	Clinic					+	+	+
	Health Promotion Activities						+	
	Day Care Program						<del> </del>	
	Home Delivered Meals Program							
	Homemaker Service					-		
20	All Others							
	Totals (sum of lines 1-20) (2)							
	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.							

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

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	ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS				PROVIDER CCN: HHA CCN:		PERIOD : FROM TO		
			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 )	
		HHA COST CENTER	14	15	16	17	18	19	
1	1	Administrative and General							
2	2	Skilled Nursing Care							
3	3	and an analysis							
4	4	o companional control of							
5	5	op							
6	- 6	Medical Social Services							
7	- 7	Home Health Aide							
8		Supplies							
9		Drugs							
10		DME							
11	11								
12		Home Dialysis Aide Services							
13		Respiratory Therapy							
14	14	1 11 19 1 19							
15	15								
16		Health Promotion Activities							
17		Day Care Program							
18		Home Delivered Meals Program							
19		Homemaker Service							
20		All Others							
21		Totals (sum of lines 1-20) (2)							
22	22								
		divided by the sum of column 18,							
		line 21, minus column 18, line 1,							
		rounded to 6 decimal places.							

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

4190 (Cont.) WORKSHEET H-2, PART I

TOTAL HHA COSTS 20	
	1
	2
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	3 4 5 6
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	11
	12
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	14
	15
	16
	17
	18
	19
	20
	21
	22

	OCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET H-2	<u>)</u> ,
COST	S TO HHA COST CENTERS					FROM		PART II	
STAT	ISTICAL BASIS			HHA CCN:		то			
			PITAL						
			D COSTS	1		ADMINIS-		LAUNDRY	
		BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	OPERATION	& LINEN	
		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	OF PLANT	SERVICE	
		( Square	( Dollar Value	( Gross	RECONCIL-	( Accumulated	( Square	( Pounds of	
		Feet )	or Square Feet )	Salaries )	IATION	Cost )	Feet )	Laundry )	
	HHA COST CENTER	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
	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
	Total cost to be allocated								22
23	Unit Cost Multiplier								23

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS				PROVIDER CCN: HHA CCN:		PERIOD: FROM TO		WORKSHEET H-2 PART II	
	HHA COST CENTER	HOUSE- KEEPING ( Hours of Service )	DIETARY ( Meals Served ) 8	NURSING ADMINIS- TRATION ( Direct Nursing Hrs.)	CENTRAL SERVICES & SUPPLY ( Costed Requis.)	PHARMACY ( Costed Requis.)	MEDICAL RECORDS & LIBRARY ( Time Spent )	SOCIAL SERVICE (Time Spent)	
	Administrative and General	,	0	+	10	- 11	12	15	
	Skilled Nursing Care								
	Physical Therapy								
	Occupational Therapy								
5	Speech Pathology								
	Medical Social Services								
7	Home Health Aide								
8	Supplies								
9	Drugs								
10	DME								
11	Telemedicine								
12	Home Dialysis Aide Services								
13	Respiratory Therapy								
14	Private Duty Nursing								
15	Clinic								
16	Health Promotion Activities								
17	Day Care Program								
	Home Delivered Meals Program								
	Homemaker Service								
	All Others								
21	Totals (sum of lines 1-20)								
22	Total cost to be allocated								
23	Unit Cost Multiplier								

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, ALLOCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		
COSTS TO HHA COST CENTERS STATISTICAL BASIS			HHA CCN:		FROM TO		
HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION ( Assigned Time )	OTHER GENERAL SERVICE (SPECIFY) 15	SUBTOTAL ( sum of cols. 3A through 15 )	POST STEPDOWN ADJUSTMENTS 17	SUBTOTAL ( cols. 16 ± 17 ) 18	ALLOCATED HHA A&G ( see Pt. II ) 19	
1 1 Administrative and General	14	15	16	1/	10	19	
2 2 Skilled Nursing Care 3 3 Physical Therapy							
4 4 Occupational Therapy							
5 5 Speech Pathology							
6 6 Medical Social Services							
7 7 Home Health Aide							
8 8 Supplies							
9 9 Drugs							
10 10 DME							
11 11 Telemedicine							
12 12 Home Dialysis Aide Services							
13 13 Respiratory Therapy							
14 14 Private Duty Nursing							
15 15 Clinic							
16 16 Health Promotion Activities							
17 17 Day Care Program							
18 18 Home Delivered Meals Program							
19 19 Homemaker Service							
20 20 All Others							
21 21 Totals (sum of lines 1-20)							
22 22 Total cost to be allocated							
23 23 Unit Cost Multiplier							

WORKSHEET H-2, PART II

TOTAL HHA COSTS 20	
-	1
	2
	3
	2 3 4 5 6
	5
	7
	8
	9
	10
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	14
	15
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	21
	22
	23

JIMIT						1 01	CIVI CIVID-2	J <del>-1</del> U-1U					+130 ( <i>(</i>	
APPORTIONMENT OF PATIENT	SERVI	CE COSTS						PROVIDER CCN	V:	PERIOD : FROM		WORKSHEET H	-3,	
								HHA CCN:		то				
Check applicable box:		[] Title V	[] Title	XVIII	[ ] Title XIX			1						
PART I - COMPUTATION OF T	HE AG	GREGATE P	ROGRAM C	OST	[] 11110 11111									
	From,	Facility	Shared	Total		Average		Program Visits			Cost of Services			
•	Wkst.	Costs	Ancillary	HHA		Cost		Part E	3			art B	Total	
	H-2,	( from	Costs	Costs		Per Visit		Not Subject	Subject	1	Not Subject	Subject	Program Cost	
	Pt. I,	Wkst. H-2.	( from	( col. 1 +	Total	( col. 3		to Deductibles	to Deductibles		to Deductibles	to Deductibles	( sum of	
	col. 20,	Pt. I )	Pt. II )	col 2)	Visits	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	& Coinsurance	& Coinsurance	cols. 9-10)	
Patient Services	line -	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Care	2													
2 Physical Therapy	3													
3 Occupational Therapy	4													
4 Speech Pathology	5													
5 Medical Social Services	6													
6 Home Health Aide	7													
7 Total (sum of lines 1-6)														
			•		•	!		•			!			
Patient Services by CBSA												Program Visits		
												P	art B	
												Not Subject	Subject	
										CBSA		to Deductibles	to Deductibles	
										No. (1)	Part A	& Coinsurance	& Coinsurance	
										1	2	3	4	
8 Skilled Nursing Care														
9 Physical Therapy														
10 Occupational Therapy														
11 Speech Pathology														
12 Medical Social Services														
13 Home Health Aide														
14 Total (sum of lines 8-13)														
											•			
Supplies and Drugs Cost			Facility					Pro		am Covered Charges		Cost of Services		
Computations			Costs	Shared		Total			Part I			Part B		
		From	( from	Ancillary	Total	Charges			Not Subject	Subject		Not Subject	Subject	
		Wkst. H-2,	Wkst.	Costs	HHA	( from	Ratio		to	to		to	to	
		Pt. I,	H-2,	( from	Cost	ННА	( col. 3		Deductibles &	Deductibles &		Deductibles &	Deductibles &	
		col. 20,	Pt. I )	Pt. II )	( cols. 1 + 2 )	records )	÷ col. 4 )	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	
Other Patient Services		line -	1	2	3	4	5	6	7	8	9	10	11	
15 Cost of Medical Supplies		8												
16 Cost of Drugs		9												
DART II APPORTIONMENT OF	F COST	OF IIIIA CI	EDVICEC FI	IDMICHED	DV CHARED	CKILLED MI	IDCING FACI	ITV DEDARTME	NITC					
PART II - APPORTIONMENT OF	r COST	OF HHA SI	ERVICES FU	JRNISHED	BY SHARED					Chausa	IIIIA Chanad /	\ill C	T	
						From		Charge	Total HHA			Ancillary Costs	Transfer to Pt. 1 -	
						Wkst. C,		atio	( from provider records )		( col. 1 x col. 2 )		Pt. 1 -	
1 Physical Therapy						col. 3, line -		1	-	<u> </u>	3	1	col. 2, line 2	
2 Occupational Therapy						45			-				col. 2, line 2	
3 Speech Pathology						45			-				col. 2, line 3	
4 Cost of Medical Supplies						48							col. 2, line 4	
5 Cost of Drugs						40			<del> </del>				col. 2, line 15	

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

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4190 (Cont.	FORM CMS-2540-10	DRAFT
4130 (COIII.	1 OKW CW3-2540-10	DIA

