DRAFT

#### FORM CMS-2552-10

4090 (Cont.)

This report is requi	red by law (42 USC 139	5g; 42 CFR 413.20(b)	. Failure to report can result in all interin	n		FORM APPROVED
payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).					OMB NO. 0938-0050	
HOSPITAL ANI	D HOSPITAL HEAL	TH CARE	PROVIDER CCN:	PER	IOD	WORKSHEET S
COMPLEX COS	ST REPORT CERTIF	FICATION		FRO	Μ	PARTS I, II & III
AND SETTLEM	IENT SUMMARY			TO		
PART I - COST	REPORT STATU	S	•			•
Provider use onl	у	1. [] Electron	ically filed cost report		Date:	Time:
		2. [] Manuall	y submitted cost report			
		3. [ ] If this is	an amended report enter the numb	er of times the prov	vider resubmitted this cost a	report
		4 [] Medicar	e Utilization. Enter "F" for full or '	'L" for low.		
Contractor	5. [ ] Cost Report	rt Status	6. Date Received:		10. NPR	Date:
use only	(1) As Submitte	ed	7. Contractor No.:		11. Contr	ractor's Vendor Code:
	(2) Settled with	out audit	8. [ ] Initial Report for this l	Provider CCN	12.[]If	line 5, column 1 is 4: Enter number of
	(3) Settled with	audit	9. [ ] Final Report for this P	rovider CCN	tin	mes reopened = 0-9.
	(4) Reopened					
	(5) Amended					

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Officer or Administrator of Provider(s)

Title

Date

#### PART III - SETTLEMENT SUMMARY

			TITLE				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED - RHC						10
	HOSPITAL-BASED - FQHC						11
	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL						200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 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.

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4003.1-4003.3) Rev.

40-503

OSPITAL AND HOSPITAL HEALTH CARE		FORM CMS-2552-2	10		_				DRA
OMPLEX IDENTIFICATION DATA				PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I		
ospital and Hospital Health Care Complex Address:							1		
1 Street:	P.O. Box:								
2 City:	State:	Zip Code:	County:						
ospital and Hospital-Based Component Identification:	•								
	Component	CCN	CBSA	Provider	Date	Pa	yment System (P, T, O, o	N)	
Component	Name	Number	Number	Type	Certified	V	XVIII	XIX	_
0	1	2	3	4	5	6	7	8	-
3 Hospital	*	-	5		5		,	0	
4 Subprovider- IPF									
5 Subprovider- IRF									+
			_						
6 Subprovider- (Other)									
7 Swing Beds-SNF									$\rightarrow$
8 Swing Beds-NF									
9 Hospital-Based SNF									
10 Hospital-Based NF									
11 Hospital-Based OLTC									
12 Hospital-Based HHA									
13 Separately Certified ASC									
14 Hospital-Based Hospice									
15 Hospital-Based Health Clinic-RHC									
16 Hospital-Based Health Clinic-FQHC									
17 Hospital-Based (CMHC, CORF and OPT)						_			
18 Renal Dialysis									
19 Other									
20 Cost Reporting Period (mm/dd/yyyy)	From:	To:							
21 Type of control (see instructions)									
patient PPS Information							1	2	
22 Does this facility qualify and is it currently received	ving payments for disproportionate share	hospital adjustment, in accorda	nce with 42 CFR 412.1	06?					
In column 1, enter "Y" for yes or "N" for no. Is t	this facility subject to 42 CFR 412.106 (	c)(2) (Pickle amendment hospita	al)? In column 2, enter	"Y" for yes or "N" for no.					
Did this hospital resolute interim un	care payments for this cost reporting per	iod? Enter in column 1, "Y" for	ves or "N" for no for	the portion of the cost report	ing period occurring prior to Octo	per 1.			
2.01 Did this hospital receive interim uncompensated				the portion of the cost report					2
				are portion of the cost report					2
Enter in column 2 "Y" for yes or "N" for no for the	he portion of the cost reporting period of	ccurring on or after October 1. (	see instructions)						2
Enter in column 2 "Y" for yes or "N" for no for the 23 Which method is used to determine Medicaid day	he portion of the cost reporting period or ys on lines 24 and/or 25 below? In colu	ccurring on or after October 1. ( mn 1, enter 1 if date of admission	see instructions) n, 2 if census days, or 3	if date of discharge.					
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Enter in column 2 "Y" for yes or "N" for no for 1 23 Which method is used to determine Medicaid day Is the method of identifying the days in this cost 24 If this provider is an IPPS hospital, enter the in-stel eligible unpaid days in col. 2, out-of-state Medic in col. 4, Medicaid HMO paid and eligible but un 25 If this provider is an IRF, enter the in-state Medic days in col. 2, out-of-state Medic days in col. 4, Medicaid HMO paid and eligible but un 26 Enter your standard geographic classification (no 27 Enter your standard geographic classification (no 28 If this is a sole community hospital (SCH), enter 29 If this is a sole community hospital (SCH), enter	he portion of the cost reporting period o ys on lines 24 and/or 25 below? In colu reporting period different from the meth different from the meth did days in col. 3, out-of-state Medi paid days in col. 5, and other Medicaid caid paid days in col. 5, and other Medicaid caid paid days in col. 5, and other Medicaid col. 3, out-of state Medicaid eligible un paid days in col. 5. ot wage) status at the beginning of the cost vage) status at the end of the cost repr aphic reclassification in column 2. the number of periods SCH status in eff CH status. Subscript line 36 for numbe	curring on or after October 1. ( mn 1, enter 1 if date of admission od used in the prior cost reportin e Medicaid caid eligible unpaid days days in col. 6. d eligible unpaid paid days st reporting period. Enter "1" for rtring period. Enter "1" for rtring period. Enter "1" for rtring period. Enter olumn 1, ect in the cost reporting period.	see instructions) n, 2 if census days, or 3 g period? In column 2 In-State Medicaid paid days 1 rurban or "2" for rural "1" for rurban or "2" for enter subsequent dates	i if date of discharge. , enter "Y" for yes or "N" fo In-State Medicaid eligible unpaid days 2 2 r rural.	r no. Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	HMO days	Medicaid days	
Enter in column 2 "Y" for yes or "N" for no for 1           23         Which method is used to determine Medicaid da Is the method of identifying the days in this cost           24         If this provider is an IPPS hospital, enter the in-stel eligible unpaid days in col. 2, out-of-state Medic days in col. 4, Medicaid HMO paid and eligible but un in col. 4, Medicaid HMO paid and eligible but un in col. 4, Medicaid HMO paid and eligible but un in col. 4, Medicaid HMO paid and eligible but un encol. 4, Medicaid HMO paid and eligible but un in col. 4, Medicaid geographic classification (no fl applicable enter the effective date of the geogr. 35           26         Enter your standard geographic classification (no fl applicable enter the effective date of the geogr. 36           37         If this is a sole community hospital (SCH), enter enter applicable beginning and ending dates of S 37           38         Medicae dependent hospital (MDH),	he portion of the cost reporting period o ys on lines 24 and/or 25 below? In colu reporting period different from the meth tate Medicaid paid days in col. 1, in-stat aid paid days in col. 3, out-of-state Medi caid paid days in col. 5, and other Medicaid caid paid days in col. 5, and other Medicaid caid paid days in col. 1, in-state Medicaid caid paid days in col. 1, in-state Medicaid caid paid days in col. 1, in-state Medicaid col. 3, out-of state Medicaid eligible un paid days in col. 5. rt wage) status at the beginning of the co rt wage) status at the beginning of the cost repathic reclassification in column 2. the number of periods SCH status in eff iCH status. Subscript line 36 for numbe	curring on or after October 1. ( mn 1, enter 1 if date of admission od used in the prior cost reportin e Medicaid caid eligible unpaid days days in col. 6. deligible unpaid paid days st reporting period. Enter "1" for rrting period. Enter "1" for rrting period. Enter in column 1, ect in the cost reporting period. or of periods in excess of one and in effect in the cost reporting period.	see instructions) n, 2 if census days, or 3 g period? In column In-State Medicaid paid days 1 urban or "2" for rural "1" for urban or "2" fo enter subsequent dates riod.	i if date of discharge. , enter "Y" for yes or "N" fo In-State Medicaid eligible unpaid days 2 2	r no. Out-of State Medicaid paid days 3 3 Beginning:	Out-of State Medicaid eligible unpaid days	HMO days 5	Medicaid days	
Enter in column 2 "Y" for yes or "N" for no for 1 23 Which method is used to determine Medicaid day Is the method of identifying the days in this cost 24 If this provider is an IPPS hospital, enter the in-st eligible unpaid days in col. 2, out-of-state Medic. in col. 4, Medicaid HMO paid and eligible but un 25 If this provider is an IRF, enter the in-state Medic in col. 4, Medicaid HMO paid and eligible but un 26 Enter your standard geographic classification (no 17 Enter your standard geographic classification (no 17 If applicable enter the effective date of the geogra 37 If this is a ole community hospital (SCH), enter 36 Enter applicable beginning and ending dates of S 37 If this is a Medicare dependent hospital (MDH).	he portion of the cost reporting period o ys on lines 24 and/or 25 below? In colu reporting period different from the meth different from the meth different from the cost of the cost of the cost aid paid days in col. 3, out-of-state Medi- caid paid days in col. 5, and other Medicaid caid paid days in col. 5, and other Medicaid col. 3, out-of state Medicaid eligible un paid days in col. 5. It wage) status at the beginning of the cost twage) status at the end of the cost report aphic reclassification in column 2. It wage) status at the end of the cost report aphic reclassification in column 2. It wage) status at the end of the cost report aphic reclassification in column 2. It wage) status at the periods SCH status in effi SCH status. Subscript line 36 for numbe enter the number of periods SCH SH sfor numb	curring on or after October 1. ( mn 1, enter 1 if date of admission od used in the prior cost reportin e Medicaid caid eligible unpaid days days in col. 6. d eligible unpaid paid days st reporting period. Enter "1" for rring period. Enter in column 1, ect in the cost reporting period. r of periods in excess of one and in effect in the cost reporting one and in effect in the cost reporting one r of periods in excess of one and	see instructions) n, 2 if census days, or 3 g period? In column 2 In-State Medicaid paid days 1 r urban or "2" for rural "1" for urban or "2" for enter subsequent dates enter subsequent dates enter	i if date of discharge. , enter "Y" for yes or "N" fo In-State Medicaid eligible unpaid days 2 2	r no.  Out-of State Medicaid paid days 3 3 Beginning: Beginning:	Out-of State Medicaid eligible unpaid days	HMO days 5	Medicaid days	
Enter in column 2 "Y" for yes or "N" for no for 1           23         Which method is used to determine Medicaid day Is the method of identifying the days in this cost           24         If this provider is an IPPS hospital, enter the in-stel eligible unpaid days in col. 2, out-of-state Medic days in col. 4, Medicaid HMO paid and eligible but un           25         If this provider is an IRF, enter the in-state Medic days in col. 4, Medicaid HMO paid and eligible but un           26         Enter your standard geographic classification (no If applicable enter the effective date of the geogr.           26         Enter your standard geographic classification (no If applicable enter the effective date of the geogr.           35         If this is a sole community hospital (SCH), enter a Enter applicable beginning an ending dates of S and If this is a Medicare dependent hospital (MDH),	he portion of the cost reporting period o ys on lines 24 and/or 25 below? In colu reporting period different from the meth tate Medicaid paid days in col. 1, in-stat aid paid days in col. 3, out-of-state Medi paid days in col. 5, and other Medicaid col. 3, out-of state Medicaid eligible un paid days in col. 5, and other Medicaid aid pais in col. 5. at wage) status at the beginning of the cor tr wage) status at the end of the cost repr aphic reclassification in column 2. the number of periods SCH status in eff CH status. Subscript line 36 for numbe enter the number of periods MDH status. ADH status. Subscript line 36 for number and payment adjustment for low volume h	curring on or after October 1. ( mn 1, enter 1 if date of admission od used in the prior cost reportin e Medicaid caid eligible unpaid days days in col. 6. d eligible unpaid paid days st reporting period. Enter "1" for rtring period. Enter "1" for rtring period. Enter "1" for et in the cost reporting period. et in the cost reporting period. in effect in the cost reporting per er of periods in excess of one and in effect in the cost of one and spitals in accordance with 42 C	see instructions) n, 2 if census days, or 3 g period? In column 2 In-State Medicaid paid days 1 rurban or "2" for rural "1" for urban or "2" for enter subsequent dates rirod. d enter subsequent date R 412.101(b)(2)(ii)? F	i if date of discharge. , enter "Y" for yes or "N" fo In-State Medicaid eligible unpaid days 2 - - - - - - - - - - - - -	r no.  Out-of State Medicaid paid days 3 3 Beginning: Beginning:	Out-of State Medicaid eligible unpaid days	HMO days 5	Medicaid days	

FORM CMS-2552-10 (03-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

DRAFT FORM CMS-2552-10						4090 (	Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CO	CN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
			10	V	XVIII	XIX	T
Prospective Payment System (PPS)-Capital				1	2	3	
45 Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see ins							45
46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If ye 47 Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes or "N" for no.	es, complete Worksheet L, Part III an	d L-1, Parts	through III.	_			46
48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							47
Teaching Hospitals				1	2	3	
56 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							56
57 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no i If column 2 is "N", complete Worksheet D, Parts III & IV and D-2, Part II, if applicable.	in column 2. If column 2 is "Y", con		sheet E-4.				57
58 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.							58
59 Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.							59
60 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.8			ions)		IME	Direct GME	60
	Y/N	1	2	3	IME 4	Direct GME 5	-
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	)		2	5	4	5	61
	,				IME	Direct GME	
				1	2	3	
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitte							61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with 61.03 Enter the base line FTE count for primary care and/or general surgery residents.		ACA). (see ii	istructions)				61.02
61.04 Enter the oase line FTE count for primary care and/of general surgery residents, which is used for determining compliance will 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period							61.03
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or		minus line 61	.03), (see instructions)				61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surge							61.06
					Unweighted	Unweighted	
					IME	Direct GME	
			Program Name	Program Code	FTE Count	FTE Count 4	-
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count enter program. 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count			1				61.10
GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expand Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count. GME FTE unweighted count.							61.20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)         62           Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HR							62
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost rep	porting period of HRSA THC progra	m. (see instr	uctions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63 Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no.	If yes, complete lines 64-67. (see i	nstructions)					63
				Unweighted FTEs	Unweighted FTEs	Ratio (col. 1/	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settingsThis base year is your cost reporting period that begins				Nonprovider Site	in Hospital	(col. 1 + col. 2))	64
64 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-pr in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		e to rotations	occurring				64
				Unweighted	Unweighted	Ratio	
F	Due many N		December Cold	FTEs	FTEs	(col. 3/	
	Program Name		Program Code	Nonprovider Site	in Hospital 4	(col. 3 + col. 4)) 5	-
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that	1		2		4		65
trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.14

Rev.