4190 (Cont.)		FORM C	MS-2540-10			DRAFT
CALCULATION OF SNF-BASED HHA			PROVIDER CCN:	PERIOD:	WORKSHEET H-4,	
REIMBURSEMENT SETTLEMENT			THE VIBER CO. I.	FROM	1 '	
KEIMBOKOEMENT SETTEEMENT			HHA CCN:	TO TO	-  '' '' '' ''	
			IIIII CCIV.	10	-	
					!	
Check applicable box:	[] Title V	[ ] Title XVIII	[ ] Title XIX			
·						
PART I - COMPUTATION OF THE L	ESSER OF REASON	ABLE COST OR CUSTO	MARY CHARGES			
				Pa	nrt B	
				Not Subject to	Subject to	
				Deductibles	Deductibles	
			Part A	& Coinsurance	& Coinsurance	
Description			1	2	3	
Reasonable Cost of Part A & Part B Service	S					
1 Reasonable cost of services (see in	nstructions)					1
2 Total charges						2
Customary Charges						
3 Amount actually collected from pa	tients liable for paymen	nt				3
for services on a charge basis (from						
4 Amount that would have been reali		2				4
for payment for services on a charge	ge basis had such					
payment been made in accordance		)				
5 Ratio of line 3 to line 4 (not to exce						5
6 Total customary charges (see instr	uctions)					6
7 Excess of total customary charges					1	7

8

9

## PART II - COMPUTATION OF <u>SNF-BASED</u> HHA REIMBURSEMENT SETTLEMENT

cost (complete only if line 6 exceeds line 1)

9 Primary payer amounts

8 Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)

		Part A Services	Part B Services	
	Description	1	2	1
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 (see instructions)			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			35
	CMS Pub. 15-2, section 115.2			

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DRAFT	FORM CMS-2540-10	4190 (Cont.)
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ANALYSIS OF PAYM HHA FOR SERVICES RENDERED TO PROG				PROVIDER CCN:  HHA CCN:	PERIOD : FROM TO	WORKSH	EET H-5		
					Part A		Part B		
			Ī	mm/dd/yyyy	Amount	mm/dd/yyyy		Amount	
	Description		Γ	1	2	3		4	
	nents paid to provider								1
2 Interim payments	payable on individual bills, either submitted								2
or to be submitted	to the intermediary/contractor for services		- 1						
	st reporting period. If none, enter zero.								
	h retroactive lump sum								3.01
1 "	t based on subsequent revision of	Program	.02						3.02
	the cost reporting period	to	.03						3.03
Also show date of		Provider	.04						3.04
If none, write "NC	ONE," or enter a zero. (1)		.05						3.05
			.50						3.50
		Provider	.51						3.51
		to	.52						3.52
		Program	.53						3.53
			.54						3.54
	of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99						3.99
	M PAYMENTS (sum of lines 1, 2, and 3.99)								4
(Transfer to Wkst.	H-4, Part II, column as appropriate, line 32)								
TO BE COMPLE	TED BY CONTRACTOR								
5 List separately eac		Program	.01						5.01
payment after desl	review. Also show	to	.02						5.02
date of each paym	ent.	Provider	.03						5.03
If none, write "NC	NE," or enter a zero. (1)	Provider	.50						5.50
		to	.51						5.51
		Program	.52						5.52
SUBTOTAL (sur	n of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99						5.99
6 Determine net sett	lement amount (balance	Program to Provider	.01						6.01
due) based on the	cost report (1)	Provider to Program	.02						6.02
7 TOTAL MEDICA	RE PROGRAM LIABILITY (see instructions)	<del>-</del>							7
8 Name of Contractor Co				ctor Number	•				8

<sup>(1)</sup> 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.

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4190	(Cont.)	FOR	M CMS-2540-10		D			
	ANALYSIS OF SNF-BASED RHC/FQHC COSTS			PROVIDER CCN:		PERIOD:		WORKSHEET I-1
						FROM	_	
				RHC/FQHC CCN:		то	_	
	Check applicable box: [ ] RHC	[ ] FQHC						
						RECLASSIFIED		NET EXPENSES
						TRIAL		FOR
		COMPEN-	OTHER	TOTAL	RECLASSIFI-	BALANCE		ALLOCATION
		SATION	COSTS	( col. 1 + col. 2 )	CATIONS	( col. 3 +/- col. 4 )	ADJUSTMENTS	( col. 5 +/- col.6 )
	L.,	1	2	3	4	5	6	7
	TH CARE STAFF COSTS							
	Physician							
	Physician Assistant							
	Nurse Practitioner							
	Visiting Nurse							
	Other Nurse							
	Clinical Psychologist							
	Clinical Social Worker							
	Laboratory Technician							
	Other health care staff costs							
	Subtotal (sum of lines 1 - 9)							
	S UNDER AGREEMENT							
	Physician Services Under Agreement							
	Physician Supervision Under Agreement							
	Other costs under agreement							
	Subtotal (sum of lines 11 - 13)							
	R HEALTH CARE COSTS							
	Medical Supplies							
	Transportation (Health Care Staff)							
	Depreciation - Medical Equipment							
	Professional Liability Insurance							
	Other health care costs							
	Subtotal (sum of lines 15 - 19)							
22	Total cost of health care services							
	(sum of lines 10, 14, and 21)							
	S OTHER THAN RHC/FQHC SERVICES							
	Pharmacy							
	Dental							
	Optometry							
	All other non reimbursable costs							
28	Total nonreimbursable costs (sum of lines 23 - 26)							

RHC/FQHC OVERHEAD

29 RHC/FQHC costs

30 Administrative costs

31 Total RHC/FQHC overhead (sum of lines 29-30)
32 Total RHC/FQHC costs (sum of lines 22, 28 and 31)

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

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## AFT

DRA	RAFT			FORM CM	S-2540-10			4190 (C
ALLC	LOCATION OF OVERHEAD					PERIOD:		WORKSHEET I-2
TO SI	NF-BASED RHC/FQHC	SERVICES				FROM		
				RHC/FQHC C	CN:	то		
С	heck applicable box:	[ ] RHC	[ ] FQHC					
PART	I - VISITS AND PI	RODUCTIVITY						
	1 110110 11110 11			Number		Productivity	Minimum	Greater of
				of FTE	Total	Standard	Visits	Column 2 or
				Personnel	Visits	(1)	( col. 1 x col. 3 )	Column 4
				1	2	3	4	5
1	Physicians					4200		
2	Physician Assistants					2100		
3	Nurse Practitioners					2100		
4	Subtotal (sum of lines	: 1 - 3)						
5	Visiting Nurse							
6								
7	Clinical Social Worker							
	Medical Nutrition The							
		ment Training (FQHC only)						
	Total FTEs and visits	,						
11	Physician Services Un	der Agreements						
DADT	II DETERMINATI	ON OF TOTAL ALLOWAR	DIE COST ADDITICADI	TE TO SNE DAS	ED DUC / FOU	C SEDVICES		
		are services (from Wkst. I-1, o		LE IU SNF-DAS.	ED KIIC / FQII	C SERVICES		
		costs (from Wkst I-1, col 7, li						
		xcluding overhead (sum of line						
15		services (line 12 divided by lin						
16		erhead (from Wkst. I-1, col. 7,						
17		ead allocated to RHC/FQHC (s						
/	Provider overne	(c						ļ

18 Total overhead (sum of lines 16 and 17)

19 Overhead applicable to RHC/FQHC services (lines 15 X line 18)
 20 Total allowable cost of RHC/FQHC services (sum of lines 12 and 19)

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

<u>ont. )</u>

4190 (C	ont.)	FORM CMS-2540-10			DRAFT
CALCULA	TION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET I-3	
SETTLEMI	ENT FOR SNF-BASED RHC/FQHC SERVICES	DUC/FOUC CCN.	FROM	—	
		RHC/FQHC CCN:	то	_	
	Check applicable box: [ ] Title V [ ] Title XVIII	[ ] Title XIX			
	Check applicable box: [ ] RHC [	FQHC			
DADTI	DETERMINATION OF DATE FOR CHE DACED DISCROSS CE	DVICEC			
	DETERMINATION OF RATE FOR <i>SNF-BASED</i> RHC/FQHC SEI Total allowable cost of RHC/FQHC services (from Wkst. I-2, Pt. II, li				1
	Cost of vaccines and their administration (from Wkst. I-4, line 15)	ne 20)			2
	Total allowable cost excluding vaccine (line 1 minus line 2)				3
	Total FTEs and visits (from Wkkst. I-2, col. 5, line 10)				4
	Physicians' visits under agreement (from Wkst. I-2, col. 5, line 11)				5
	Total adjusted visits (line 4 plus line 5)				6
	Adjusted cost per visit (line 3 divided by line 6)				7
	radjusted cost per visit (inte s divided by inte s)			<u> </u>	<u> </u>
CALCULA	ATION OF LIMIT		Prior to	On or after	
	ough 14: Fiscal year RHC/FQHC use columns 1 and 2.		January 1	January 1	
	ough 14: Calendar year RHC/FQHC use column 2 only.		1	2	
	Rate per visit limit (from your contractor)				8
9	Rate for Program covered visits (see instructions)				9
	- CALCULATION OF SETTLEMENT FOR SNF-BASED RHC/FQH				
	Program covered visits excluding mental health services (from contract				10
	Program cost excluding costs for mental health services (line 9 x line 1				11
	Program covered visits for mental health services (from contractor reco	ords)			12
	Program covered cost for mental health services (line 9 x line 12)				13
	Limit adjustment for mental health services (see instructions)	10)			14
	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 a	nd 2)			15
	Total Program charges (see instructions) (from contractor records)	1.			15.01
	Total Program preventive charges (see instructions) (from provider re	cords)			15.02
	Total Program preventive costs ((line 15.02/line 15.01) times line 15)	7) + 00)			15.03
	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17 Total Program cost (see instructions)	times .80)			15.04 15.05
	Primary payer amounts				15.05
	Less: Beneficiary deductible for RHC only (see instructions) (from co	ontractor records)			17
	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions)				18
	Net Program cost excluding vaccines (see instructions)	may (nom conductor records)			19
	Program cost of vaccines and their administration (from Wkst. I -4, lin	e 16)			20
	Total reimbursable Program cost (line 19 plus 20)	10)			21
	Reimbursable bad debts				22
22.01	Adjusted reimbursable bad debts (see instructions)				22.01
	Reimbursable bad debts for dual eligible beneficiaries (see instructions	5)			23
	Other adjustments	,			24
	Net reimbursable amount (see instructions)				25
	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 RHC/FQHC/Program (see instructions)				28
29	Protested amounts (nonallowable cost report items) in accordance with	CMS Publ. 15-2, § 115.2			29

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AFT FO		4190 (C				
	PERIOD: FROM TO	WORKSHEET I-4				
Check applicable box: [ ] Title V [ ] Title XVIII	[ ] Title XIX	-	1			
Check applicable box: [ ] RHC [	] FQHC					
CULATION OF COST		PNEUMOCOCCAL	INFLUENZA			
	1	2				
Health care staff cost (from Wkst. I-1, col. 7, line 10)						
Ratio of pneumococcal and influenza vaccine staff time to total health care s						
Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)						
Medical supplies cost - pneumococcal and influenza vaccine (from your rec						
Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)						
Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22)						
Total overhead (from Wkst. I-2, line 19)						
Ratio of pneumococcal and influenza vaccine direct cost to total direct cost						
Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)						
Total number of pneumococcal and influenza vaccine injections (from your						
Medicare cost of pneumococcal and influenza vaccine and their administration						
	ion (sum of					
cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)						
	Check applicable box: [ ] Title V [ ] Title XVIII Check applicable box: [ ] RHC [ ] CULATION OF COST  Health care staff cost (from Wkst. I-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care see the pneumococcal and influenza vaccine staff cost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (sum of lines 3 and 4) Total direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4) Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22) Total overhead (from Wkst. I-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine injections (from your Cost per pneumococcal and influenza vaccine injections (from your Cost per pneumococcal and influenza vaccine injections (line 10 divided by Number of pneumococcal and influenza vaccine injections administered to Medicare cost of pneumococcal and influenza vaccine and their administration Total cost of pneumococcal and influenza vaccine and their administration Medicare cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration Medicare cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration total cost of pneumococcal and influenza vaccine and their administration to	PUTATION OF SNF-BASED RHC/FQHC PNEUMOCOCCAL    NFLUENZA VACCINE COST	PETATION OF SNF-BASED RHC/FQHC PNEUMOCOCCAL  NFLUENZA VACCINE COST  Check applicable box: [ ] Title V [ ] Title XVIII [ ] Title XIX  Check applicable box: [ ] RHC  CULATION OF COST  PNEUMOCOCCAL  Health care staff cost (from Wkst. I-1, col. 7, line 10)  Ratio of pneumococcal and influenza vaccine staff time to total health care staff time  Pneumococcal and influenza vaccine staff cost (line 1 x line 2)  Medical supplies cost - pneumococcal and influenza vaccine (from your records)  Direct cost of pneumococcal and influenza vaccine injection (line 1 x line 2)  Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22)  Total overhead (from Wkst. I-2, line 19)  Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)  Total pneumococcal and influenza vaccine injections (from your records)  Total number of pneumococcal and influenza vaccine injections (from your records)  Cost per pneumococcal and influenza vaccine injections (from your records)  Cost per pneumococcal and influenza vaccine injections administration (sum of lines 5 and 9)  Total cost of pneumococcal and influenza vaccine injections administration (sum of lines 5 and 9)  Total cost of pneumococcal and influenza vaccine injections administration (sum of line 12 x line 13)  Total cost of pneumococcal and influenza vaccine and their administration (sum of			

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)

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4190 (Cont. )	FORM CMS-2540-10			Γ	
ANALYSIS OF PAYMENTS TO	PROVIDER CCN:		PERIOD :	WORKSHEET I - 5	
SNF-BASED RHC/FQHC FOR SERVICES RENDERED		F	FROM		
	RHC/FQHC CCN:	7	ГО ОТ		
Check applicable box: [ ] RHC	[ ] FOHC				
спеск аррпсавіе вох.	[ ] rQnC				
			mm/dd/yyyy	Amount	
Description			1	2	
1 Total interim payments paid to RHC/FQHC					
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.					
3 List separately each retroactive lump sum		.01			
adjustment amount based on subsequent revision of	Program	.02			
the interim rate for the cost reporting period	to	.03			
Also show date of each payment.	RHC/FQHC	.04			
If none, write "NONE," or enter a zero. (1)		.05			
		.50			
	RHC/FQHC	.51			
	to	.52			
	Program	.53			
		.54			
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.	98)	.99			
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)					
(Transfer to Wkst. I-3, line 26)					
				•	
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement	Program	.01			
payment after desk review. Also show	to	.02			
date of each payment.	RHC/FQHC	.03			
If none, write "NONE," or enter a zero. (1)	RHC/FQHC	.50	<u> </u>		
	to	.51			
	Program	.52	•		
SUPTOTAL (sum of lines 5.01 5.49 minus sum of lines 5.50 5.	08)	00			

Program to RHC/FQHC

RHC/FQHC to Program

.01

.02

Contractor Number

6 Determine net settlement amount (balance

Name of Contractor

due) based on the cost report (1)
TOTAL MEDICARE PROGRAM LIABILITY (see instructions)

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

RAFT

1 2

3.01
3.02
3.03
3.04
3.05
3.50
3.51
3.52
3.53
3.54
3.99
4

5.01 5.02 5.03 5.50 5.51 5.52 5.99 6.01 6.02 7

11-12 FORM CMS-2540-10
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ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-1
TO COST CENTERS FOR CMHC		FROM	PART I
	COMPONENT CCN:	то	

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

<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

16

17 18

20 21

22

16 Drugs and Biologicals17 Medical Supplies

18 Medical Appliances

21 All Other

19 Durable Medical Equipment - Rented20 Durable Medical Equipment - Sold

23 Unit Cost Multiplier (see instructions)

22 Totals (sum of lines 1-21) (1)

<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

11-12 11-12 FORM CMS-2540-10

WORKSHEET J-1	ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD:
PART I	TO COST CENTERS FOR CMHC		FROM
		COMPONENT CCN:	то

			i		ı	
NURSING ADMINIS- TRATION			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES
9		COMPONENT COST CENTER	10	11	12	13
	1 1	Administrative and General				
	2 2	Skilled Nursing Care				
		Physical Therapy				
		Occupational Therapy				
		Speech Pathology				
	6 6	Medical Social Services				
	7 7	Respiratory Therapy				
		Psychiatric/Psychological Services				
		Individual Therapy				
		Group Therapy				
		Individualized Activity Therapy				
		Family Counseling				
		Diagnostic Services				
		Appr. Patient Training & Education				
		Prosthetic and Orthotic Devices				
		Drugs and Biologicals				
		Medical Supplies				
		Medical Appliances				
	19 19	Durable Medical Equipment - Rented				
		Durable Medical Equipment - Sold				
		All Other				
	22 22	Totals (sum of lines 1-21) (1)				
	23 23	Unit Cost Multiplier (see instructions)				

<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

## 4190 (Cont.) 4190 (Cont.)

## FORM CMS-2540-10

4190 (Colit.) 4190 (Colit.)			FORWI CWI3-2540-10	
	WORKSHEET J-1	ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	
	PART I	TO COST CENTERS FOR CMHC		
_			COMPONENT CCN:	
_			COM GILLIT GGI	
NURSING &				
ALLIED	OTHER			POST
	-			
HEALTH	GENERAL			STEP-DOWN
EDUCATION	SERVICE		SUBTOTAL	ADJUSTMENTS
14	15	COMPONENT COST CENTER	16	17
		1 1 Administrative and General		
		2 2 Skilled Nursing Care		
		3 3 Physical Therapy		
		4 4 Occupational Therapy		
		5 5 Speech Pathology		
		6 6 Medical Social Services		
		7 7 Respiratory Therapy		
		8 8 Psychiatric/Psychological Services		
		9 9 Individual Therapy		
		10 10 Group Therapy		
		11 11 Individualized Activity Therapy		
		12 12 Family Counseling		
		13 13 Diagnostic Services		
		14 Appr. Patient Training & Education		
		15 Prosthetic and Orthotic Devices		
		16 16 Drugs and Biologicals		
		17 17 Medical Supplies		
		18 18 Medical Appliances		
		9 19 Durable Medical Equipment - Rented		
		20 20 Durable Medical Equipment - Sold		
		21 21 All Other		
		22 22 Totals (Sum of lines 1-21) (1)		
		23 Unit Cost Multiplier (see instructions)		