4090 (Cont.) FORM CMS-2552-10	0				0	DI	RAFT
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDE	R CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings—Effective for cost reporting periods beginning on or 66 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-pr unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided b)	rovider settings. Enter in column		f	1	2	3	66
	- · · ·			Unweighted FTEs	Unweighted FTEs	Ratio (col. 3/	
	Program Name		Program Code	Nonprovider Site	in Hospital 4	(col. 3 + col. 4)) 5	-
67 Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							67
Inpatient Psychiatric Facility PPS				1	2	3	٦
70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no 71 If line 70 ves:	).						70
Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before Nover Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ex Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	nter "Y" for yes or "N" for no. the beginning of the fourth year,		(see 42 CFR 412.424(d)(1)(iii)(c))				
Inpatient Rehabilitation Facility PPS				1	2	3	
75       Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for         76       If line 75 yes:         Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or b         Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Et         Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	before November 15, 2004? Ente nter "Y" for yes or "N" for no. the beginning of the fourth year,		"N" for no.				75
Long Term Care Hospital PPS							
Boll Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.							80
TEFRA Providers							
<ul> <li>85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</li> <li>86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N"</li> </ul>	6						85 86
86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter Y" for yes of IN	IOF NO.				V	XIX	86
Title V and XIX Services           90         Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.					1	2	90
91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for	or no in the applicable column.						91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" i	for no in the applicable column.						92
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicab	ble column.						93
94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.							94
95 If line 94 is "Y", enter the reduction percentage in the applicable column.							95
96 Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 97 If line 96 is "Y", enter the reduction percentage in the applicable column.							96 97
3/ If the 30 is it, enter the reduction percentage in the applicable column.							9/

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

	WORKSHEET S-2		
SPITAL AND HOSPITAL HEALTH CARE PROVIDER CCN: PERIOD	WORKSHEET 5-2		
MPLEX IDENTIFICATION DATA FROM	PART I (CONT.)		
то			
ral Providers	1	2	
105 Does this hospital qualify as a Critical Access Hospital (CAH)?			105
06 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			107
If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II.			
108 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no.			108
Physical Occup	tional Speech	Respiratory	
109 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109
	•		<b>-</b>
iscellaneous Cost Reporting Information			
15 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.			115
If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals			
providers) based on the definition in CMS 15-1 §2208.1.			
16 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			116
17 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			117
18 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.			118
3.01 List amounts of malpractice premiums and paid losses:	ums Paid losses	Self insurance	118.01
			-
3.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			118.02
19 What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			119
20 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a			120
rural hospital with <100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.			
21 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			121
			_
ansplant Center Information			
25 Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			125
26 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126
27 If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127
28 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128
29 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129
30 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130
31 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131
32 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132
33 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133
34 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

Form CMS-2552-10 (03-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1) Rev. 5

4090 (Cont.)	FORM CMS-25	552-10						03-1
OSPITAL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD		WORKSHEET S-2		
OMPLEX IDENTIFICATION DATA				FROM		PART I (CONT.)		
				то				
ll Providers								
						1	2	
	ts as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes	s or "N" for no in column 1.						14
If yes, and home office costs are claimed, enter in colu	umn 2 the home office chain number. (see instructions)							
this facility is part of a chain organization, enter on lines 14	41 through 143 the name and address of the home office and e	nter the home office contrac	tor name and contractor n	umber.				
141 Name:		Contractor's Name			Contractor's Number:			1
142 Street:	P. O. Box:			-				1
143 City:	State:	Zip Code:						1
144 Are provider based physicians' costs included in Work		1 1 00000						1
	, line 74 are they costs for inpatient services only? Enter "Y" f	for yes or "N" for no.						1
	e previously filed cost report? Enter "Y" for yes or "N" for no		ib. 15-2, section 4020)					1
If yes, enter the approval date (mm/dd/yyyy) in colum	un 2.							
								_
147 Was there a change in the statistical basis? Enter "Y"								
148 Was there a change in the order of allocation? Enter "								
149 Was there a change to the simplified cost finding meth	hod? Enter "Y" for yes or "N" for no.							1
oes this facility contain a provider that qualifies for an exem	nption from the application of the lower of costs or charges?			Title X	VIII			
Enter "Y" for yes or "N" for no for each component for Part A				Part A	Part B	Title V	Title XIX	
····· · · · · · · · · · · · · · · · ·				1	2	3	4	_
155 Hospital						-		1
156 Subprovider - IPF								1
157 Subprovider - IRF								1
158 Subprovider - Other								1
159 SNF								1
160 HHA								1
161 CMHC								1
Multicampus			1					_
165 Is this hospital part of a multicampus hospital that has	one or more campuses in different CBSAs? Enter "Y" for yes	s or "N" for no.						1
166 If line 165 is yes, for each campus enter the name in c	column 0, county in column 1, state in column 2, ZIP in colum	n 3 CBSA in column 4 FT	E/Campus in column 5					1
100 If fine 105 is yes, for each campus enter the name in e	Name	n 5, CD5/1 in Column 4, 1 1.	County	State	Zip Code	CBSA	FTE/Campus	- 1
	0		1	2	3	4	5	_
	~						, , , , , , , , , , , , , , , , , , ,	-
			1			1	-	
lealth Information Technology (HIT) incentive in the Americ	can Recovery and Reinvestment Act							
167 Is this provider a meaningful user under §1886 (n)? E	Enter "Y" for yes or "N" for no.							

167 Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.			167
168 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
169 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			169
170 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

10-12	FORM CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2	
REIMBURSEMENT QUESTIONNAIRE		FROM	Part II	
		то		

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.	
Enter all dates in the mm/dd/yyyy format.	

# COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2	1	
1 Has the provider changed ownership immediately prior to the beginning of the cost reporting period?					1
If yes, 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?					2
If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.					
3 Is the provider involved in business transactions, including management contracts, with individuals or entiti	ies				3
(e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, i					
staff, management personnel, or members of the board of directors through ownership, control, or family an					
other similar relationships? (see instructions)					
Jourd on the relationships (see instructions)					
		Y/N	Туре	Date	
Financial Data and Reports		1	2	3	-
4 Column 1: Were the financial statements prepared by a Certified Public Accountant?		1	2		4
Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy o	an optor				4
	or enter				
date available in column 3. (see instructions) If no, see instructions.					5
					5
If yes, submit reconciliation.					
			37/37	17.01	
			Y/N	Y/N	_
Approved Educational Activities			1	2	
6 Column 1: Are costs claimed for nursing school?					6
Column 2: If yes, is the provider is the legal operator of the program?					
7 Are costs claimed for allied health programs? If yes, see instructions.					7
8 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting perio	od?				8
If yes, see instructions.					
9 Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.					9
10 Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instruct					10
11 Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Wo	orksheet A?				11
If yes, see instructions.					
Bad Debts				Y/N	
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.					12
13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye	es, submit copy.				13
					14
14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					14
14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				<u> </u>	14
					14
14       If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.         Bed Complement       15         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.				I	
Bed Complement					
Bed Complement	Part A		Part	B	15
Bed Complement	Part A Y/N	Date	Part Y/N	B Date	
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.				Date	
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data	Y/N	Date	Y/N	-	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Y/N	Date	Y/N	Date	
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         16       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y/N	Date	Y/N	Date	15 16 17
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         17       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been	Y/N	Date	Y/N	Date	15 16 17
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         16       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y/N	Date	Y/N	Date	15 16 17 18
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         18       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.         19       If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other	Y/N	Date	Y/N	Date	15
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         18       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.         19       If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y/N	Date	Y/N	Date	15 16 16 17 17 18 18 19
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         18       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.         19       If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.         20       If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other?	Y/N	Date	Y/N	Date	15 16 17 18
Bed Complement         15       Did total beds available change from the prior cost reporting period? If yes, see instructions.         PS&R Report Data         16       Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         17       Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?         18       If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)         18       If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.         19       If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y/N	Date	Y/N	Date	15 16 16 17 17 18 18 19

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4004.2) Rev. 3

40-509

4090 (Cont.)	FORM CMS-2552-10					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN: PERIOD WORKSHEET S-2					
REIMBURSEMENT QUESTIONNAIRE	FROM Part II (CONT.)					
	TO					

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

# COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost						
22 Have assets been relifed for Medicare purposes? If yes, see instructions.			22			
23 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period?			23			
If yes, see instructions.						
24 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instruction	ns.		24			
25 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25			
26 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26			
27 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			27			
Interest Expense						
28 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructi	ons.		28			
29 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded de	epreciation		29			
account? If yes, see instructions.	•					
30 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30			
31 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31			
<ul> <li>32 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.</li> <li>33 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.</li> </ul>						
Provider-Based Physicians			-			
34 Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions			34			
35 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the	cost		35			
reporting period? If yes, see instructions.						
	Y/N					
Home Office Costs	1	2				
36 Are home office costs claimed on the cost report?			36			
37 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37			
38 If line 36 is yes, was the fiscal year end of the home office different from that of the provider?			38			
If yes, enter in column 2 the fiscal year end of the home office.			39			
	39 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					
40 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40			
Cost Report Preparer Contact Information						
41 First name: Last name:	Title:		41			
42 Employer:			42			
43 Phone number: E-mail Address:			43			

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4004.2) 40-510

09-14					FORM	I CMS-2	552-10			1				1	4090 (0	Jont.
HOSPITAL AND HOSPITAL HEALTH CARE COM	<b>IPLEX</b>									PROVIDE	R CCN:	PERIOD		WORKS	HEET S-3	
STATISTICAL DATA												FROM_		PART I		
					T .:	· D / O			<b>E</b> 11		1	то		1		<del></del>
					Inpatier	it Days / Ou	tpatient Visi	ts / Trips	Full	Time Equiva	lents		Disc	harges		_
	Worksheet									<b>F</b> 1					<b>T</b> . 1	
	A						(m) (	Total	Total	Employees					Total	
	Line		Bed Days	CAH	<b>T</b> (1) <b>T</b>	Title	Title	All	Interns &	On	Nonpaid		Title	Title	All	
Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents		Workers	Title V	XVIII	XIX	Patients	4
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	<u> </u>
1 Hospital Adults & Peds. (columns 5,																1
6, 7 and 8 exclude Swing Bed, Observation Be	20															
and Hospice days) (see instructions for col.	1															
2 for the portion of LDP room available beds)																
2 HMO and other (see instructions)																2
3 HMO IPF Subprovider																3
4 HMO IRF Subprovider																4
5 Hospital Adults & Peds. Swing Bed SNF																5
6 Hospital Adults & Peds. Swing Bed NF																6
7 Total Adults and Peds. (exclude																7
observation beds) (see instructions)																
8 Intensive Care Unit																8
9 Coronary Care Unit																9
10 Burn Intensive Care Unit																10
11 Surgical Intensive Care Unit																11
12 Other Special Care																12
13 Nursery																13
14 Total (see instructions)																14
15 CAH visits																15
16 Subprovider - IPF																16
17 Subprovider - IRF									1							17
18 Subprovider - Other	1 1															18
19 Skilled Nursing Facility																19
20 Nursing Facility	-				-											20
21 Other Long Term Care	+															21
22 Home Health Agency														-		22
23 ASC (Distinct Part)	+ +								-							22
24 Hospice (Distinct Part)	+								<u> </u>							23
24 Hospice (Distinct Part) 24.10 Hospice (non-distinct part)	+	_						<u> </u>								24
25 CMHC	+															24.1
26 RHC/FQHC (specify)	+				-											25
27 Total (sum of lines 14-26)																26
27 Total (sum of lines 14-26) 28 Observation Bed Days									-					-	-	27
28 Observation Bed Days 29 Ambulance Trips															-	28
30 Employee discount days (see instructions)																30
31 Employee discount days -IRF																31
32 Labor & delivery (see instructions)		_														32
32.01 Total ancillary labor & delivery room																32.0
outpatient days (see instructions)																
33 LTCH non-covered days																- 33

4090 (Cont.)	FOR	M CMS-25	52-10				09-14
HOSPITAL WAGE INDEX INFORMATION		PROVIDER C	:dn:	PERIOD FROM TO		WORKSHEET PART II	5-3
Part II - Wage Data		-					
	Worksheet A Line Number	Amount Reported 2	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3) 4	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
SALARIES	1	2	3	4	3	0	
1 Total salaries (see instructions)							1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A - Administrative							4
4.01 Physician-Part A - Teaching							4.01
5 Physician-Part B					-		4.01
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)							7
7.01 Contracted interns & residents (in an approved program)							7.01
8 Home office personnel							7.01
9 SNF							9
10 Excluded area salaries (see instructions)							10
OTHER WAGES AND RELATED COSTS							10
11 Contract labor : Direct Patient Care							11
Contract labor: Top level management and other management and administrative services							12
13 Contract labor: Physician-Part A - Administrative							13
14 Home office salaries & wage-related costs							14
15 Home office: Physician Part A - Administrative							15
16 Home office & Contract Physicians Part A - Teaching							16
WAGE-RELATED COSTS							
17 Wage-related costs (core) (see instructions)							17
18 Wage-related costs (other) (see instructions)							18
19 Excluded areas							19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - Administrative							22
22.01 Physician Part A - Teaching							22.01
23 Physician Part B							23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)							25