<sup>(1)</sup> Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

PERIOD:	WORKSHEET J-1
FROM	PART I
TO	

SUBTOTAL 18	ALLOCATED A & G ( see Pt. II ) 19	TOTAL ( sum of cols. 18 and 19 ()	
			1
			2
			3
			4
			5
			6
			1 2 3 4 5 6
			8
			9
			10
			11
			12
			13
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			19
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			21
			22
			23

11-12 FORM CMS-2540-10	4190	0	(
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ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-1	
TO COST CENTERS FOR CMHC		FROM	PART II	
	COMPONENT CCN:	то		

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

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Al	LLC	OCATION OF GENERAL SERVICE COSTS OST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:		PERIOD: FROM TO	
			PLANT OPERATION MAINTENANCE & REPAIRS ( Square Feet )	LAUNDRY & LINEN SERVICE ( Pounds of Laundry )	HOUSE - KEEPING ( Hours of Service )	DIETARY ( Meals Served )
		COMPONENT COST CENTER	5	6	7	8
1	1	Administrative and General				
2		Skilled Nursing Care				
3		Physical Therapy				
4		Occupational Therapy				
5		Speech Pathology				
6	6	Medical Social Services				
7	7	Respiratory Therapy				
8		Psychiatric/Psychological Services				
9		Individual Therapy				
		Group Therapy				
11		Individualized Activity Therapy				
		Family Counseling				
		Diagnostic Services				
		App. Patient Training & Education				
	_	Prosthetic and Orthotic Devices				
		Drugs and Biologicals				
		Medical Supplies				
		Medical Appliances				
19	19	Durable Medical Equipment - Rented				

20 20 Durable Medical Equipment - Sold

22 22 Totals (sum of lines 1-21)
23 23 Total cost to be allocated
24 24 Unit Cost Multiplier

21 21 All Other

11-12 11-12 FORM CMS-2540-10

9 Individual Therapy

12 Family Counseling

13 Diagnostic Services

16 Drugs and Biologicals

17 Medical Supplies

21 All Other

11 Individualized Activity Therapy

14 App. Patient Training & Education

18 Medical Appliances19 Durable Medical Equipment - Rented

20 Durable Medical Equipment - Sold

22 Totals (sum of lines 1-21)

23 Total cost to be allocated24 Unit Cost Multiplier

15 Prosthetic and Orthotic Devices

10 Group Therapy

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18 19 20

21

22

11-12 11-12					FORIVI CIVIS-2540-10				
WORKSHEET J-1	A	LLO	CATION OF GENERAL SERVICE COSTS	PROVIDER			PERIOD:		
PART II	T	O C	OST CENTERS FOR CMHC				FROM		
					COMPONENT CCN:		то		
NURSING				CENTRAL					
ADMINIS-				SERVICES		MEDICAL			
TRATION				& SUPPLY	PHARMACY	RECORDS &	SOCIAL		
( Direct Nursing				( Costed	( Costed	LIBRARY	SERVICES		
Hours of Service )				Requisitions )	Requisitions )	( Time Spent )	( Time Spent )		
9			COMPONENT COST CENTER	10	11	12	13		
	1	1	Administrative and General						
	2	2	Skilled Nursing Care						
	3	3	Physical Therapy						
	4	4	Occupational Therapy						
	5	5	Speech Pathology						
	6	6	Medical Social Services						
	7	7	Respiratory Therapy						
	8	8	Psychiatric/Psychological Services						

	4190 (C	iont.)
	WORKSHEET J-1	
_	PART II	
_		
_		
NURSING &		
ALLIED	OTHER	
HEALTH	GENERAL	
EDUCATION	SERVICE	
( Assigned Time )	( )	
14	15	1
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
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		20
		21
		22
		23
		24

4190 (Cont.)	FORM CMS-2540-10	RM CMS-2540-10			2
COMPLITATION OF CMHC	DD	OVIDER CCN:	DEDIOD ·	WORKSHEET I - 2	Ξ

4150 (Golff.)	1 01011 01115 25-10 10		11 1
COMPUTATION OF CMHC	PROVIDER CCN:	PERIOD:	WORKSHEET J-2
REHABILITATION COSTS		FROM	PART I
	COMPONENT CCN:	TO	

PART	I - APPORTIONMENT OF CMHC COST	CENTERS									
	•	Total Costs	Fotal Costs Ratio of Title V			Title	XVIII	Title XIX		$\Box$	
		( from Wkst. J-1,	Total	Costs to		Costs		Costs		Costs	1
		Pt. I, col. 20)	Charges	Charges	Charges	( col. 3 x col. 4 )	Charges	( col. 3 x col. 6 )	Charges	( col. 3 x col. 8 )	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
	Individualized Activity Therapy										11
12	Family Counseling										12
	Diagnostic Services										13
14	App. Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
19	Durable Medical Equipment - Rented										19
20	Durable Medical Equipment - Sold										20
21	All Other										21
22	Totals (sum of lines 2-21)										22

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DRAFT	FORM	I CMS-2540-1	10				4190 (C	Cont.)
COMPUTATION OF CMHC REHABILITATION COSTS			PROVIDER CCN:		PERIOD : FROM		WORKSHEET J - PART II	2
REIMBERTATION COSTS			COMPONENT CC	<b>1</b> :	то			
PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED B	V CHADED DEDARTMENTS							
PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED B	Ratio of	Titl	o V	Title	XVIII	Title	XIX	_
	Costs to	110	Costs	11116	Costs	1100	Costs	-
	Charges	Charges	( col. 3 x col. 4 )	Charges	( col. 3 x col. 6 )	Charges	( col. 3 x col. 8 )	
	3	4	5	6	7	8	9	
23 Oxygen (Inhalation) Therapy								23
24 Physical Therapy								24
25 Occupational Therapy								25
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)								31
(Transfer to Wkst. J-3)								

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

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	TION OF REIMBURSEMENT SETTLEMENT BASED COMMUNITY MENTAL HEALTH CENTER	PROVIDER CCN:	PERIOD:	WORKSHEET J-3
	BASED COMMUNITY MENTAL HEALTH CENTER			" OTTE DIE
SERVICES			FROM	
		COMPONENT CCN:	то	_
Ci	neck applicable box: [] Title V [] Title XVIII [] Titl	e XIX		
				PROGRAM
				COST
1 (	Cost of component services (from Wkst. J-2, Pt. II, line 31)			0001
	PPS payments received excluding outliers			
3 (	Outlier payments			
	Primary payer payments			
5 ′	Total reasonable cost (see instructions)			
CUSTOMA	ARY CHARGES			
6	Total charges for program services			
7	Excess of customary charges over reasonable cost (see instructions)			
	Excess of reasonable cost over customary charges (see instructions)			
	ATION OF REIMBURSEMENT SETTLEMENT			-
	Total reasonable cost (see instructions)			
	Part B deductible billed to program patients			
	Part B coinsurance billed to program patients (from provider records)			
	Net cost (line 9 minus lines 10 and 11)			
	Reimbursable bad debts (from provider records) (see instructions)			
	Adjusted reimbursable bad debts (see instructions)			
	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
15	Net reimbursable amount (see instructions)			
	Other adjustments (see instructions) (specify)			
	Γotal cost (line 15 plus or minus line 16)			
17.01 S	equestration amount (see instructions)			
	Interim payments (see instructions)			
	Γentative settlement (for contractor use only)			
	Balance due component/program (see instructions)			
21	Protested amounts (nonallowable cost report items) in accordance with CMS	Pub. 15-2, section 115.2		

FORM CMS-2540-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4155)

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DIG	101	111 01110 2040 10			7130	(Cont.)
ANA	LYSIS OF PAYMENTS TO	PROVIDER CCN:		PERIOD:	WORKSHEET J - 4	
SNF-I	BASED CMHC			FROM		
FOR S	SERVICES RENDERED	COMPONENT CCN:		то		
TO PI	ROGRAM BENEFICIARIES					
		•		mm/dd/yyyy	Amount	
	Description			1	2	
1	Total interim payments paid to <i>CMHC</i>					1
2	Interim payments payable on individual bills, either submitted					2
	or to be submitted to the intermediary/contractor for services					
	rendered in the cost reporting period. If none, enter zero.					
3	List separately each retroactive lump sum		.01			3.01
	adjustment amount based on subsequent revision of	Program	.02			3.02
	the interim rate for the cost reporting period	to	.03			3.03
	Also show date of each payment.	Provider	.04			3.04
	If none, write "NONE," or enter a zero. (1)		.05			3.05
			.50			3.50
		Provider	.51			3.51
		to	.52			3.52
		Program	.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)					4
	(Transfer to Wkst. J-3: Pt. I, line 18)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative	Program	.01			5.01
	settlement payment after desk review.	to	.02			5.02
		Provider	.03			5.03
	Also show date of each payment.	Provider	.50			5.50
	If none, write "NONE," or enter a zero. (1)	to	.51			5.51
		Program	.52			5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99			5.99
6	Determine net settlement amount (balance	Program to Provider	.01			6.01
	due) based on the cost report (1)	Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contr	actor Number		8
			1			1

<sup>(1)</sup> 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.