09-13				FORM CMS-2552-10				
HOSPIT	AL WAGE INDEX INFORMATION		PROVIDER C	CN:	PERIOD		WORKSHEET S	5-3
					FROM		PART II & III	
				_	ТО			
Part II -	Wage Data			-				
		Worksheet		Reclassification	Adjusted	Paid Hours	Average	
		A		of Salaries	Salaries	Related	Hourly Wage	
		Line	Amount	(from	(column 2 ±	to Salaries	(column 4 ÷	
		Number	Reported	Worksheet A-6)	,	in column 4	column 5)	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
		4						26
27	Administrative & General	5						27
	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7						30
31	Laundry & Linen Service	8						31
	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10						34
	Dietary under contract (see instructions)							35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13						38
39	Central Services and Supply	14						39
	Pharmacy	15						40
41	Medical Records & Medical Records Library	16						41
42	Social Service	17						42
43	Other General Service	18						43
Part III -	Hospital Wage Index Summary							
	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)							3
4	Subtotal other wages and related costs (see instructions)							4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)							6
7	Total overhead cost (see instructions)							7

4090 (Cont.)	09-13		
HOSPITAL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD FROM	WORKSHEET S-3, PART IV
Part IV - Wage Related Cost		110	
Part A - Core List			1 1
			Amount Reported

		Reported	
	RETIREMENT COST		
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
	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	Accident Insurance (If employee is owner or beneficiary)		12
	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
	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		
	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above) (see instructions)		21
	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)		24

Part B - Other than Core Related Cost 25 Other Wage Related Costs (specify)\_\_\_\_

25

10-12	FORM CMS-2552-10			4090 (Cont.)
HOSPITAL CONTRACT LABOR AND BENEFIT COST		PROVIDER CCN:	PERIOD:	WORKSHEET S-3,
			FROM	PART V
			10	

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

		Contract	Benefit	
	Component	Labor	Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider- IPF			3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
	Hospital-Based Hospice			13
	Hospital-Based Health Clinic RHC			14
	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

OSPITAL-BASED HOME HEALTH AGENCY FATISTICAL DATA			PERIOD: FROM TO			ET S-4	
HOME HEALTH AGENCY STATISTICAL DATA			County	:			
		Title V	Title XVIII		Other	Total	Τ
Description		1	2	3	4	5	╇
1 Home Health Aide Hours							+
2 Unduplicated Census Count (see instructions)							1
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES				Nur	nber of Emplo	WOOS	т
Enter the number of hours in					l Time Equiva	0	
your normal work week			-	Staff	Contract	Total	-
you nomina work week			-	1	2	3	-
3 Administrator and Assistant Administrator(s)				-	-	t – –	+
4 Director(s) and Assistant Director(s)						<u> </u>	+
5 Other Administrative Personnel						1	$^{+}$
6 Direct Nursing Service						1	$^{+}$
7 Nursing Supervisor						<u> </u>	t
8 Physical Therapy Service						1	†
9 Physical Therapy Supervisor							t
10 Occupational Therapy Service							$^{+}$
11 Occupational Therapy Supervisor							+
12 Speech Pathology Service							t
13 Speech Pathology Supervisor							$^{+}$
14 Medical Social Service							$^+$
15 Medical Social Service Supervisor							$^{+}$
16 Home Health Aide							$^{+}$
17 Home Health Aide Supervisor							t
18 Other (specify)							T
							-
HOME HEALTH AGENCY CBSA CODES							_
							- L
19 Enter the number of CBSAs where you provided services during the cost rep							+
19       Enter the number of CBSAs where you provided services during the cost rep         20       List those CBSA code(s) serviced during this cost reporting period (line 20 d)		).					1
			-		1		±
20 List those CBSA code(s) serviced during this cost reporting period (line 20		Full E	pisodes			Total	1 T
20 List those CBSA code(s) serviced during this cost reporting period (line 20 e		Full E Without	With	LUPA	PEP only	(columns 1	
20 List those CBSA code(s) serviced during this cost reporting period (line 20		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20 List those CBSA code(s) serviced during this cost reporting period (line 20 o		Full E Without	With			(columns 1	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Skilled Nursing Visit Charges         23       Physical Therapy Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visits         24       Physical Therapy Visit Charges         23       Physical Therapy Visit Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visits         24       Physical Therapy Visit Charges         25       Occupational Therapy Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visits         24       Physical Therapy Visit         25       Occupational Therapy Visits         26       Occupational Therapy Visit Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visit Charges         24       Physical Therapy Visit Charges         25       Occupational Therapy Visit Charges         26       Occupational Therapy Visit Charges         27       Speech Pathology Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Skilled Nursing Visit Charges         23       Physical Therapy Visits         24       Physical Therapy Visits         25       Occupational Therapy Visits         26       Occupational Therapy Visits         27       Speech Pathology Visits         28       Speech Pathology Visit Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visit Charges         24       Physical Therapy Visits         25       Occupational Therapy Visits         26       Occupational Therapy Visit Charges         27       Speech Pathology Visit         28       Speech Pathology Visit         29       Medical Social Service Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits Charges         23       Physical Therapy Visits         24       Physical Therapy Visits         25       Occupational Therapy Visits         26       Occupational Therapy Visits         27       Speech Pathology Visit Charges         28       Speech Pathology Visit Charges         29       Medical Social Service Visits         30       Medical Social Service Visit Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Shylied Nursing Visit Charges         23       Physical Therapy Visit Charges         24       Physical Therapy Visit Charges         25       Occupational Therapy Visit Charges         26       Ccupational Therapy Visit Charges         27       Speech Pathology Visit Charges         28       Speech Pathology Visit Charges         29       Medical Social Service Visit Charges         31       Home Health Aide Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visits         23       Physical Therapy Visit Charges         23       Physical Therapy Visit Charges         24       Physical Therapy Visit Charges         25       Occupational Therapy Visit Charges         26       Occupational Therapy Visit Charges         27       Speech Pathology Visits         28       Speech Pathology Visits         29       Medical Social Service Visit Charges         21       Medical Social Service Visit Charges         23       Home Health Aide Visits         32       Home Health Aide Visits		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visit         23       Shilled Nursing Visit Charges         23       Physical Therapy Visit         24       Physical Therapy Visit         25       Occupational Therapy Visits         26       Occupational Therapy Visit Charges         27       Speech Pathology Visits         28       Speech Pathology Visits         29       Medical Social Service Visits         30       Medical Social Service Visit Charges         31       Home Health Aide Visit Charges         32       Home Health Aide Visit Charges         33       Total visits (sum of lines 21, 23, 25, 27, 29, and 31)		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visit Charges         23       Physical Therapy Visit         24       Physical Therapy Visits         25       Occupational Therapy Visits         26       Occupational Therapy Visit Charges         27       Speech Pathology Visit Charges         28       Speech Pathology Visit Charges         29       Medical Social Service Visits         30       Medical Social Service Visits         31       Home Health Aide Visit Charges         32       Home Health Aide Visit Charges         33       Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         34       Other Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visit Charges         23       Physical Therapy Visits         24       Physical Therapy Visits         25       Occupational Therapy Visit Charges         26       Occupational Therapy Visit Charges         27       Speech Pathology Visit         28       Speech Pathology Visit Charges         29       Medical Social Service Visits         30       Medical Social Service Visits         31       Home Health Aide Visits         32       Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         34       Other Charges         35       Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20       List those CBSA code(s) serviced during this cost reporting period (line 20 of PPS ACTIVITY         21       Skilled Nursing Visits         22       Skilled Nursing Visit Charges         23       Physical Therapy Visit         24       Physical Therapy Visits         25       Occupational Therapy Visit Charges         26       Occupational Therapy Visit Charges         27       Speech Pathology Visit Charges         28       Speech Pathology Visit Charges         29       Medical Social Service Visits         30       Medical Social Service Visits         31       Home Health Aide Visits         32       Home Health Aide Visit Charges         33       Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         34       Other Charges		Full E Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4006)

09-13 Hospital renal dialysis department	TORM	PROVIDER		PERIOD:		4090 ( WORKSHEE	
STATISTICAL DATA		TROVIDER		FROM			1 0-0
				то			
RENAL DIALYSIS STATISTICS							
	Outp	atient	Train	0	Home		
DECONTION	Derulau	III als Elson	Hemo-	CAPD	Hemo-	CAPD	
DESCRIPTION	Regular 1	High Flux 2	dialysis 3	CCPD 4	dialysis 5	CCPD 6	
1 Number of patients in program at	±				5	0	1
end of cost reporting period							
2 Number of times per week patient							2
receives dialysis							
3 Average patient dialysis time including setup							
4 CAPD exchanges per day							4
5 Number of days in year dialysis furnished							
6 Number of stations							
7 Treatment capacity per day per station							
8 Utilization (see instructions)							
9 Average times dialyzers re-used							
10 Percentage of patients re-using dialyzers							10
					1		-
ESRD PPS 10.01 Is the dialysis facility approved as a low-volume facility	for this cost reporting po	wied?			1	2	10.0
Enter "Y" for yes or "N" for no. (see instructions)	tor this cost reporting pe	1100:					10.0
10.02 Did your facility elect 100% PPS effective January 1, 201	112 Entor "V" for yos o	"N" for no					10.0
(See instructions for "new" providers.)	II. LINCI I IOI yes of	14 IOI IIO.					10.02
10.03 If you responded "N" to line 10.02, enter in column 1 the	year of transition for pe	riods prior to Janu	arv 1 and				10.03
enter in column 2 the year of transition for periods after I			ary r and				10.00
r i i j i i i i i i i i i i i i i i i i							-
TRANSPLANT INFORMATION							
11 Number of patients on transplant list							11
12 Number of patients transplanted during the cost reporting	; period						12
EPOETIN							_
13 Net costs of Epoetin furnished to all maintenance dialysis		r					1.
14 Epoetin amount from Worksheet A for home dialysis pro							14
15 Number of EPO units furnished relating to the renal dialy							1
16 Number of EPO units furnished relating to the home dialy	ysis department						1
ARANESP							
17 Net costs of ARANESP furnished to all maintenance dial	voic patients by the prov	ridor				1	1
17 Net costs of ARANESP furnished to an maintenance dial 18 ARANESP amount from Worksheet A for home dialysis		luei					1
19 Number of ARANESP units furnished relating to the rena							19
20 Number of ARANESP units furnished relating to the relations							2
20 Humber of Alexinets fullished relating to the non	ic diarysis department						20
PHYSICIAN PAYMENT METHOD (Enter "X" for appli-	cable method(s))						
21 MCP	INITIAL M	ETHOD					2
			Net Cost of			A Number of ES.	
		ESA	ESAs for	ESAs for		Units - Home	
	l De	scription	Renal Patient	s Home Patients	d Dialysis Dent	Dialysis Dent	

		Net Cost of	Net Cost of	Number of ESA	Number of ESA	
	ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
	Description	<b>Renal Patients</b>	Home Patients	Dialysis Dept.	Dialysis Dept.	
Erythropoiesis-Stimulating Agents (ESA) Statistics:	1	2	3	4	5	
22 Enter in column 1 the ESA description. Enter in column 2 the net						22
costs of ESAs furnished to all renal dialysis patients.						
Enter in column 3 the net cost of ESAs furnished to all home						
dialysis program patients. Enter in column 4 the number of						
ESA units furnished to patients in the renal dialysis department.						
Enter in column 5 the number of units furnished						
to patients in the home dialysis program. (see instructions)						

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4007)

4090 (Cont.)	FORM CMS-2552-10				09-13
HOSPITAL-BASED COMMUNITY MENTAL HEALTH	CENTER AND	PROVIDER CCN:	PERIOD:	WORKSHEET S-6	
OTHER OUTPATIENT REHABILITATION			FROM		
PROVIDER STATISTICAL DATA		COMPONENT CCN:	то		

COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

\_\_\_\_

Check	[] CMHC	[] OOT		
applicable	[] CORF	[] OSP		
box:	[] OPT			

Enter the number of hours in your normal workweek \_\_\_\_\_

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

10-1	2 FORM CMS-25	52-10	4090 (Cor			
	PECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7		
STAT	STICAL DATA		FROM TO	-		
			10	-		
			Y/N	Date		
			1	2		
1	If this facility contains a hospital-based SNF, were all patients under managed care or wa utilization? Enter "Y" for yes and do not complete the rest of this worksheet.	s there no Medicare			1	
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing	beds? Enter "Y" for			2	
-	yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column				-	
		SNF	Swing Bed SNF	TOTAL		
	Group 1	Days 2	Days 3	(sum of col. 2 + 3) 4	-	
3	RUX	2	5	4	3	
4	RUL				4	
5	RVX				5	
6	RVL				6	
7	RHX RHL				7	
9	RMX				0 9	
10	RML	1			10	
11	RLX				11	
12	RUC				12	
13	RUB				13	
14 15	RUA RVC				14 15	
16	RVB				16	
17	RVA				17	
18	RHC				18	
19	RHB				19	
20	RHA				20	
21 22	RMC RMB				21 22	
23	RMA				23	
24	RLB				24	
25	RLA				25	
26	ES3				26	
27 28	ES2 ES1	_		-	27 28	
28	HE2				28	
30	HE1				30	
31	HD2				31	
32	HD1				32	
33	HC2				33	
34 35	HC1 HB2				34 35	
36	HB1				36	
37	LE2				37	
38	LE1				38	
39	LD2				39	
40	LD1	+			40	
41 42	LC2 LC1				41 42	
43	LB2				43	
44	LB1				44	
45	CE2				45	
46	CE1				46	
47 48	CD2 CD1				47 48	
48	CDI CC2	+	+	1	48	
50	CC1	+			50	
51	CB2				51	
52	CB1				52	
53	CA2				53	
54	CA1				54	

4090	O(Cont.) FO	ORM CMS-2552-10						
PROS	PECTIVE PAYMENT FOR SNF ISTICAL DATA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-7 (CONT.)				
				-				
		SNF	Swing Bed SNF	TOTAL				
	Group	Days	Days	(sum of col. 2 + 3)				
	1	2	3	4				
55	SE3				55			
56	SE2				56			
57	SE1				57			
58	SSC				58			
59	SSB				59			
60	SSA				60			
61	IB2				61			
62	IB1				62			
63	IA2				63			
64	IA1				64			
65	BB2				65			
66	BB1				66			
67	BA2				67			
68	BA1				68			
69	PE2				69			
70	PE1				70			
71	PD2				71			
72	PD1				72			
73	PC2				72 73			
74	PC1				74			
75	PB2				75			
76	PB1				76			
77	PA2				77			
78	PA1				78			
199	AAA				199			
200	TOTAL				200			

SNF SERVICES

		CBSA at	CBSA on/after	
		Beginning of	October 1 of the	
		Cost Reporting	Cost Reporting	
		Period	Period (if applicable)	ĺ
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning			201
	of the cost reporting period.			
	Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			

A notice published in the Federal Register Volume 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 202 through 207: Enter in column 1 the amount of the 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 7, column 3. In column 3, enter "Y" or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

				Associated with	
				Direct Patient Care	i i
		Expenses	Percentage	and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (Specify)				206
207	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)				207

DRA	AFT				FORM	A CMS	-2552-	10	4090 (Cor						Cont.)	
HOSP	ITAL-BASED RHC/FQHC STA	TISTICAL	DATA				PROVII	ER CCN	I:		PERIOI FROM			WORK	SHEET S	-8
							COMPO	NENT C	CN.		TO					
							Comic		crt.		10	<b> </b>				
Check		al-based F	RHC													
applic	able box: [] Hospin	al-based F	QHC													
Clinic	Address and Identification:															
1	Street:															1
2	City:	State:			Zip Cod	e:			County:							2
3	HOSPITAL-BASED FQHCs O	NLY: De	signation	- Enter "F	R" for rura	ıl or "U" f	or urban									3
Source	e of Federal Funds:															
											Grant	Award			Date 2	
												1			2	<u> </u>
				Act)												4
5				DUC A												5
	Health Services for the Homel		n 340(d),	PHS Act	)											
	Appalachian Regional Commi	ssion														7
8																8
9	Other (specify)															9
														1	2	T
10	Does this facility operate as oth	ner than a	hospital-b	ased RHO	c or FQH	C? Enter	"Y" for y	es or "N"	for no in	column 1						10
	If yes, indicate the number of o						5									
Facilit	y hours of operations (1)															
		Sur	ndav	Mo	ndav	Tue	sdav	Wedn	iesday	Thu	sday	Fri	dav	Sati	ırday	T
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	1
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	1
11	Clinic		1	1		1									İ	11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1.			13
	If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			
14	RHC/FQHC name:         CCN number:			14

4090 (Cont.)	FORM CMS-2552-10			DRAFT				
HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-9 PARTS I <i>THROUGH</i> IV				
		HOSPICE CCN:	то					
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								

				Unduplicated Da	ys		
			Title XVIII	Title XIX		Total	
			Skilled Nursing	Nursing	All	(sum of	
	Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
	1	2	3	4	5	6	1
1 Hospice Continuous Home Care							1
2 Hospice Routine Home Care							2
3 Hospice Inpatient Respite Care							3
4 Hospice General Inpatient Care							4
5 Total Hospice Days							5

### PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving							6
	Hospice Care							
7	Total Number of Unduplicated Contin-							7
	uous Care Hours Billable to Medicare							
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

# PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

			Unauplicatea 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					

The describence of D

## PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ENDING ON OR AFTER OCTOBER 1, 2015

				Total (sum of	
	Title XVIII	Title XIX	Other	cols. 1 through 3)	
	1	2	3	4	
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.

09-1	.3 FORM CMS-2552	FORM CMS-2552-10					
HOSP	ITAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10			
CARE	E DATA		FROM	_			
			то	_			
	mpensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 colu	umn (l)			1		
1	Cost to charge ratio (worksheet C, Part 1 line 202 column 3 divided by line 202 colu	imn 8)			1		
Medio	aid (see instructions for each line)						
	Net revenue from Medicaid				2		
3	Did you receive DSH or supplemental payments from Medicaid?				3		
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicai	d?			4		
	If line 4 is no, enter DSH or supplemental payments from Medicaid				5		
	Medicaid charges				6		
7	Medicaid cost (line 1 times line 6)				7		
8	Difference between net revenue and costs for Medicaid program (line 7 minus lines	2 and 5).			8		
	If line 7 is less than the sum of lines 2 and 5, then enter zero.						
State	Children's Health Insurance Program (SCHIP) (see instructions for each line)						
_	Net revenue from stand-alone SCHIP				9		
	Stand-alone SCHIP charges				10		
11	Stand-alone SCHIP cost (line 1 times line 10)				11		
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line	e 9).			12		
	If line 11 is less than line 9, then enter zero.						
	state or local government indigent care program (see instructions for each line)						
	Net revenue from state or local indigent care program (not included on lines 2, 5 or 5 Charges for patients covered under state or local indigent care program (not included				13		
14		I In lines 6 of 10)			14		
	Difference between net revenue and costs for state or local indigent care program (li	ne 15 minus line 13)			15		
10	If line 15 is less than line 13, then enter zero.	ne 15 minus mie 15)			10		
Unco	mpensated care (see instructions for each line)						
17					17		
	Government grants, appropriations or transfers for support of hospital operations				18		
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care prog	rams (sum of lines 8, 12 and	d 16)		19		
		Uninsured	Insured	Total			
		patients	patients	(col. 1 + col. 2)			
		1	2	3	-		
20	Total initial obligation of patients approved for charity care (at full charges excludin	g			20		
	non-reimbursable cost centers) for the entire facility						
21					21		
22					22		
23	Cost of charity care (line 21 minus line 22)				23		
24	Does the amount in line 20, column 2 include charges for patient days beyond a leng	th of stay limit imposed on	natients covered		24		
24	by Medicaid or other indigent care program?	sur or say mine imposed on	patients covered				
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's ler	ngth of stay limit (see instru	ctions)		25		
	Total bad debt expense for the entire hospital complex (see instructions)		,		26		
27	Medicare bad debts for the entire hospital complex (see instructions)				27		
28					28		
29		es line 28)			29		
30	Cost of uncompensated care (line 23 column 3 plus line 29)				30		
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31		

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4012)

4090 (	Cont.)		FORM CMS	-2552-10				DI	RAFT
	AL-BASED FQHC IDENTIFICATION DATA					PROVIDER CCN:	PERIOD: FROM:	WORKSHEET S-11, PART I	
						COMPONENT CCN:	TO:		
PARTI	- HOSPITAL-BASED FQHC IDENTIFICATION DATA	4							
					Type of control	Date	V/I	Date of	T
					(see instructions)	Decertified	Decertification	CHOW	4
10	ite Name:	1			2	3	4	5	<u> </u>
	iteet:	P.O. Box:			<b>I</b>				1
	Citv:	State:	Zip Code:	County:	Designation - Enter "R"	for rural or "U" for urban	•		3
	s this hospital-based FQHC part of an entity that owns								4
	nter the entity's information below.	, icuses or controls in	uniple i Qiles: Enter i						4
	Iame of Entity:								5
	treet:	P.O. Box:		HRSA Award Numbe	r:				6
	City:	State:		Zip Code:					7
				r		1	2	3	<u> </u>
Consolio	dated Cost Report					Y/N	Date Requested	Date Approved	+
8 Is	s this hospital-based FQHC filing a consolidated cost 1	report per CMS Pub.	100-04, chapter 9, §30.8?	P Enter "Y" for yes or "N" for	no in column 1.		•		8
	see instructions) If yes, complete line 9. If no, leave line			10 10 10					
					CCN	CBSA	Date Requested	Date Approved	
		1			2	3	4	5	
	ite Name:								9
	-Based FQHC Operations					1	2	3	
	Vhat type of organization is this hospital-based FQHC haracters in column 2. (see instructions)	? If you operate as n	nore than one sub-type of	an organization, enter any or	all of the applicable alpha				10
	ased FQHC reported								11
	n line 1, column 2 receive a grant under §330 of the P.								
	f the response to line 11 is yes, indicate in column 1, th olumn 2 and enter the grant award number in column				the grant award in				12
	Malpractice								
13 "Y									13
	es or "N" for no in column 1. If column 1 is yes, enter	the effective date of o	coverage in column 2.						
Interns of	and Residents		Ŭ			•			
14 L	Did this hospital-based FQHC receive a Teaching Heal	lth Center developme	nt grant authorized under	Part C of Title VII of the PHS	SAct from HRSA? Enter "Y"	far			14
y.	es or "N" for no in column 1. If yes, enter in column 2	the number of FTE r	esidents that your hospita	Il-based FQHC trained and re	cceived funding through your				
T	HC grant in this cost reporting period.								

FORM CMS-2552-10 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4010.1)

40-523.1

DRAFT										
HOSPITAL-BASI	ED FQHC IDENTIFICATION DATA				PROVIDER CCN: COMPONENT CCN: SUBCOMPONENT CCN	PERIOD: FROM TO	WORKSHEET S-11, PART II			
PART II - HOSPI	ITAL-BASED FOHC CONSOLIDATED COST I	REPORT PARTICIPANT IDENTIFICATION DATA								
	,		Date Certified	Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW			
	1		2	3	4	5	6			
1 Site Name								1		
2 Street:	P.O. Box:			-				2		
3 City:	State:	Zip Code: County:		Designation - Enter "R	" for rural or "U" for urban			3		
Hospital-Based F				-	1	2	3			
	e of organization is this hospital-based FQHC? eable alpha characters in column 2. (see instruc	If you operate as more than one sub-type of an organiz tions)	ation, enter any or all	of				4		
5 Did this h	ospital-based FQHC receive a grant under §33	80 of the PHS Act during this cost reporting period? En	ter "Y" for yes or "N"	or no. (complete line 6)				5		
		pe of HRSA grant that was awarded (see instructions). If you received more than one grant subscript this line		rant award in				6		
Medical Malprac	ctice					•		_		
		or annual redeeming application for medical malpractic is yes, enter the effective date of coverage in column 2.	ce coverage under the	FTCA with HRSA?				7		
Interns and Resid										
Enter "Y"		Center development grant authorized under Part C of in column 2 the number of FTE residents that your FQF						8		

40-523.2

4090 (Cont.)	FORM CMS-2552-10								
HOSPITAL-BASED FQHC IDENTIFICATION DATA	PROVIDER CCN:								
	COMPONENT CCN:	FROM		PART III					
	COMPONENT CCN:	10	то						
PART III - HOSPITAL-BASED FQHC STATISTICAL DATA									
				Total					
	COMPONENT	Title	Title	All					
	CCN Titl	le V XVIII	XIX	Patients					
	0 1	1 2	3	4					
1 Medical Visits					1				
2 Total Medical Visits					2				
3 Mental Health Visits					3				
4 Total Mental Health Visits					4				

			FORM CMS-2552-10					0	9-13	
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE C	OF EXPENSES		PROVIDER CCN:	-	PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		GENERAL SERVICE COST CENTERS			-		-			
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3	00300	Other Capital Related Costs							-0-	3
4		Employee Benefits Department								4
5		Administrative and General								5
		Maintenance and Repairs								6
		Operation of Plant								7
		Laundry and Linen Service								8
		Housekeeping								9
		Dietary								10
		Cafeteria								11
		Maintenance of Personnel								12
		Nursing Administration								13
		Central Services and Supply								14
		Pharmacy								15
		Medical Records & Medical Records Library								16
		Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
		Subprovider - IRF								41
42	04200	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
		Nursing Facility								45
46	04600	Other Long Term Care								46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4013)

10-12					FORM CMS-2552-10					Cont.)
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE	E OF EXPENSES		PROVIDER CCN:	-	PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		ANCILLARY SERVICE COST CENTERS	1	2	5	4	5	0	/	<u> </u>
50	05000	Operating Room								50
		Recovery Room								51
		Labor Room and Delivery Room								52
		Anesthesiology								53
		Radiology-Diagnostic								54
		Radiology-Therapeutic								55
		Radioisotope								56
		Computed Tomography (CT) Scan								57
		Magnetic Resonance Imaging (MRI)								58
		Cardiac Catheterization								59
		Laboratory								60
		PBP Clinical Laboratory Services-Program Only								61
		Whole Blood & Packed Red Blood Cells								62
		Blood Storing, Processing, & Trans.								63
		Intravenous Therapy								64
		Respiratory Therapy								65
		Physical Therapy								66
		Occupational Therapy								67
		Speech Pathology								68
		Electrocardiology								69
70	07000	Electroencephalography								70
		Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

# FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4013)

4090	4090 (Cont.)				FORM CMS-2552-10					
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE	OF EXPENSES		PROVIDER CCN:		PERIOD: FROM	-	WORKSHEET A	
							TO RECLASSIFIED		NET EXPENSES	<u> </u>
		COST CENTER DESCRIPTIONS			TOTAL	RECLASSIFI-	TRIAL BALANCE		FOR ALLOCATION	
		(omit cents)	SALARIES 1	OTHER	(col. 1 + col. 2)	CATIONS	$(\operatorname{col.} 3 \pm \operatorname{col.} 4)$	ADJUSTMENTS	$(\operatorname{col.} 5 \pm \operatorname{col.} 6)$	<u> </u>
		OTHER REIMBURSABLE COST CENTERS	1	2	3	4	5	6	/	<u> </u>
.94	09400	Home Program Dialysis								94
		Ambulance Services								95
		Durable Medical Equipment-Rented								96
		Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
		Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
		Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
		Interest Expense							- 0 -	113
		Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)								118
		NONREIMBURSABLE COST CENTERS								
		Gift, Flower, Coffee Shop, & Canteen								190
		Research								191
192		Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)				- 0 -				200

10-12 FORM CMS-2552-10									4090 (C	Cont.)		
	ASSIFICATIONS			PROVIDER CCN:	PERIOI FROM _ TO		WORKSHEET	A-6				
				INCREA	SES		DECREASES			1	Wkst.	
		CODE									A-7	
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	Ref.	
		1	2	3	4	5	6	7	8	9	10	
1												1
2				+								2
3		_				-	-					3
4				+				+ +			<b></b>	4
6												6
7		_										7
8											-	8
9											-	9
10											-	10
11											-	11
12											-	12
13												13
14												14 15
15												15
16												16
17				+								17
18		_										18
19 20				+				+				19
20												20 21
21				+ +				+ +				21
22		_									+	23
23		_									-	24
25											-	24 25
26											-	26
27											-	27
28											-	28
29											-	29
30												30
31												31
32												32 33
33												33
34				+				4			<b>_</b>	34 35
35												35
	Total reclassifications (sum of columns 4 and 5											500
1	must equal sum of columns 8 and 9)											

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

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4014)