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ANA	LYSIS OF HOSPICE COSTS						PROVIDER CCN	I:	PERIOD : FROM		WORKSHEET K	
							HOSPICE CCN:		то			
		SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS ( from Wkst. K-2 )	TRANSPOR- TATION ( see instruct. )	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 )	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	10	
GENI	ERAL SERVICE COST CENTERS											
	Capital Related Costs-Bldg. and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance										I	3
4	Transportation - Staff										I	4
5	Volunteer Service Coordination											5
6	Administrative and General											6
INPA	TIENT CARE SERVICE											
7	Inpatient - General Care										I	7
8	Inpatient - Respite Care											8
VISIT	ING SERVICES											
9	Physician Services										1	9
10	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
12	Physical Therapy											12
13	Occupational Therapy											13
14	Speech/ Language Pathology											14
	Medical Social Services											15
16	Spiritual Counseling											16
17	Dietary Counseling											17
	Counseling - Other											18
19	Home Health Aide and Homemaker											19
20	HH Aide & Homemaker-Cont. Home Care											20
21	Other											21
OTHE	R 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										1	27
28	Imaging Services											28
29	Labs and Diagnostics										1	29
30	Medical Supplies										1	30
31	Outpatient Services (including E/R Dept.)										1	31
32	Radiation Therapy											32
33	Chemotherapy											33
	Other											34
	ICE NONREIMBURSABLE SERVICE											
	Bereavement Program Costs											35
	Volunteer Program Costs											36
	Fundraising											37
	Other Program Costs											38
39	Total (sum of lines 1 through 38)	1	I	1		I	1	I	1	1	1	39

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HOS	PICE COMPENSATION ANALYSIS					PROVIDER CCN:		PERIOD:		WORKSHEET K-1	
SAL	ARIES AND WAGES							FROM			
						HOSPICE CCN:		то			
		ADMINIS-		SOCIAL	SUPER-		TOTAL				
		TRATOR	DIRECTOR	SERVICES	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	1
GEN	RAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
5	Volunteer Service Coordination										5
	Administrative and General										6
INPA	TIENT CARE SERVICE										
7	Inpatient - General Care										7
	Inpatient - Respite Care										8
VISI	ING SERVICES										
9	Physician Services										9
	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
	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
OTH	R 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
	Radiation Therapy										32
33	Chemotherapy										33
34											34
HOS	ICE 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)

<sup>(1)</sup> Transfer the amount in column 9 to Wkst. K, col. 1

419	J (Cont.)			FORM	4 CMS-2540-	10					11-12
HOS	PICE COMPENSATION ANALYSIS					PROVIDER CCN:		PERIOD:		WORKSHEET K	-2
EMP	LOYEE BENEFITS (PAYROLL RELATED)							FROM			
						HOSPICE CCN:		то			
		ADMINIS-		SOCIAL	SUPER-		TOTAL				
		TRATOR	DIRECTOR	SERVICES	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	7
GEN	ERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg. and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
INPA	TIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
VISI	ΓING 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
	Other										21
OTH	ER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy	1			1						32
33	Chemotherapy										33
34	Other										34

35

HOSPICE NONREIMBURSABLE SERVICE 35 Bereavement Program Costs

36 Volunteer Program Costs

37 Fundraising 38 Other Program Costs 39 Total (sum of lines 1 through 38)

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

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11-1				FURIV	1 GM3-2340-					4190 (	
	ICE COMPENSATION ANALYSIS					PROVIDER CCN:		PERIOD:		WORKSHEET K-	.3
CON	TRATED SERVICES / PURCHASED SERVIC	ES						FROM			
						HOSPICE CCN:		то			
		_	-								
		ADMINIS		SOCIAL	SUPER-		TOTAL				
		TRATOR	DIRECTOR	SERVICES	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	_
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	
	RAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
	TIENT CARE SERVICE										_
	Inpatient - General Care										7
	Inpatient - Respite Care										8
	ING SERVICES										
	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services										15
	Spiritual Counseling										16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker										19
	HH Aide & Homemaker-Cont. Home Care										20
	Other										21
	R HOSPICE SERVICE COSTS										
	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services										28
	Labs and Diagnostics										29
30	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy										32
	Chemotherapy						1	1			33
	Other										34
	ICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs							1			35
	Volunteer Program Costs		ļ		ļ		ļ	1	1		36
	Fundraising	1	ļ	ļ					1		37
	Other Program Costs										38
39	Total (sum of lines 1 through 38)										39

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

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	GENERAL SERVICE COST						HOSPICE CCN:		FROM TO		7
	COST CENTED DESCRIPTIONS	NET EXPENSES FOR COST ALLOC. (1) ( from Wkst. K, col. 10 )	CAPITAL REI BUILDS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICE COORDI- NATOR	SUBTOTAL ( cols. 0 through 5 )	ADMINIS- TRATIVE & GENERAL	TOTAL 7	
CENT	COST CENTER DESCRIPTIONS	0	1	2	3	4	5	5A	6	/	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip. Plant Operation and Maintenance										3
	Transportation - Staff										4
<del></del>	Volunteer Service Coordination										5
	Administrative and General										6
	TIENT CARE SERVICE									_	10
	Inpatient - General Care										7
	Inpatient - General Care  Inpatient - Respite Care									+	8
	ING SERVICES										+-
	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
	Medical Social Services										15
	Spiritual Counseling										16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker										19
	HH Aide & Homemaker-Cont. Home Care										20
	Other										21
	ER HOSPICE SERVICE COSTS										
	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	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
	Other										34
	ICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs										35
	Volunteer Program Costs										36
	Fundraising		·								37
	Other Program Costs										38
39	Total (sum of lines 1 through 38)	1		I	1	1	1	1			39

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COST ALLOCATION - HOSPICE STATISTICAL BASIS				PROVIDER CCN:		PERIOD : FROM		WORKSHEET K PART II	4
				HOSPICE CCN:		то			
	CAPITAL RE	LATED COST					ADMINIS-	+	$\neg$
		MOVABLE	PLANT		VOLUNTEER		TRATIVE &		
	BUILDS.	EQUIPMENT	OPERATION	TRANS-	SERVICE		GENERAL		
	& FIXTURES	( Dollar Value or	& MAINT.	PORTATION	COORDINATOR	RECONCI-	( Accumulated		
	( Square Feet )	Square Feet )	( Square Feet )	( Mileage )	( Hours )	LIATION	Cost )	TOTAL	
COST CENTER DESCRIPTIONS	1	2	3	4	5	6A	6	7	┑
GENERAL SERVICE COST CENTERS						-			
1 Capital Related Costs-Bldg, and Fixt.									
2 Capital Related Costs-Movable Equip.									
3 Plant Operation and Maintenance									3
4 Transportation - Staff									
5 Volunteer Service Coordination									- 5
6 Administrative and General									-
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		I	I	I	1	i	i		40

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

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

41-388 R

-12	TT-T	<u> </u>	1 ORM GM5-2540-10						
	ALLC	OCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		
	COST	S TO HOSPICE COST CENTERS					FROM	_	
					HOSPICE CCN:		то	_	
			PLANT						
			OPERATION	LAUNDRY			NURSING	CENTRAL	
			MAINTENANCE	& LINEN	HOUSE-		ADMINIS-	SERVICES &	
			& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	SUPPLY	
		HOSPICE COST CENTER (1)	5	6	7	8	9	10	
1	1	Administrative and General							
2	2	Inpatient - General Care							
3	3	Inpatient - Respite Care							
4	4								
5	5	Nursing Care							
6	6								
7	7								
8	8	Occupational Therapy							
9	9								
10	10	Medical Social Services - Direct							
11	11	Spiritual Counseling							
12	12	Dietary Counseling							
13		Counseling - Other							
14		Home Health Aide and Homemakers							
15	15	HH Aide & Homemaker - Cont. Home Care							
16	16	Other							
17	17	Drugs, Biologicals and Infusion							
18	18	Analgesics							
19	19	Sedative/Hypnotics							
20	20	Other - Specify							
21	21	Durable Medical Equipment/Oxygen							
22	22	Patient Transportation							
23	23	Imaging Services							
24	24	Labs and Diagnostics							
25	25	Medical Supplies							
26	26	Outpatient Services (incl. E/R Dept.)							
27	27	Radiation Therapy							
28	28								
29	29	Other							
30	30	Bereavement Program Costs							
31	31	Volunteer Program Costs							

32 32 Fundraising

35 35 Unit Cost Multiplier

33 Other Program Costs
34 Totals (sum of lines 1 through 33)

 $<sup>(1) \ \</sup> Columns \ 0 \ through \ 16, line \ 34 \ must \ agree \ with \ the \ corresponding \ columns \ of \ \ Wkst. \ B, \ Part \ I, \ line \ 83.$ 

4190 (Cont.) 4190 (Cont.)