4090 (Cont.)		FO	RM CMS-2552	2-10				1	10-12
RECONCILIATION OF CAPITAL COSTS CENTERS				PROVIDER CCN:		PERIOD:		WORKSHEET A-7	7,
						FROM		PARTS I, II & III	·
						ТО		- , -	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES				-				
				Acquisitions		Disposals		Fully	T
		Beginning		1		and	Ending	Depreciated	
Description		Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
Description		1	2	3	4	5	6	7	+
1 Land		1	-	5		5		· · · · · · · · · · · · · · · · · · ·	1
2 Land Improvements								+	2
3 Buildings and Fixtures								+	3
4 Building Improvements								+	4
5 Fixed Equipment									5
6 Movable Equipment									6
7 HIT-designated Assets								+	7
8 Subtotal (sum of lines 1-7)									8
							l		9
9 Reconciling Items									
10 Total (line 7 minus line 9)									10
PART II - RECONCILIATION OF AMOUNTS FROM W	ORKSHEET A, COI	LUMN 2, LINES 1 A	AND 2		UN O (A DI O D O A A				
			i		SUMMARY OF CAR	TAL		T . 1 (1)	4
						_	Other Capital-	Total (1)	
- · · ·					Insurance	Taxes	Related Costs	(sum of	
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1-2)							l		3
(1) The amount in columns 9 through 14 must equal the amo	ount on Worksheet A,	column 2, lines 1 and	2. Enter in each col	umn the appropriate a	mounts including any	y directly assigned co	st that may have been i	ncluded in Worksheet	t A,
column 2, lines 1 and 2.									
* All lines numbers are to be consistent with Worksheet A		tal cost centers.							
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS								
		COMPUTAT	ION OF RATIOS			ALLOCATION O	F OTHER CAPITAL		
			Gross Assets					Total	
		Capitalized	for Ratio	Ratio			Other Capital-	(sum of	
Description	Gross Assets	Leases	(col. 1 - col. 2)	(see instructions)	Insurance	Taxes	Related Costs	cols. 5 through 7)	
*	1	2	3	4	5	6	7	8	+
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1-2)				1.000000					3
			1				·		- <u>-</u> -
				S	UMMARY OF CAL	PITAL			T
			1			1	Other Capital-	Total (2)	1
					Insurance	Taxes	Related Costs	(sum of	
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*		9	10	11	12	13	14	15	1
1 Capital Related Costs-Buildings and Fixtures			10		12	10		+ 10	1
2 Capital Related Costs-Dundings and Fixtures								+	2
3 Total (sum of lines 1-2)							<u> </u>	+	3
(2) The amounts on lines 1 and 2 must equal the correspond	ing amounts on Mork	sheet A column 7 lir	L los 1 and 2 Columns	9 through 1/ should	include related		<u> </u>		
(2) The amounts on mics 1 and 2 must equal the correspond		,		s anough 14 should	menuae relateu				

Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.) FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4015)

ADJU	STMENTS TO EXPENSES	RM CMS-2552		PERIOD:	WORKS	<mark>)90 (С</mark> неет а	
				FROM			
				то			
					I		
				EXPENSE CLASSIFICA	TION ON		
	DESCRIPTION (1)			WORKSHEET A TO/FRO	M WHICH	Wkst.	
				THE AMOUNT IS TO BE	ADJUSTED	A-7	
		BASIS/CODE (2)	AMOUNT	COST CENTER	LINE #	Ref.	
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		
3	Investment income - other (chapter 2)						
4	Trade, quantity, and time discounts (chapter 8)						
5	Refunds and rebates of expenses (chapter 8)						
6	Rental of provider space by suppliers (chapter 8)						
7	Telephone services (pay stations excluded) (chapter 21)						
	Television and radio service (chapter 21)						
9	Parking lot (chapter 21)						
10	Provider-based physician adjustment	Worksheet A-8-2					1
	Sale of scrap, waste, etc. (chapter 23)						1
12	Related organization transactions (chapter 10)	Worksheet A-8-1					1
13	Laundry and linen service						1
	Cafeteria-employees and guests						
	Rental of quarters to employee and others						1
16	Sale of medical and surgical						1
	supplies to other than patients						
17							1
	Sale of medical records and abstracts						1
	Nursing school (tuition, fees, books, etc.)						1
	Vending machines						2
21	Income from imposition of interest,						2
	finance or penalty charges (chapter 21)						
22	Interest expense on Medicare overpayments and						4
	borrowings to repay Medicare overpayments						
23	Adjustment for respiratory therapy						2
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		
24	Adjustment for physical therapy costs						
	in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		1
	Depreciation - buildings and fixtures			Buildings and Fixtures	1		2
	Depreciation - movable equipment			Movable Equipment	2		2
	Non-physician Anesthetist			Nonphysician Anesthetist	19		2
29	Physicians' assistant						2
30	Adjustment for occupational therapy costs						3
	in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		L
	Hospice (non-distinct) (see instructions)			Adults and Pediatrics	30		30.9
31	Adjustment for speech pathology costs						1.5
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		
	CAH HIT Adjustment for Depreciation						3
	Other adjustments (specify) <sup>(3)</sup>						3
50	TOTAL (sum of lines 1 thru 49)						
	(Transfer to Worksheet A, column 6, line 200)						1

Description - all chapter references in this column pertain to CMS Pub. 15-1
 Basis for adjustment (see instructions)

 A. Costs - if cost, including applicable overhead, can be determined
 B. Amount Received - if cost cannot be determined
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4016)

Rev. 4

4090 (Cont.)	FORM CMS-2552	2-10			09-13
STATEMENT OF COSTS OF SERVICES	PR	ROVIDER CCN:	PERIOD:	WORKSHEET A-8-1	
FROM RELATED ORGANIZATIONS AND			FROM		
HOME OFFICE COSTS			то		

#### A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

					Amount	Net		
				Amount of	included in	Adjustments	Wkst.	
				Allowable	Wkst. A	(col. 4 minus	A-7	
	Line No.	Cost Center	Expense Items	Cost	column 5	col. 5) *	Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	5 TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet							5
	A-8, colur	nn 2, line 12.						

\* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

### B. 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 B 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.

				Relate	ed Organization(s) and/or	Home Office	
			Percentage		Percentage		
	Symbol		of		of	Type of	
	(1)	Name	Ownership	Name	Ownership	Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

10-1	2		FO	RM CMS-255	2-10	4090 (Cont.)				
PROV	IDER-BA	SED PHYSICIANS ADJUSTMENTS			PROVIDER CCN:		PERIOD:	WORKSHEET A-8-2		
							FROM			
							ТО			
		Cost Center/					Physician/		5 Percent of	
	Wkst. A	Physician	Total	Professional	Provider	RCE	Provider	Unadjusted	Unadjusted	
	Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

			Cost of	Provider	Physician	Provider				
		Cost Center/	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line #	Identifier	Education	col. 12	Insurance	col. 14	RCE Limit	Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

FORM CMS-2552-10 (10-2012)(INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4018)

Rev. 3

4090 (Cont.)						10-12		
REASONABLE COST DETERMINATION		PROVIDER CCN:	PERIOD:	WORKSHEET A-8-3,				
FURNISHED BY OUTSIDE SUPPLIER	FURNISHED BY OUTSIDE SUPPLIERS							PARTS I & II
							то	
Check applicable box:	[] Occupational	[] Physical	[] Respiratory	[] Speech Pathology				
PART I - GENERAL INFORMATION								

PARI	I - GENERAL INFORMATION						
1	Total number of weeks worked (excluding aides) (see instructions)						1
2	Line 1 multiplied by 15 hours per week						2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see inst	tructions)					3
4	Number of unduplicated days in which therapy assistant was on provider site but neither su	pervisor nor therapist wa	s on provider site (see in	structions)			4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by thera	py assistant and on whic	h				6
	supervisor and/or therapist was not present during the visit(s)) (see instructions)						
7	Standard travel expense rate						7
8	Optional travel expense rate per mile			8			
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked						9
10	AHSEA (see instructions)						10
11	Standard travel allowance (columns 1 and 2, one-half of column 2,						11
	line 10; column 3, one-half of column 3, line 10)						
12	Number of travel hours (see instructions)			12			
13	Number of miles driven (see instructions)						13
-							

### PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	14
15	Therapists (column 2, line 9 times column 2, line 10)	15
16	Assistants (column 3, line 9 times column 3, line10)	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	17
18	Aides (column 4, line 9 times column 4, line 10)	18
19	Trainees (column 5, line 9 times column 9, line 10)	19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2,	
	make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.	 
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2 line 9 for respiratory therapy or columns 1 through 3 line 9 for all others)	21

	21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	21
	22	Weighted allowance excluding aides and trainees (line 2 times line 21)	22
_	23	Total salary equivalency (see instructions)	23

FORM CMS-2552-10 (10-2012	) (INSTRUCTIONS FOR	<b>THIS FORM ARE PUBLISHE</b>	D IN CMS PUB. 15-2, SECTIONS 4019)

10-12			FOR	M CMS-2552-10				40	)90 (Cont.)
REASONABLE COST DETERMINATI	ON FOR THERAPY SERVIC	ES				PROVIDER CCN:	PERIOD:	WORKSHEET	A-8-3,
FURNISHED BY OUTSIDE SUPPLIER	s						FROM	PARTS III & I	V
							ТО		
Check applicable box:	[] Occupational []	Physical [	] Respiratory	[] Speech Pathology					
PART III - STANDARD AND OPTIO	NAL TRAVEL ALLOWAN	CE AND TRAV	EL EXPENSE C	COMPUTATION - PROVI	DER SITE				
Standard Travel Allowance									<u> </u>
24 Therapists (line 3 times column 2									24
25 Assistants (line 4 times column 3,									25
26 Subtotal (line 24 for respiratory th									26
	27 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)								27
28 Total standard travel allowance an	1	e provider site (s	sum of lines 26 an	id 27)					28
Optional Travel Allowance and Option									
29 Therapists (column 2, line 10 time		line 12 )							29
30 Assistants (column 3, line 10 time									30
31 Subtotal (line 29 for respiratory the second									31
32 Optional travel expense (line 8 tir		r respiratory the	rapy or sum of co	lumns 1-3, line 13 for all oth	ners)				32
33 Standard travel allowance and sta									33
34 Optional travel allowance and star	ndard travel expense (sum of li	nes 27 and 31)							34
35 Optional travel allowance and opt	ional travel expense (sum of li	nes 31 and 32)							35
PART IV - STANDARD AND OPTIO	NAL TRAVEL ALLOWANC	CE AND TRAV	EL EXPENSE C	COMPUTATION - SERVIO	CES OUTSI	DE PROVIDER SITE			
Standard Travel Expense									
36 Therapists (line 5 times column 2	. ,								36
37 Assistants (line 6 times column 3,	, line 11)								37
38 Subtotal (sum of lines 36 and 37)									38
39 Standard travel expense (line 7 tir									39
Optional Travel Allowance and Option									
40 Therapists (sum of columns 1 and		10)							40
41 Assistants (column 3, line 9 times	s column 3, line 10)								41
42 Subtotal (sum of lines 40 and 41)									42
43 Optional travel expense (line 8 tir									43
Total Travel Allowance and Travel Exp	ense - Offsite Services: Comp	lete one of the fe	ollowing					•	
three lines 44, 45, or 46, as appropriate.									
44 Standard travel allowance and sta	ndard travel expense (sum of li	nes 38 and 39)	(see instructions)						44
45 Optional travel allowance and sta	ndard travel expense (sum of li	nes 39 and 42) (	see instructions)						45
46 Optional travel allowance and opt	ional travel expense (sum of lin	nes 42 and 43) (	see instructions)						46

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-2, SI	ECTIONS 4019)
Derr 2	

4090 (Cont.)		10-12				
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8 PARTS V-VI	-3,
Check applicable box: [] Occupational [] Physical	[] Respiratory [] Speech Path	ology				
PART V - OVERTIME COMPUTATION		A	Aides	<b>T</b>	T1	
	Therapists	Assistants 2	Aldes	Trainees	Total 5	
47 Overtime hours worked during reporting period (if column 5,	1	2	3	4	5	47
line 47, is zero or equal to or greater than 2,080, do not complete						4/
lines 48-55 and enter zero in each column of line 56)						
48 Overtime rate (see instructions)						48
49 Total overtime (including base and overtime allowance) (multiply						40
line 47 times line 48)						43
CALCULATION OF LIMIT						
50 Percentage of overtime hours by category (divide the hours in each						50
column on line 47 by the total overtime worked in column 5, line 47)						50
51 Allocation of provider's standard work year for one full-time						51
employee times the percentages on line 50) (see instructions)						01
DETERMINATION OF OVERTIME ALLOWANCE						
52 Adjusted hourly salary equivalency amount (see instructions)						52
53 Overtime cost limitation (line 51 times line 52)						53
54 Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55 Portion of overtime already included in hourly computation at the AHSEA (i	multiply					55
line 47 times line 52)						
56 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in	1 column 5 the					56
sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	for all others.)					
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS C	OST AD IUSTMENT					
57 Salary equivalency amount (from line 23)	USI ADJUSI MENI					57
58 Travel allowance and expense - provider site (from lines 33, 34, or 35))						58
59 Travel allowance and expense - Offsite services (from lines 54, 61 55))						59
60 Overtime allowance (from column 5, line 56)						60
61 Equipment cost (see instructions)						61
62 Supplies (see instructions)						62
63 Total allowance (sum of lines 57-62)						63
64 Total cost of outside supplier services (from provider records)						64
65 Excess over limitation (line 64 minus line 63; if negative, enter zero)						65

Rev. 3

09-13		FO	RM CMS-255	2-10				4090 (0	Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7) 0	CAPITAL RELATED COSTS				TO	<u> </u>		
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
GENERAL SERVICE COST CENTERS	0	1	2	4	4/1	5	0	/	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits Department					1				4 5 6
5 Administrative and General							1		5
6 Maintenance and Repairs								7	6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration									13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library									16
17 Social Service									17
18 Other General Service (specify)						_			18
19 Nonphysician Anesthetists									19
20 Nursing School 21 Intern & Res. Service-Salary & Fringes (Approved)								_	20 21
22 Intern & Res. Other Program Costs (Approved)									21
23 Paramedical Education Program (specify)									22
INPATIENT ROUTINE SERVICE COST CENTERS									25
30 Adults and Pediatrics (General Routine Care)									30
31 Intensive Care Unit	+ +		1	1			1	1	31
32 Coronary Care Unit	+ +		1	1			1	1	32
33 Burn Intensive Care Unit	+ +								33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF									41
42 Subprovider (specify)									42
43 Nursery									43
44 Skilled Nursing Facility									44
45 Nursing Facility									45
46 Other Long Term Care									46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

4090 (Cont.)		FO	RM CMS-255	2-10				(	09-13
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD:		WORKSHEET B,	
						FROM		PART I	
						TO			
	NET EXPENSES		ITAL						
	FOR COST	RELATE	D COSTS						
	ALLOCATION			EMPLOYEE		ADMINIS-	MAIN-		
COST CENTER DESCRIPTIONS	(from Wkst.	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	
	A col. 7)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	_
	0	1	2	4	4A	5	6	7	_
ANCILLARY SERVICE COST CENTERS									
50 Operating Room									50
51 Recovery Room									51
52 Labor Room and Delivery Room									52
53 Anesthesiology									53
54 Radiology-Diagnostic									54
55 Radiology-Therapeutic									55
56 Radioisotope									56
57 Computed Tomography (CT) Scan									57
58 Magnetic Resonance Imaging (MRI) 59 Cardiac Catheterization									58 59
60 Laboratory	_								60 61
61 PBP Clinical Laboratory Services-Program Only 62 Whole Blood & Packed Red Blood Cells	-								61
63 Blood Storing, Processing, & Trans.									62
64 Intravenous Therapy									64
65 Respiratory Therapy									65
66 Physical Therapy									66
67 Occupational Therapy									67
68 Speech Pathology									68
69 Electrocardiology									69
70 Electroencephalography									70
71 Medical Supplies Charged to Patients									70
72 Implantable Devices Charged to Patients									72
73 Drugs Charged to Patients									73
74 Renal Dialysis									74
75 ASC (Non-Distinct Part)									75
76 Other Ancillary (specify)									76
OUTPATIENT SERVICE COST CENTERS									
88 Rural Health Clinic (RHC)									88
89 Federally Qualified Health Center (FQHC)									89
90 Clinic									90
91 Emergency									91
92 Observation Beds									92
93 Other Outpatient Service (specify)									93

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09-13		FO	RM CMS-255	2-10				4090 (0	Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)		ITAL ED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
OTHER REIMBURSABLE COST CENTERS	0	1	2	4	4A	5	6	7	
94 Home Program Dialysis									94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold									97
98 Other Reimbursable (specify)									98
99 Outpatient Rehabilitation Provider (specify)									99
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
101 Home Health Agency									101
SPECIAL PURPOSE COST CENTERS									
105 Kidney Acquisition									105
106 Heart Acquisition									106
107 Liver Acquisition									107
108 Lung Acquisition									108
109 Pancreas Acquisition									109
110 Intestinal Acquisition									110
111 Islet Acquisition									111
112 Other Organ Acquisition (specify)									112
115 Ambulatory Surgical Center (Distinct Part)									115
116 Hospice									116
117 Other Special Purpose (specify)									117
118 SUBTOTALS (sum of lines 1-117)									118
NONREIMBURSABLE COST CENTERS									
190 Gift, Flower, Coffee Shop, & Canteen									190
191 Research									191
192 Physicians' Private Offices									192
193 Nonpaid Workers									193
194 Other Nonreimbursable (specify)									194
200 Cross Foot Adjustments									200
201 Negative Cost Centers									201
202 TOTAL (sum lines 118-201)									202

4090 (Cont.)	FOF	M CMS-25	52-10					09-1			
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CO	CN:		PERIOD: FROM TO			WORKSHEET PART I	`В,
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment	1										2
4 Employee Benefits Department	7										4 5 6 7 8
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria											11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply											14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing School											20
21       Intern & Res. Service-Salary & Fringes (Approved)         22       Intern & Res. Other Program Costs (Approved)	_										21 22
23 Paramedical Education Program (specify)											22
INPATIENT ROUTINE SERVICE COST CENTERS											23
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)	1	1		1							35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider (specify)											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

10-12			FORM CMS-2552-10 PROVIDER CCN: PERIOD:							4090 (Cont.	
COST ALLOCATION - GENERAL SERVICE COSTS	1		1	PROVIDER CO	CN:	1	PERIOD: FROM TO		1	WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
ANCILLARY SERVICE COST CENTERS		-									
50 Operating Room											50
51 Recovery Room											51
52 Labor Room and Delivery Room											52
53 Anesthesiology											53
54 Radiology-Diagnostic											54
55 Radiology-Therapeutic											55
56 Radioisotope											56
57 Computed Tomography (CT) Scan											57
58 Magnetic Resonance Imaging (MRI)											58
59 Cardiac Catheterization											59
60 Laboratory											60
61 PBP Clinical Laboratory Services-Program Only											61
62 Whole Blood & Packed Red Blood Cells											62
63 Blood Storing, Processing, & Trans.											63
64 Intravenous Therapy											64
65 Respiratory Therapy											65
66 Physical Therapy											66
67 Occupational Therapy											67
68 Speech Pathology											68
69 Electrocardiology											69
70 Electroencephalography											70
71 Medical Supplies Charged to Patients											71
72 Implantable Devices Charged to Patients											72
73 Drugs Charged to Patients											73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)											75
76 Other Ancillary (specify)											76
OUTPATIENT SERVICE COST CENTERS											<b></b>
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)											89
90 Clinic										ļ	90
91 Emergency											91
92 Observation Beds											92
93 Other Outpatient Service (specify)											93

4090 (Cont.)	FOR	M CMS-25	52-10					10-12			
COST ALLOCATION - GENERAL SERVICE COSTS	ST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:					WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
OTHER REIMBURSABLE COST CENTERS											
94 Home Program Dialysis											94
95 Ambulance Services											95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
101 Home Health Agency											101
SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition											106
107 Liver Acquisition											107
108 Lung Acquisition											108
109 Pancreas Acquisition											109
110 Intestinal Acquisition											110
111 Islet Acquisition											111
112 Other Organ Acquisition (specify)											112
115 Ambulatory Surgical Center (Distinct Part)											115
116 Hospice											116
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1-117)											118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen											190
191 Research											191
192 Physicians' Private Offices											192
193 Nonpaid Workers											193
194 Other Nonreimbursable (specify)											194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118-201)											202

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09-14			FO	RM CMS-255	2-10				4090	(Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD: FROM		WORKSHEET E PART I	3,
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	TO SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS	10	15	20			25		25	20	
1       Capital Related Costs-Buildings and Fixtures         2       Capital Related Costs-Movable Equipment         4       Employee Benefits Department         5       Administrative and General         6       Maintenance and Repairs         7       Operation of Plant         8       Laundry and Linen Service         9       Housekeeping         10       Dietary         11       Cafeteria         12       Maintenance of Personnel         13       Nursing Administration         14       Central Services and Supply         15       Pharmacy         16       Medical Records & Medical Records Library         17       Social Service										$ \begin{array}{c}     1 \\     2 \\     4 \\     5 \\     6 \\     7 \\     7 \\     8 \\     9 \\     10 \\     11 \\     12 \\     13 \\     14 \\     15 \\     16 \\     17 \\   \end{array} $
18       Other General Service (specify)         19       Nonphysician Anesthetists         20       Nursing School         21       Intern & Res. Service-Salary & Fringes (Approved)					-					18 19 20 21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										20
<ul><li>30 Adults and Pediatrics (General Routine Care)</li><li>31 Intensive Care Unit</li></ul>										30
31 Intensive Care Unit 32 Coronary Care Unit	+	<u> </u>		1		1				31
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit		1								34
35 Other Special Care Unit (specify)		1			1					35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

4090	(Cont.)			FO	RM CMS-255	2-10					09-14
COST	ALLOCATION - GENERAL SERVICE COSTS									WORKSHEET I PART I	3,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10	10	20			20			20	
	Operating Room		-				-				50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology							1			53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds										92
93	Other Outpatient Service (specify)										93

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10-1	2			FO	RM CMS-255	2-10				4090 (	(Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD:		WORKSHEET B	
								FROM		PART I	
							_	ТО			
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	10	19	20	21	22	23	24	25	20	-
	Home Program Dialysis										04
	Ambulance Services										94
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										98
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										100
101	SPECIAL PURPOSE COST CENTERS										101
105	Kidney Acquisition										105
	Heart Acquisition										105
	Liver Acquisition										100
	Lung Acquisition										107
	Pancreas Acquisition										100
	Intestinal Acquisition										110
	Islet Acquisition										110
	Other Organ Acquisition (specify)										111
	Ambulatory Surgical Center (Distinct Part)										112
	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1-117)										118
	NONREIMBURSABLE COST CENTERS										
	Gift, Flower, Coffee Shop, & Canteen		-								190
	Research										191
_	Physicians' Private Offices		1		1						192
	Nonpaid Workers		1		1						193
	Other Nonreimbursable (specify)		1		1						194
	Cross Foot Adjustments				1						200
	Negative Cost Centers										201
	TOTAL (sum lines 118-201)										202

4090	) (Cont.)		FO	RM CMS-255	2-10				(	09-13
ALLC	OCATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		ITAL D COSTS			то			
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	2A	4	5	0	/	
1	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment				-					
	Employee Benefits Department						-			2 4 5 6
	Administrative and General							-		5
	Maintenance and Repairs									6
	Operation of Plant									7
8	Laundry and Linen Service									8
9	Housekeeping									9
10	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
13	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing School									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
22	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									<u> </u>
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34 35
	Other Special Care Unit (specify) Subprovider IPF									40
	Subprovider IRF Subprovider (specify)									41 42
	Subprovider (specify) Nursery									42
	Nursery Skilled Nursing Facility									43
	Nursing Facility									44
	Other Long Term Care									45
46	Outer Long Term Care									46

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09-1	3		FO	RM CMS-255	2-10				4090 (C	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:	_	PERIOD: FROM TO		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		ITAL D COSTS						
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	ANCILLARY SERVICE COST CENTERS	0	1	2	2A	4	5	0	/	<u> </u>
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic							1		54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

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4090 (Cont.)		FO	RM CMS-255	2-10				(	09-13
ALLOCATION OF CAPITAL-RELATED COSTS	OCATION OF CAPITAL-RELATED COSTS					PERIOD: FROM TO		WORKSHEET B, PART II	
	DIRECTLY ASSIGNED NEW CAPITAL		TAL D COSTS	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
COST CENTER DESCRIPTIONS	RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	(sum of (cols. 0-2)	BENEFITS DEPARTMENT	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	
OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	7	
94 Home Program Dialysis					-	-			94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold									97
98 Other Reimbursable (specify)									98
99 Outpatient Rehabilitation Provider (specify)									99
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
101 Home Health Agency									100
SPECIAL PURPOSE COST CENTERS									101
105 Kidney Acquisition									105
106 Heart Acquisition									105
107 Liver Acquisition									100
108 Lung Acquisition									108
109 Pancreas Acquisition									109
110 Intestinal Acquisition									110
111 Islet Acquisition									111
112 Other Organ Acquisition (specify)									112
115 Ambulatory Surgical Center (Distinct Part)									115
116 Hospice									116
117 Other Special Purpose (specify)									117
118 SUBTOTALS (sum of lines 1-117)									118
NONREIMBURSABLE COST CENTERS									
190 Gift, Flower, Coffee Shop, & Canteen									190
191 Research			1	1					191
192 Physicians' Private Offices									192
193 Nonpaid Workers									193
194 Other Nonreimbursable (specify)									194
200 Cross Foot Adjustments									200
201 Negative Cost Centers									201
202 TOTAL (sum lines 118-201)									202

09-1	3			FORM CMS-2552-10 PROVIDER CCN: PERIOD:							4090 (0	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS		PROVIDER C	CN:					WORKSHEET I			
								FROM			PART II	
				<b>i</b>				то		i		
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
	COST CENTER DESCRIPTIONS	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA		TRATION		PHARMACY		SERVICE	
		8	9	10	11	12	13	14	15	16	17	1
	GENERAL SERVICE COST CENTERS											
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
	Employee Benefits Department											4
	Administrative and General											5
	Maintenance and Repairs											6
	Operation of Plant											7
	Laundry and Linen Service											8
	Housekeeping				1							9
	Dietary					-						10
	Cafeteria											11
	Maintenance of Personnel							4				12
	Nursing Administration											13
	Central Services and Supply Pharmacy									4		14 15
	Medical Records & Medical Records Library										4	15
	Social Service											16
	Other General Service (specify)											17
10	Nonphysician Anesthetists											10
	Nursing School											20
	Intern & Res. Service-Salary & Fringes (Approved)											21
	Intern & Res. Other Program Costs (Approved)											22
	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit											31
32	Coronary Care Unit											32
	Burn Intensive Care Unit											33
	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											35
	Subprovider IPF											40
	Subprovider IRF											41
	Subprovider (specify)											42
	Nursery											43
	Skilled Nursing Facility											44
	Nursing Facility											45
46	Other Long Term Care											46

4090 (Cont.)	FORM CMS-2552-10							09-			
ALLOCATION OF CAPITAL-RELATED COSTS	DCATION OF CAPITAL-RELATED COSTS						PERIOD: FROM TO			WORKSHEET PART II	В,
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
ANCILLARY SERVICE COST CENTERS	0	5	10		12	15	14	15	10	1/	
50 Operating Room											50
51 Recovery Room											51
52 Labor Room and Delivery Room											52
53 Anesthesiology											53
54 Radiology-Diagnostic											54
55 Radiology-Therapeutic											55
56 Radioisotope											56
57 Computed Tomography (CT) Scan											57
58 Magnetic Resonance Imaging (MRI)											58
59 Cardiac Catheterization											59
60 Laboratory											60
61 PBP Clinical Laboratory Services-Program Only											61
62 Whole Blood & Packed Red Blood Cells											62
63 Blood Storing, Processing, & Trans.											63
64 Intravenous Therapy											64
65 Respiratory Therapy											65
66 Physical Therapy											66
67 Occupational Therapy											67
68 Speech Pathology											68
69 Electrocardiology											69
70 Electroencephalography											70
71 Medical Supplies Charged to Patients											71
72 Implantable Devices Charged to Patients											72
73 Drugs Charged to Patients											73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)											75
76 Other Ancillary (specify)											76
OUTPATIENT SERVICE COST CENTERS											
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)											89
90 Clinic											90
91 Emergency											91
92 Observation Beds											92
93 Other Outpatient Service (specify)											93