## FORM CMS-2540-10

WORKSHEET K-5	ALLOCATION OF GENERAL SERVICE	PROVIDER CCN:	PERIOD:
Part I	COSTS TO HOSPICE COST CENTERS		FROM
		HOSPICE CCN:	то

PHARMACY 11		HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE 15	SUBTOTAL ( sum of cols. 3A through 15 )
11	1 1	Administrative and General	12	15	14	15	10
		Inpatient - General Care					
		Inpatient - General Care  Inpatient - Respite Care					
		Physician Services					
		Nursing Care					
		Nursing Care- Continuous Home Care					
		Physical Therapy					
		Occupational Therapy					
		Speech/ Language Pathology					
		Medical Social Services - Direct					
		Spiritual Counseling					
		Dietary Counseling					
		Counseling - Other					
		Home Health Aide and Homemakers					
		HH Aide & Homemaker - Cont. Home Care					
		Other					
		Drugs, Biologicals and Infusion					
		Analgesics					
		Sedative/Hypnotics					
	20 20						
	21 21						
		Patient Transportation					
		Imaging Services					
	24 24	Labs and Diagnostics					
		Medical Supplies					
		Outpatient Services (incl. E/R Dept.)					
	29 29	Other					
	30 30						
	31 31						
	32 32						
		Other Program Costs					
		Totals (sum of lines 1 through 33)					
		Unit Cost Multiplier					

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

	11-12
WORKSHEET K-5	
Part I	
TOTAL	
HOSPICE	
COSTS	
18	İ
	1
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	WORKSHEET K-5 Part I  TOTAL HOSPICE COSTS

11-12	1 OKW CW13-2340-10				4130 (
ALLOCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD:		WORKSHEET K-5,	
TO HOSPICE COST CENTERS - STATISTICAL BASIS					PART II
	HOSPICE CCN:		FROM TO		
				_	
	CAPITAL	CAPITAL			ADMINIS-
	RELATED	RELATED			TRATIVE &
	BLDGS. &	MOVABLE	EMPLOYEE		GENERAL
	FIXTURES	EQUIPMENT	BENEFITS	RECONCIL-	( Accumulated
	( Square Feet )	( Dollar Value )	( Gross Salaries )	IATION	Cost )
HOSPICE COST CENTER (1)	1	2	3	4a	4
1 Administrative and General	-	_		10	<del>'</del>
2 Inpatient - General Care					
3 Inpatient - Respite Care					
4 Physician Services					
5 Nursing Care					
6 Nursing Care- Continuous Home Care					
7 Physical Therapy					
8 Occupational Therapy					
9 Speech/ Language Pathology					
10 Medical Social Services - Direct					
11 Spiritual Counseling					
12 Dietary Counseling					+
13 Counseling - Other					+
13 Counseling - Other  14 Home Health Aide and Homemakers					
15 HH Aide & Homemaker - Cont. Home Care					
16 Other					
17 Drugs, Biologicals and Infusion					
18 Analgesics					
19 Sedative/Hypnotics					
20 Other - Specify					
21 Durable Medical Equipment/Oxygen					
22 Patient Transportation					
23 Imaging Services					
24 Labs and Diagnostics					
25 Medical Supplies					
26 Outpatient Services (incl. E/R Dept.)					
27 Radiation Therapy					
28 Chemotherapy					
29 Other					
30 Bereavement Program Costs					
31 Volunteer Program Costs					
32 Fundraising					
33 Other Program Costs					
34 Totals (sum of lines 1 through 33)					
35 Total cost to be allocated					
36 Unit Cost Multiplier					

,		()						
	ALLC	OCATION OF GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD:		WORKSHEET K-5
	TO H	IOSPICE COST CENTERS - STATISTICAL BASIS				FROM	_	PART II
				HOSPICE CCN:		TO	_	
			PLANT	LAUNDRY			NURSING	CENTRAL
			OPERATION	& LINEN	HOUSE		ADMINIS-	SERVICES &
			MAINTENANCE	SERVICE	KEEPING		TRATION	SUPPLY
			& REPAIRS	( Pounds of	( Hours of	DIETARY	( Direct Nursing	( Costed
			( Square Feet )	Laundry )	Service )	( Meals Served )	Hours )	Requisitions )
		HOSPICE COST CENTER (1)	5	6	7	8	9	10
1	1	Administrative and General						
2	2	Inpatient - General Care						
3	3	1						
4	4							
5	5	v .						
6	6							
7	7	Physical Therapy						
8		Occupational Therapy						
9	9							
10	10							
11		Spiritual Counseling						
12		Dietary Counseling						
13	13							
14	14							
15	15							
16	16							
17		Drugs, Biologicals and Infusion						
18		Analgesics						
19	19	JF						
20		Other - Specify						
21		Durable Medical Equipment/Oxygen						
22	22	I						
23	23							
24	24	Labs and Diagnostics						
25		Medical Supplies						
26		Outpatient Services (incl. E/R Dept.)						
27	27	Radiation Therapy						
28	28							
29	29	Other						
30	30	Ü						
31	31	0						
32	32							
33	33	Other Program Costs						
34	34							
35	35							
36	36	Unit Cost Multiplier						
_								

PROVIDER CCN:

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

36 Unit Cost Multiplier

PERIOD:

TO HOSPICE COST CENTERS - STATISTICAL BASIS					PROVIDER CCN:		FROM	
	10	HOSFICE COST CENTERS - STATISTICAL DASIS			HOSPICE CCN:		TO	
					THOSPICE CCIV.		10	
PHARMACY ( Costed Requisitions )			MEDICAL RECORDS & LIBRARY ( Time Spent )	SOCIAL SERVICE ( Time Spent )	NURSING & ALLIED HEALTH EDUCATION ( Assigned Time )	OTHER GENERAL SERVICE ( Specify )	SUBTOTAL	
11		HOSPICE COST CENTER (1)	12	13	14	15	16	
	1 1	Administrative and General						
	2 2	Inpatient - General Care						
	3 3	Inpatient - Respite Care						
		Physician Services						
	5 5	Nursing Care						
	6 6	Nursing Care- Continuous Home Care						
		Physical Therapy						
	8 8	Occupational Therapy						
	9 9	Speech/ Language Pathology						
	10 10	Medical Social Services - Direct						
		Spiritual Counseling						
	12 12	P Dietary Counseling						
	13 13	Counseling - Other						
	14 14	Home Health Aide and Homemakers						
	15 15	HH Aide & Homemaker - Cont. Home Care						
		6 Other						
	17 17	7 Drugs, Biologicals and Infusion						
		B Analgesics						
		Sedative/Hypnotics						
		Other - Specify						
	21 21	Durable Medical Equipment/Oxygen						
		Patient Transportation						
		Imaging Services						
		Labs and Diagnostics						
		Medical Supplies						
		Outpatient Services (incl. E/R Dept.)						
	27 27	Radiation Therapy						
		3 Chemotherapy						
		Other						
		Bereavement Program Costs						
		Volunteer Program Costs						
		P Fundraising						
		Other Program Costs						
		Totals (sum of lines 1 through 33)						
		Total cost to be allocated						
	20 20	Linit Cont Moderation	1	1	1	1		

4190 (Cont.)
WORKSHEET K-5
PART II

ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS 18	
		1
		2
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APPO	ORTIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET K-5	
				FROM	Part III	
			HOSPICE CCN:	то		
PART	III - COMPUTATION OF TOTAL HOSPICE SHARED COS	STS				
		Wkst. C,	Cost to	Total Hospice	Hospice Shared	
		col. 3,	Charge	Charges	Ancillary Costs	
COST CENTER			Ratio	( from provider records )	( col. 1 x col. 2 )	
		0	1	2	3	
ANC	ILLARY 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

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Die ii i	1 01411 01110 2010 10		1150 (Cont.)
CALCULATION OF HOSPICE PER DIEM COST	PROVIDER CCN:	PERIOD:	WORKSHEET K-6
		FROM	
	HOSPICE CCN:	то	