09-1	3			FOR	M CMS-25	52-10					4090 (0	Cont.)
ALLC	CATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM TO			WORKSHEET B, PART II	
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1-117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191												191
192	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	TOTAL (sum lines 118-201)											202

4090	) (Cont.)		FOF	M CMS-255	52-10						09-13
	OCATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment	1									2
4	Employee Benefits Department	1									$ \begin{array}{r} 2\\ 4\\ 5\\ 6 \end{array} $
5	Administrative and General	1									5
6	Maintenance and Repairs	1									6
7	Operation of Plant	1									7 8
	Laundry and Linen Service	1									8
	Housekeeping	1									9
	Dietary	1									10
	Cafeteria	1									11
	Maintenance of Personnel	1									12
	Nursing Administration	1									13
	Central Services and Supply	1									14
	Pharmacy	1									15
	Medical Records & Medical Records Library	1									16
	Social Service	1									17
	Other General Service (specify)		1								18
	Nonphysician Anesthetists										19
	Nursing School				-						20
	Intern & Res. Service-Salary & Fringes (Approved)										21
	Intern & Res. Other Program Costs (Approved)										22
	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										<u> </u>
30	Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit	1									31
	Coronary Care Unit	1									32
	Burn Intensive Care Unit	1								1	33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	Subprovider IPF	1									40
	Subprovider IRF	1							1	1	41
	Subprovider (specify)	1							1	1	42
	Nursery	1							1	1	43
	Skilled Nursing Facility	1							1	1	44
	Nursing Facility	1							1	1	45
	Other Long Term Care	1									46
									1		

10-1	2		FOR	M CMS-255	52-10					4090 (0	Cont.)
ALLC	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	:N:	PERIOD: FROM TO		WORKSHEET	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS			-					-	-	
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room					1					52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
56	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62											62
63											63
	Intravenous Therapy										64
65	Respiratory Therapy										65
66											66
	Occupational Therapy										67
68	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
92									L		92
93	Other Outpatient Service (specify)										93

4090 (0	Cont.)		FOR	M CMS-255	52-10						10-12
ALLOCA	TION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
OT	HER REIMBURSABLE COST CENTERS										
94 Ho	ome Program Dialysis					1	1				94
95 Ar	nbulance Services										95
96 Di	urable Medical Equipment-Rented					1	1				96
97 Dı	arable Medical Equipment-Sold										97
98 Ot	her Reimbursable (specify)					1	1				98
99 Ou	Itpatient Rehabilitation Provider (specify)										99
100 Int	tern-Resident Service (not appvd. tchng. prgm.)										100
	ome Health Agency										101
	ECIAL PURPOSE COST CENTERS										
105 Ki	dney Acquisition										105
106 He	eart Acquisition										106
107 Li	ver Acquisition						1				107
108 Lu	ing Acquisition										108
	ncreas Acquisition					1	1				109
110 Int	testinal Acquisition										110
111 Isl	et Acquisition					1	1				111
112 Ot	her Organ Acquisition (specify)										112
115 Ar	nbulatory Surgical Center (Distinct Part)										115
116 Ho	ospice										116
117 Ot	her Special Purpose (specify)										117
118 SU	JBTOTALS (sum of lines 1-117)										118
NC	NREIMBURSABLE COST CENTERS										
190 Gi	ft, Flower, Coffee Shop, & Canteen										190
	esearch										191
192 Ph	ysicians' Private Offices										192
193 No	onpaid Workers										193
194 Ot	her Nonreimbursable (specify)										194
200 Cr	oss Foot Adjustments										200
201 Ne	egative Cost Centers										201
202 TC	OTAL (sum lines 118-201)										202

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COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	1
					то			
	BLDGS. & FIXTURES	LATED COST MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT		ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
COST CENTER DESCRIPTIONS	(SQUARE FEET) 1	(DOLLAR VALUE) 2	(GROSS SALARIES) 4	RECONCIL- IATION 5A	(ACCUM. COST) 5	(SQUARE FEET) 6	(SQUARE FEET) 7	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits Department						4		2 4 5
5 Administrative and General					_		_	5
6 Maintenance and Repairs								6
7 Operation of Plant			-		-			7
8 Laundry and Linen Service					-			8
9 Housekeeping 10 Dietary								9
10 Dietary 11 Cafeteria								10
12 Maintenance of Personnel								11
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)								30
31 Intensive Care Unit								31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34         Surgical Intensive Care Unit           35         Other Special Care Unit (specify)								34 35
40 Subprovider IPF								40
40 Subprovider IPF 41 Subprovider IRF		+			+	+	+	40
41 Subprovider IKF 42 Subprovider (specify)								41
43 Nursery								42
44 Skilled Nursing Facility								44
45 Nursing Facility		1			1	1	1	45
46 Other Long Term Care						1	1	46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

4090 (Cont.)	RM CMS-255	CMS-2552-10 0						
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B-1	1
					FROM			
					TO			
		LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
	BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
	FIXTURES	EQUIPMENT	DEPARTMENT	DECOVOR	GENERAL	REPAIRS	OF PLANT	
COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	-
ANCILLARY SERVICE COST CENTERS	1	2	4	5A	5	6	7	-
50 Operating Room								50
51 Recovery Room								50
52 Labor Room and Delivery Room								52
53 Anesthesiology								53
53 Allesinesiology 54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT) Scan								57
58 Magnetic Resonance Imaging (MRI)								58
59 Cardiac Catheterization								59
60 Laboratory								60
61 PBP Clinical Laboratory Services-Program Only								61
62 Whole Blood & Packed Red Blood Cells								62
63 Blood Storing, Processing, & Trans.								63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged to Patients								71
72 Implantable Devices Charged to Patients								72
73 Drugs Charged to Patients								73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS								
88 Rural Health Clinic (RHC)								88
89 Federally Qualified Health Center (FQHC)								89
90 Clinic								90
91 Emergency								91
92 Observation Beds								92
93 Other Outpatient Service (specify)								93

09-13	FO	RM CMS-255	2-10				4090 (0	Cont.)
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B-1	1
					FROM			
					то			
		LATED COST	EMPLOYEE		ADMINIS-	MAIN-		
	BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	_
	1	2	4	5A	5	6	7	
OTHER REIMBURSABLE COST CENTERS								
94 Home Program Dialysis								94
95 Ambulance Services								95
96 Durable Medical Equipment-Rented								96
97 Durable Medical Equipment-Sold								97
98 Other Reimbursable (specify)								98
99 Outpatient Rehabilitation Provider (specify)								99
100 Intern-Resident Service (not appvd. tchng. prgm.)								100
101 Home Health Agency								101
SPECIAL PURPOSE COST CENTERS								
105 Kidney Acquisition								105
106 Heart Acquisition								106
107 Liver Acquisition								107
108 Lung Acquisition								108
109 Pancreas Acquisition								109
110 Intestinal Acquisition								110
111 Islet Acquisition								111
112 Other Organ Acquisition (specify)								112
115 Ambulatory Surgical Center (Distinct Part)								115
116 Hospice								116
117 Other Special Purpose (specify)								117
118 SUBTOTALS (sum of lines 1-117)								118
NONREIMBURSABLE COST CENTERS								
190 Gift, Flower, Coffee Shop, & Canteen								190
191 Research								191
192 Physicians' Private Offices								192
193 Nonpaid Workers								193
194 Other Nonreimbursable (specify)								194
200 Cross foot adjustments								200
201 Negative cost centers								201
202 Cost to be allocated (per Worksheet B, Part I)								202
203 Unit cost multiplier (Worksheet B, Part I)								203
204 Cost to be allocated (per Worksheet B, Part II)								204
205 Unit cost multiplier (Worksheet B, Part II)								205
$\mathbf{r}$								

4090	(Cont.)			FOR	M CMS-25	52-10					(	09-13
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	Г В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
	GENERAL SERVICE COST CENTERS	-										
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment	-										2
4	Employee Benefits Department	-										4
	Administrative and General											5
	Maintenance and Repairs											6
	Operation of Plant											7
	Laundry and Linen Service			]								8
	Housekeeping											9
	Dietary					1						10
	Cafeteria						4					11
	Maintenance of Personnel							4				12
	Nursing Administration	_							-			13
	Central Services and Supply Pharmacy									4		14 15
	Medical Records & Medical Records Library											15
	Social Service	-										17
	Other General Service (specify)	_										18
	Nonphysician Anesthetists											19
	Nursing School											20
	Intern & Res. Service-Salary & Fringes (Approved)											21
	Intern & Res. Other Program Costs (Approved)											22
23	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit											31
	Coronary Care Unit									ļ		32
	Burn Intensive Care Unit						L	L				33
	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											35
	Subprovider IPF						l	l				40
	Subprovider IRF											41
	Subprovider (specify) Nursery											42 43
	Skilled Nursing Facility											43
	Nursing Facility				1		<u> </u>	<u> </u>		1		44
	Other Long Term Care				1		<u> </u>	<u> </u>		1		45
40	Ould Lolly Telli Gale	_		L			I	I			l	40

10-1	2			FOR	M CMS-25	52-10					4090 (C	Cont.)
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD:		WORKSHEET	
									FROM			
		LANDER			1				то			
		LAUNDRY & LINEN	HOUSE-			MAIN- TENANCE OF	NURSING ADMINIS-	CENTRAL SERVICES &		MEDICAL RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAPETERIA	PERSONNEL	TRATION	SUPPLY	DUADMACN		SERVICE	
	COST CENTED DECONDUCING		(HOURS OF	(MEALS	CAFETERIA (MEALS	(NUMBER	(DIRECT		PHARMACY	LIBRARY (TIME		
	COST CENTER DESCRIPTIONS	(POUNDS OF LAUNDRY)	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)	(COSTED REQUIS.)	(COSTED REQUIS.)	SPENT)	(TIME SPENT)	
		LAUNDRY)	9	10	11	12	13	14 REQUIS.)	15 REQUIS.J	16	17 SPENT)	4
	ANCILLARY SERVICE COST CENTERS	0	5	10	11	12	15	14	15	10	17	<u> </u>
50	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
65	Respiratory Therapy											65
	Physical Therapy											66
	1 15											67
	Speech Pathology											68
	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											<b></b>
	Rural Health Clinic (RHC)										L	88
	Federally Qualified Health Center (FQHC)											89
90												90
	Emergency											91
												92
93	Other Outpatient Service (specify)											93

4090	(Cont.)			FOR	M CMS-25	52-10						10-12
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	ſ В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
	OTHER REIMBURSABLE COST CENTERS	0	5	10			10		10	10		
	Home Program Dialysis											94
	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
	Liver Acquisition											107
	Lung Acquisition											108
	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
117	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1-117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross foot adjustments											200
201	Negative cost centers											201
202	Cost to be allocated (per Worksheet B, Part I)											202
203	Unit cost multiplier (Worksheet B, Part I)											203
204	Cost to be allocated (per Worksheet B, Part II)											204
205	Unit cost multiplier (Worksheet B, Part II)											205

09-14		FOR	M CMS-255	52-10					4090 (	Cont.)
COST ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM		WORKSHEET	B-1
							ТО			
		NON-			RESIDENTS	PARA-		INTERN &		
	OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
	GENERAL	ANES-	SCHOOL	FRINGES	COSTS	EDUCATION		COST & POST		
COST CENTER DESCRIPTIONS	SERVICE (SPECIFY)	THETISTS (ASGND TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	SUBTOTAL	STEPDOWN ADJUSTMENTS	TOTAL	
	18	(ASGND TIME) 19	20	21	22	23	24	25	26	-
GENERAL SERVICE COST CENTERS	10	10	20			20		20	20	
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment	]									2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs	1									6
7 Operation of Plant	1									7
8 Laundry and Linen Service	4									8
9 Housekeeping	4									9
10 Dietary	4									10
11 Cafeteria	4									11
12 Maintenance of Personnel	4									12
<ul><li>13 Nursing Administration</li><li>14 Central Services and Supply</li></ul>	4									13 14
15 Pharmacy	4									14
16 Medical Records & Medical Records Library	4									16
17 Social Service	-									17
18 Other General Service (specify)		1								18
19 Nonphysician Anesthetists										19
20 Nursing School				1						20
21 Intern & Res. Service-Salary & Fringes (Approved)					1					21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34 35
35 Other Special Care Unit (specify) 40 Subprovider IPF										40
40 Subprovider IPF 41 Subprovider IRF						+				40
41 Subprovider (specify)		1								41 42
43 Nursery										43
44 Skilled Nursing Facility	1	1		1		1				44
45 Nursing Facility	1	1			İ					45
46 Other Long Term Care										46

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

4090 (Cont.)		FOR	M CMS-255	52-10						09-14
COST ALLOCATION - STATISTICAL BASIS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET	B-1
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
ANCILLARY SERVICE COST CENTERS	10	10	20			20		20	20	
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93

40-560

09-13		FOR	M CMS-255	52-10					4090 (0	Cont.)
COST ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	Ń:	PERIOD: FROM TO		WORKSHEET	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
OTHER REIMBURSABLE COST CENTERS										<u> </u>
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)										118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross foot adjustments										200
201 Negative cost centers										201
202 Cost to be allocated (per Worksheet B, Part I)										202
203 Unit cost multiplier (Worksheet B, Part I)										203
204 Cost to be allocated (per Worksheet B, Part II)										204
205 Unit cost multiplier (Worksheet B, Part II)										205