		Tittle XVIII	Title XIX	Other	Total	
		1	2	3	4	
1	Total cost					1
	(see instructions)					
2	Total unduplicated days					2
	(Wkst. S-8, line 5, col. 6)					
3	Average cost per diem					3
	(line 1 divided by line 2)					
4	Unduplicated Medicare days					4
	(Wkst. S-8, line 5, col. 1)					
5	Average Medicare cost					5
	(line 3 times line 4)					
6	Unduplicated Medicaid days					6
	(Wkst. S-8, line 5, col. 2)					
7	Average Medicaid cost					7
	(line 3 times line 6)					
8	Unduplicated SNF days					8
	(Wkst. S-8, line 5, col. 3)					
9	Average SNF cost					9
	(line 3 times line 8)					
10	Unduplicated NF days					10
	(Wkst. S-8, line 5, col. 4)					
11	Average NF cost					11
	(line 3 times line 10)					
12	Other unduplicated days					12
	(Wkst. S-8, line 5, col. 5)					
13	Average cost for other days					13
	(line 3 times line 12)					

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ANALY	YSIS OF SNF-BASED HOSPICE COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET O	
							FROM		
						HOSPICE CCN:	TO		
				SUBTOTAL		-			$\overline{}$
				( col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
		SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	$(col. 5 \pm col. 6)$	
		1	2	3	4	5	6	7	
GENE	RAL SERVICE COST CENTERS								
1	0100 Cap Rel Costs-Bldg & Fixt*								1
2	0200 Cap Rel Costs-Mvble Equip*								2
3	0300 Employee Benefits Department*								3
4	0400 Administrative & General *								4
5	0500 Plant Operation & Maintenance*								5
6	0600 Laundry & Linen Service*								6
7	0700 Housekeeping*								7
8	0800 Dietary*								8
9	0900 Nursing Administration*								9
10	1000 Routine Medical Supplies*								10
11	1100 Medical Records*								11
12	1200 Staff Transportation*								12
13	1300 Volunteer Service Coordination*								13
14	1400 Pharmacy*								14
15	1500 Physician Administrative Services*	1							15
16	1600 Other General Service*								16
17	1700 Patient/Residential Care Services								17
DIREC	CT PATIENT CARE SERVICE COST CENT	ERS							
25	2500 Inpatient Care-Contracted**								25
26	2600 Physician Services**								26
27	2700 Nurse Practitioner**								27
28	2800 Registered Nurse**								28
29	2900 LPN/LVN**								29
30	3000 Physical Therapy**								30
31	3100 Occupational Therapy**								31
32	3200 Speech/ Language Pathology**								32
33									33
34									34
35									35
36	3600 Counseling - Other**								36
37	3700 Hospice Aide and Homemaker Serv	rices**	1					1	37
38	3800 Durable Medical Equipment/Oxyge		1					1	38
									39

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

FORM CMS-2540-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164)

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ANALYSIS OF SNF-BASED	HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
		SALARIES 1	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 )	
DIRECT PATIENT CARE S	ERVICE COST CENTERS (Cont.)								
40 4000 Imaging Se	vices**								40
41 4100 Labs and D									41
	oplies-Non-routine**								42
43 4300 Outpatient									43
	adiation Therapy**								44
45 4500 Palliative C									45
	nt Care Services (specify)**								46
NONREIMBURSABLE COS									
60 6000 Bereavemen									60
61 6100 Volunteer F									61
62 6200 Fundraisin									62
	lliative Medicine Fellows*								63
64 6400 Palliative C									64
65 6500 Other Phys									65
66 6600 Residential									66
67 6700 Advertising							<u> </u>		67
68 6800 Telehealth/									68
69 6900 Thrift Store									69
	cility Room & Board*								70
	eimbursable (specify)*								71
100 Total									100

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<sup>\*</sup> Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

4190 (Cont.)	.) FORM CMS-2540-10	DRAFT
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ANALYSIS OF SNF-BASED HOSPICE COSTS						PERIOD:	WORKSHEET O-1	
HOSPICE CONTINUOUS HOME CARE						FROM		
					HOSPICE CCN:	TO		
			SUBTOTAL					
			( col. 1 plus	RECLASSI-		ADJUST-	TOTAL	
	SALARIES	OTHER	col. 2)	FICATIONS	SUBTOTAL	MENTS	( col. 5 ± col. 6 )	
	1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy								45
46 Other Patient Care Svc (specify)								46
100 Total *								100

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 50

41-398 Rev.

DRAFT	FORM CMS-2540-10			4190 (Cont.
ANALYSIS OF SNF-BASED HOSPICE COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET O-2

DRAFI			FURIVI CIVIS-2540-	10	4190 (Colit.)					
ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE ROUTINE HOME CARE					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-2			
					HOSPICE CCN:	то				
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )			
	1	2	3	4	5	6	7	7		
DIRECT PATIENT CARE SERVICE COST CENTERS										
25 Inpatient Care - Contracted								25		
26 Physician Services								26		
27 Nurse Practitioner								27		
28 Registered Nurse								28		
29 LPN/LVN								29		
30 Physical Therapy								30		
31 Occupational Therapy								31		
32 Speech/ Language Pathology								32		
33 Medical Social Services								33		
34 Spiritual Counseling								34		
35 Dietary Counseling								35		
36 Counseling - Other								36		
37 Hospice Aide and Homemaker Services								37		
38 Durable Medical Equipment/Oxygen								38		
39 Patient Transportation								39		
40 Imaging Services								40		
41 Labs and Diagnostics								41		
42 Medical Supplies-Non-routine								42		
43 Outpatient Services								43		
44 Palliative Radiation Therapy								44		
45 Palliative Chemotherapy								45		
46 Other Patient Care Svc (specify)								46		
100 Total *								100		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

4190 (Cont.)	FORM CMS-2540-1 <sub>FORM CMS-2540-10</sub>		DRAFT
ANALYSIS OF SNF-BASED HOSPICE COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET O-3
HOSPICE INPATIENT RESPITE CARE	HOSPICE CCN:	FROM	

					HOSPICE CCN:	ТО		
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )	
DIRECT DATIENT CARE CEDUICE COCT CENTERS	1	2	3	4	5	6	7	+-
DIRECT PATIENT CARE SERVICE COST CENTERS								-
25 Inpatient Care - Contracted								2
26 Physician Services								2
27 Nurse Practitioner								2
28 Registered Nurse								2
29 LPN/LVN								2
30 Physical Therapy								3
31 Occupational Therapy								3
32 Speech/ Language Pathology								3
33 Medical Social Services								3
34 Spiritual Counseling								3
35 Dietary Counseling								3
36 Counseling - Other								3
37 Hospice Aide and Homemaker Services								3
38 Durable Medical Equipment/Oxygen								3
39 Patient Transportation								3
40 Imaging Services								4
41 Labs and Diagnostics								4
42 Medical Supplies-Non-routine								4
43 Outpatient Services								4
44 Palliative Radiation Therapy								4
45 Palliative Chemotherapy								4
46 Other Patient Care Svc (specify)								4
100 Total *								10

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

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DRAFT FORM CMS-2540-10 4190 (Cont
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ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE GENERAL INPATIENT CARE						PERIOD: FROM	WORKSHEET O-4	
HOSTICE GENERAL INTIMENT GIRE					HOSPICE CCN:	TO		
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )	
	1	2	3	4	5	6	7	7
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy		•						44
45 Palliative Chemotherapy		•						45
46 Other Patient Care Svc (specify)								46
100 Total *								100

<sup>\*</sup> Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

4190 (Cont.)	FORM CMS-2540-1	0	Γ	DRAFT
COST ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET EXPENSES FOR ALLOCATION		FROM		
	HOSPICE CCN:	TO		
		GENERAL		
	HOSPICE	SERVICE		
	DIRECT	EXPENSES	TOTAL	
	EXPENSES	FROM WKST B	EXPENSES	
	( see instructions )	( see instructions )	( sum of cols. 1 + 2 )	
Descriptions	( see instructions )	( see instructions )	(34111 0) Cols. 1 + 2 )	-
GENERAL SERVICE COST CENTERS	-	_	,	
1 Cap Rel Costs-Bldg & Fixt				1
2 Cap Rel Costs-Mvble Equip				2
3 Employee Benefits				3
4 Administrative & General				4
5 Plant Operation and Maintenance				5
6 Laundry & Linen Service				6
7 Housekeeping				7
8 Dietary				8
9 Nursing Administration				9
10 Routine Medical Supplies				10
11 Medical Records				11
12 Staff Transportation				12
13 Volunteer Service Coordination				13
14 Pharmacy				14
15 Physician Administrative Services				15
16 Other General Service (specify)				16
17 Patient/Residential Care Services				17
LEVEL OF CARE				
50 Hospice Continuous Home Care				50
51 Hospice Routine Home Care				51
52 Hospice Inpatient Respite Care				52
53 Hospice General Inpatient Care				53
NONREIMBURSABLE COST CENTERS				
60 Bereavement Program				60
61 Volunteer Program				61
62 Fundraising				62
63 Hospice/Palliative Medicine Fellows				63
64 Palliative Care Program				64
65 Other Physician Services				65
66 Residential Care				66
67 Advertisina				67

DRAFT	FORM CMS-2540-10	4190 (	Cont.

COST	ALLOCATION - SNF-BASED HOSPICE GEN	NERAL SERVICE COS	STS				PROVIDER CCN: _ HOSPICE CCN:	V: PERIOD: FROM TO			WORKSHEET O-6 PART I	
		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	
	Descriptions	0	1	2	3	3A	4	5	6	7	8	
	RAL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
	Plant Operation and Maintenance											5
	Laundry & Linen Service											6
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies											10
	Medical Records											11
	Staff Transportation											12
	Volunteer Service Coordination											13
	Pharmacy											14
	Physician Administrative Services											15
	Other General Service (specify)											16
	Patient/Residential Care Services											17
	OF CARE											
	Hospice Continuous Home Care											50
	Hospice Routine Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care											53
	EIMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable (specify)											71
99	Negative Cost Center											99
100	Total											100

FORM CMS-2540-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

Rev. 41-403

COST	COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS						PROVIDER CCN: _		PERIOD:		WORKSHEET O-6	
							HOSPICE CCN:				Part I	
									TO			
		NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /		
		ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
		TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS		
	Descriptions	9	10	11	12	13	14	15	16	17	18	
	RAL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration		1									9
10	Routine Medical Supplies			1								10
11	Medical Records				1							11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy							_				14
	Physician Administrative Services											15
	Other General Service (specify)											16
	Patient/Residential Care Services											17
	OF CARE											
	Continuous Home Care											50
	Routine Home Care											51
	Inpatient Respite Care											52
	General Inpatient Care											53
	EIMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
64												64
	Other Physician Services											65
	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store				<del>                                     </del>		1					69
70	Nursing Facility Room & Board											70
70	Other Nonreimbursable (specify)											71
	Negative Cost Center					1						99
	Total		-	-	-							100
100	10(a)		1									100

COST ALLOCATION - SNF-BASED HOSPICE GENERAL S	ERVICE COST STATISTICA	AL BASIS			PROVIDER CCN:			WORKSHEET ( PART II	
	CAP REL BLDG & FIX ( Square	CAP REL MVBLE EQUIP ( Dollar	EMPLOYEE BENEFITS DEPARTMENT ( Gross	RECONCIL-	ADMINIS- TRATIVE & GENERAL ( Accum.	PLANT OP & MAINT ( Square	LAUNDRY & LINEN  (In-Facility	HOUSE- KEEPING ( Square	DIETARY  ( In-Facility
	Feet )	Value )	Salaries )	IATION	Cost)	Feet )	Days )	Feet )	Days )
Cost Center Descriptions	1	2	3	4A	4	5	6	7	8
GENERAL SERVICE COST CENTERS									
1 Cap Rel Costs-Bldg & Fixt									
2 Cap Rel Costs-Mvble Equip									
3 Employee Benefits									
4 Administrative & General									
5 Plant Operation and Maintenance									
6 Laundry & Linen Service									
7 Housekeeping									
8 Dietary									
9 Nursing Administration									
10 Routine Medical Supplies									
11 Medical Records									
12 Staff Transportation									
13 Volunteer Service Coordination									
14 Pharmacy									
15 Physician Administrative Services									_
16 Other General Service (specify)									
17 Patient/Residential Care Services									
LEVEL OF CARE									
50 Hospice Continuous Home Care									
51 Hospice Routine Home Care									
52 Hospice Inpatient Respite Care					1				
53 Hospice General Inpatient Care									+
NONREIMBURSABLE COST CENTERS									
60 Bereavement Program									
61 Volunteer Program									
62 Fundraising									
63 Hospice/Palliative Medicine Fellows									
64 Palliative Care Program		-	+		-				
			-						
65 Other Physician Services						1			
66 Residential Care									
67 Advertising									
68 Telehealth/Telemonitoring									
69 Thrift Store				-					
70 Nursing Facility Room & Board									
71 Other Nonreimbursable (specify)									
99 Negative Cost Center									
100 Total (sum of lines 1 through 99)									
101 Cost to be allocated (per Wkst. O-6, Part I)									
102 Unit cost multiplier									

FORM CMS-2540-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

Rev. 41-

COST ALLOCATION - SNF-BASED HOSPICE G	GENERAL SERVICE	PROVIDER CCN:   PERIOD:   W   HOSPICE CCN:   FROM   Po							HOSPICE CCN: FROM FROM					
	NURSING ADMINIS- TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS- PORTATION	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMINISTRA- TIVE SVCS	OTHER GENERAL SERVICE	PATIENT / RESIDENTIAL CARE SVCS					
	( Direct	( Patient	( Patient		( Hours of	(61)	( Patient	( Specify	( In-Facility	moma i				
	Nurs. Hrs. )	Days )	Days )	( Mileage )	Service )	(Charges)	Days )	Basis )	Days )	TOTAL				
Cost Center Descriptions	9	10	11	12	13	14	15	16	17	18				
GENERAL SERVICE COST CENTERS														
1 Cap Rel Costs-Bldg & Fixt	_													
2 Cap Rel Costs-Mvble Equip	_													
3 Employee Benefits	_													
4 Administrative & General	_													
5 Plant Operation and Maintenance														
6 Laundry & Linen Service														
7 Housekeeping														
8 Dietary														
9 Nursing Administration														
10 Routine Medical Supplies														
11 Medical Records														
12 Staff Transportation														
13 Volunteer Service Coordination														
14 Pharmacy														
15 Physician Administrative Services														
16 Other General Service (specify)														
17 Patient/Residential Care Services										7				
LEVEL OF CARE														
50 Continuous Home Care														
51 Routine Home Care														
52 Inpatient Respite Care														
53 General Inpatient Care														
NONREIMBURSABLE COST CENTERS														
60 Bereavement Program														
61 Volunteer Program						1								
62 Fundraising	+													
63 Hospice/Palliative Medicine Fellows	+													
64 Palliative Care Program														
65 Other Physician Services														
66 Residential Care	+													
67 Advertising														
68 Telehealth/Telemonitoring	+					<b> </b>								
						<b> </b>								
69 Thrift Store														
70 Nursing Facility Room & Board														
71 Other Nonreimbursable (specify)														
99 Negative Cost Center														
100 Total (sum of lines 1 through 99)														
101 Cost to be allocated (per Wkst. O-6, Part I)														
102 Unit cost multiplier	1		1	1	1	1	I	1						

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				(
APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL	C OF CARE	PROVIDER CCN:	PERIOD:	WORKSHEET O-7
		HOSPICE CCN:	FROM	
			TO	

	Wkst. C,	Cost to	Char	ges by LOC (fro	m Provider Rec	ords)	Shared Service Costs by LOC			
	col. 3,	Charge					НСНС	HRHC	HIRC	HGIP
	line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9
ANCILLARY SERVICE COST CENTERS										
1 Physical Therapy	44									
2 Occupational Therapy	45									
3 Speech/ Language Pathology	46									
4 Drugs, Biological and Infusion Therapy	49									
5 Durable Medical Equipment/Oxygen	51									
6 Labs and Diagnostics	40									
7 Medical Supplies	48									
8 Outpatient Services (including E/R Dept.)	63									
9 Radiation Therapy	40									
0 Other	52									
1 Totals (sum of lines 1 through 10)										

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

CALCULATION OF SNF-BASED HOSPICE PER DIEM COST	PROVIDER CCN:	PERIOD:	WORKSHEET O-8
	HOSPICE CCN:	FROM TO	
	TITLE XVIII	TITLE XIX	
	MEDICARE	MEDICAID	TOTAL
HOSPICE CONTINUOUS HOME CARE	1	2	3
1 Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 1	1)		
2 Total unduplicated days (Wkst. S-8, col. 4, line 10)			
3 Total average cost per diem (line 1 divided by line 2)			
4 Unduplicated program days (Wkst. S-8, col. as appropriate, line 10)			
5 Program cost (line 3 times line 4)			
HOSPICE ROUTINE HOME CARE			
6 Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 1			
7 Total unduplicated days (Wkst. S-8, col. 4, line 11)	.1)		
8 Total average cost per diem (line 6 divided by line 7)			
9 Unduplicated program days (Wkst. S-8, col. as appropriate, line 11)			
10 Program cost (line 8 times line 9) HOSPICE INPATIENT RESPITE CARE			
11 Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 1	.1)		
12 Total unduplicated days (Wkst. S-8, col. 4, line 12)			
13 Total average cost per diem (line 11 divided by line 12)			
14 Unduplicated program days (Wkst. S-8, col. as appropriate, line 12)			
15 Program cost (line 13 times line 14)			
HOSPICE GENERAL INPATIENT CARE			
16 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 1	11)		
17 Total unduplicated days (Wkst. S-8, col. 4, line 13)			
18 Total average cost per diem (line 16 divided by line 17)			
19 Unduplicated program days (Wkst. S-8, col. as appropriate, line 13)			
20 Program cost (line 18 times line 19)			
TOTAL HOSPICE CARE			
21 Total cost (sum of line 1 + line 6 + line 11 + line 16)			
22 Total unduplicated days (Wkst. S-8, col. 4, line 14)			
23 Average cost per diem (line 21 divided by line 22)			

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