	) (Cont.) F STEPDOWN ADJUSTMENTS	FORM CMS-2552 PROVIDER CCN:	PERIOD:		WORKSHEET B-2	09-1
051	STEL DOWN ADJOSTMENTS	TROVIDER CON.	FROM		WORRSHEET D-2	
			TO			
			WORK	SHEFT		
	DESCRIPTION		PART	LINE NO.	AMOUNT	
	1		2	3	4	
1	Adjustment for EPO costs in Renal Dialysis cost center		1	74		-
2	Adjustment for EPO costs in Renar Dialysis cost center	4	1	94		-
2	Adjustment for ARANESP costs in Renal Dialysis cost center		1	74		
	Adjustment for ARANESP costs in Kenal Dialysis cost center	contor	1	94		
	Adjustment for ESA costs in Renal Dialysis cost center (see insti		1	74		-
	Adjustment for ESA costs in Home Program Dialysis cost center (see inst		1	94		-
7	rujustnent för ESA costs in Höne Högrani Dialysis cost center	(see instructions)	1	54		-
8						
9						+
10						1
11						1
11						1
13						1
13			+	-	+	1
14			+			1
15			+	-	+	1
16			+			1
17			+			1
10			+			1
20						2
20						2
21				_		2
				_		2
23						2
24						
25						2
26						2
27						2
28						2
29				_		2
30						3
31						3
32						3
33			_			3
34						3
35						3
36						3
37						3
38						3
39				_		3
40				_		4
41						4
42						4
43						4
44						4
45						4
46						4
47						4
48						4
49						4
50						5
51						5
52						5
53						5
54						5
55						5
56						5
57						5
58						5
59			+	+	1	5

Rev. 4

10-12	FORM CMS-2552-10 ATION OF RATIO OF COSTS TO CHARGES											4090 (Cont.)	
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES							PROVIDER	- CCN:	PERIOD: FROM TO		WORKSHE PART I	ET C
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Dis- allowance	Total Costs	Inpatient	Charges Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	<u> </u>
	NT ROUTINE SERVICE COST CENTERS												- 20
	nd Pediatrics (General Routine Care)											-	30 31
31 Intensive													
32 Coronary													32
	ensive Care Unit												33
	Intensive Care Unit												34
	ecial Care (specify)												35
40 Subprovi													40
41 Subprovi													41
42 Subprovi	ider (Specify)												42
43 Nursery	-												43
	Iursing Facility												44
45 Nursing													45
	ng Term Care												46
	ARY SERVICE COST CENTERS												
50 Operatin													50
51 Recovery													51
	oom and Delivery Room												52
53 Anesthes													53
54 Radiolog													54
	y-Therapeutic												55
56 Radioiso													56
	d Tomography (CT) Scan												57
	c Resonance Imaging (MRI)												58
	Catheterization												59
60 Laborato													60
61 PBP Clir	nical Laboratory Services-Prgm. Only												61
	lood & Packed Red Blood Cells												62
	oring, Processing, & Trans.												63
64 Intraveno													64
65 Respirate													65
66 Physical													66
67 Occupati													67
68 Speech P	athology												68

	) (Cont.)			FOR	M CMS-25	52-10							10-12
COM	PUTATION OF RATIO OF COSTS TO CHARGES							PROVIDER	CCN:	PERIOD:		WORKSHEI	ET C
										FROM		PART I	
		Total Cost	1		Costs		1	Charges		то			<del></del>
		(from Wkst.	Therapy		RCE		+		Total	+	TEFRA	PPS	
	COST CENTER DESCRIPTIONS	B, Part I,	Limit	Total	Dis-	Total			(column 6	Cost or	Inpatient	Inpatient	
		col. 26)	Adj.	Costs	allowance	Costs	Inpatient	Outpatient	+ column 7)	Other Ratio	Ratio	Ratio	
		1	2	3	4	5	6	7	8	9	10	11	<u> </u>
69	Electrocardiology			-		-			-				69
	Electroencephalography												70
	Medical Supplies Charged to Patients												71
	Implantable Devices Charged to Patients												72
73	Drugs Charged to Patients												73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)												88
	Federally Qualified Health Center (FQHC)												89
	Clinic												90
	Emergency												91
	Observation Beds (see instructions)												92
93	Other Outpatient Service (specify)												93
	OTHER REIMBURSABLE COST CENTERS												
	Home Program Dialysis												94
	Ambulance Services												95
	Durable Medical Equipment-Rented												96
	Durable Medical Equipment-Sold												97
	Other Reimbursable (specify)												98
	Outpatient Rehabilitation Provider (specify)												99
	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
	SPECIAL PURPOSE COST CENTERS												
	Kidney Acquisition												105
	Heart Acquisition												106
	Liver Acquisition												107
	Lung Acquisition												108
	Pancreas Acquisition												109
	Intestinal Acquisition												110
	Islet Acquisition												111
	Other Organ Acquisition (specify)												112
	Ambulatory Surgical Center (Distinct Part)												115 116
	Hospice												
200	Other Special Purpose (specify) Subtotal (see instructions)												117 200
200	· · · · · · · · · · · · · · · · · · ·												200
201	Less Observation Beds												201
202	Total (see instructions)												202

10-1	2	FOF	RM CMS-255	52-10					4090 (C	ont.)
	ULATION OF OUTPATIENT SERVICE COST TO GE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title V [ ] Title XIX			PROVIDER CO	CN:	PERIOD: FROM		WORKSHEET C	,
							то			
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. $6 \div$ col. 7)	
		1	2	3	4	5	6	7	8	1
	ANCILLARY SERVICE COST CENTERS									
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
54	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catherization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Prgm. Only									61
62	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76

4090	(Cont.)	FOR	M CMS-255	52-10					1	0-12
	ULATION OF OUTPATIENT SERVICE COST TO	[] Title V			PROVIDER CO	CN:	PERIOD:		WORKSHEET C.	
CHAF	GE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title XIX					FROM		PART II (CONT.)	)
						i	TO			
		Total Cost	Capital Cost (Wkst B,	Operating Cost Net of		O	Cost Net of	Total Charges		1
	Cost Center Descriptions	(Wkst. B,	Part II,	Capital Cost	Capital	Operating Cost Reduction	Capital and Operating Cost	(Worksheet C,	Outpatient Cost to Charge Ratio	1
	Cost Center Descriptions	Part I, col. 26)	col. 26)	(col. 1 - col. 2)	Reduction	Amount	Reduction	Part I, column 8)	$(col. 6 \div col. 7)$	1
		1	2	3	4	5	6	7	8	1
	OUTPATIENT SERVICE COST CENTERS	-	_	5	•	5		-	0	
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
	Emergency									91
92	Observation Beds (see instructions)									92
93	Other Outpatient Service (specify)									93
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition									108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)									117
	Subtotal (sum of lines 50 thru 199)									200
	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

10-1	2	FOR	M CMS-25	52-10				4090 (Cont.)	
	RTIONMENT OF INPATIENT ROUTINE ICE CAPITAL COSTS			PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET PART I	D,
Check applic boxes:	able [] Title XVIII, Part A	[ ] PPS [ ] TEFRA							
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description INPATIENT ROUTNE SERVICE COST CENTERS	1	2	3	4	5	6	7	<u> </u>
30	Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)								200

4090	) (Cont.)	F	ORM CMS-255	2-10				10-12
APPOI	RTIONMENT OF INPATIENT ANC	ILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	),
SERVI	ICE CAPITAL COSTS				FROM		PART II	
			COMPONENT CO	N:	ТО			
Check		[] Title V	•	[] Hospital	[] Subprovider (	Other)	[] PPS	
applica	able	[] Title XVIII,	Part A	[] IPF			[] TEFRA	
boxes:		[] Title XIX		[] IRF				
			Capital					
			Related Cost		Ratio of Cost		Capital	
			(from Wkst.	Total Charges	to Charges	Inpatient	Costs	
			B, Part II,	(from Wkst. C,	(col .1 ÷	Program	(column 3 x	
			col. 26)	Part I, col. 8)	col. 2)	Charges	column 4)	
(A)	Cost Center Description		1	2	3	4	5	<u> </u>
	ANCILLARY SERVICE COST CEN	TEDE	1	2	5	4	5	-
	Operating Room	NIER5						50
								51
	Recovery Room Labor Room and Delivery Room							51
								53
	Anesthesiology							
	Radiology-Diagnostic							54
	Radiology-Therapeutic							55
	Radioisotope		_					56
	Computed Tomography (CT) Scan							57
	Magnetic Resonance Imaging (MRI)							58
	Cardiac Catheterization							60
	Laboratory							60
	PBP Clinical Laboratory Services-Pr							61
	Whole Blood & Packed Red Blood O							62
	Blood Storing, Processing, & Transf	using						63
	Intravenous Therapy							64
	Respiratory Therapy							65
	Physical Therapy							66
	Occupational Therapy							67
	Speech Pathology							68
	Electrocardiology							69
	Electroencephalography							70
	Medical Supplies Charged to Patient							71
	Implantable Devices Charged to Pati	ients						72
	Drugs Charged to Patients							73
	Renal Dialysis							74
	ASC (Non-Distinct Part)							75
	Other Ancillary (specify)							76
	Rural Health Clinic (RHC)							88
	Federally Qualified Health Center (F	QHC)						89
								90
	Emergency							91
92	Observation Beds							92
	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST C	ENTERS						
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)	-				-		98
200	Total (sum of lines 50 through 199)							200

09-1	4			FOR	M CMS-255	52-10					4090 (C	Cont.)
	RTIONMENT OF INPATIENT ROUTINE						PROVIDER CC	N:	PERIOD:		WORKSHEET D,	
SERV	ICE OTHER PASS THROUGH COSTS								FROM TO		PART III	
Check		[] Title V		[]PPS					10			
applic		[] Title XVIII,	Part A	[] TEFRA								
boxes:		[] Title XIX		[] Other								
					All	Swing-Bed					Inpatient	
					Other Medical	Adjustment	Total Costs	<b>T</b> (1	Per	<b>.</b>	Program	
			Nursing	Allied Health	Education	Amount (see	(sum of cols. 1 through 3,	Total Patient	Diem (col. 5 ÷	Inpatient Program	Pass-Through Cost	
			School	Cost	Cost	instructions)	minus col. 4)	Days	col. 6)	Days	(col. 7 x col. 8)	
(A)	Cost Center Description		1	2	3	4	5	6	7	8	9	<u> </u>
	INPATIENT ROUTINE SERVICE COST CENT	ERS										
	Adults & Pediatrics											
30	(General Routine Care)											30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											35
40	Subprovider IPF											40
41	Subprovider IRF											41
	Subprovider (Other)											42
	Nursery											43
	Skilled Nursing Facility											
44	Skilleu MulSillg Edeliity											44
45	Nursing Facility											45
200	Total (sum of lines 30-199)											200

4090	) (Cont.)	FORM CM	IS-2552-10				DR	AFT
APPO	RTIONMENT OF INPATIENT/OUTPATIENT ANCILLAI		PROVIDER CCI	N:	PERIOD:		WORKSHEET D	),
SERV	ICE OTHER PASS THROUGH COSTS				FROM		PART IV	
			COMPONENT O	CCN:	то			
Check	[] Title V	[] Hospital		vider (Other)	[] ICF/IID	[]PPS		
applica	.,	[] IPF	[ ] SNF	()		[] TEFRA		
boxes:		[] IRF	[] NF			[] Other		
					All		Total	
		Non			Other		Outpatient	
		Physician			Medical	Total cost	Cost	
		Anesthetist	Nursing	Allied	Education	(sum of col 1	(sum of col. 2,	
		Cost	School	Health	Cost	through col. 4)	3 and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Labor room and Delivery Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI)							58
59	Cardiac Catheterization							59
60	Laboratory							60
61	PBP Clinical Laboratory ServPrgm. Only							61
62	Whole Blood & Packed Red Blood Cells							62
63	Blood Storing, Processing, & Transfusing							63
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged To Patients	_						71
72	Implantable Devices Charged to Patients							72
73 74	Drugs Charged to Patients Renal Dialysis							73 74
74	ASC (Non-Distinct Part)							74
75								75
/6	OUTPATIENT SERVICE COST CENTERS							/0
88	Rural Health Clinic (RHC)							88
89	Federally Qualified Health Center (FQHC)					1		89
90	Clinic							90
91	Emergency	1						91
92	Observation Beds	1	1		1			92
93	Other Outpatient Service (specify)	1	1		1	1		93
	OTHER REIMBURSABLE COST CENTERS							<u> </u>
94	Home Program Dialysis							94
95	Ambulance Services	1				1		95
96	Durable Medical Equipment-Rented	1				1		96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
200	Total (sum of lines 50 through 199)							200

DRA	<b>AFT</b>			FORM CM	S-2552-10				4090 (C	ont.)
APPOI	RTIONMENT OF INPAT	IENT/OUTPATIEN	T ANCILLARY		PROVIDER CCN	1:	PERIOD:		WORKSHEET D	,
SERVI	ICE OTHER PASS THRO	UGH COSTS					FROM		PART IV (Cont.)	
					COMPONENT C	CN:	то		, ,	
Check		[] Title V		[] Hospital		ider (Other)	[] ICF/IID	[] PPS		
applica		[] Title XVIII, P	art A	[] IPF	[] SNF	(0110)		[] TEFRA		
boxes:		[] Title XIX		[] IRF	[] NF			[] Other		
		C			G		Inpatient	C ····	Outpatient	
					Outpatient		Program		Program	i i
			Total	Ratio	Ratio		Pass-		Pass-	1
			Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	i i
			(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	1
			Part I, col. 8)	$(col. 5 \div col. 7)$	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	i i
(A)	Cost Center Descrip	tion	7	8	9	10	11	12	13	<u> </u>
	ANCILLARY SERVICE		,	0	5	10	11	12	15	<u> </u>
	Operating Room	COST CENTERS								50
51	Recovery Room									51
52	Delivery Room and Labo	Poom								52
53	Anesthesiology	I KUUIII								53
53	Radiology-Diagnostic									53
55										54
	Radiology-Therapeutic									
56	Radioisotope	(CT) C								56 57
57	Computed Tomography (									
58	Magnetic Resonance Ima	iging (MRI)								58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory									61
62	Whole Blood & Packed F									62
63	Blood Storing, Processing	g, & Transfusing								63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography	-								70
71	Medical Supplies Charge									71
72	Implantable Devices Cha	0								72
73	Drugs Charged to Patient	S								73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
										76
	OUTPATIENT SERVICE									
88	Rural Health Clinic (RHO									88
89	Federally Qualified Healt	th Center (FQHC)								89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service									93
	OTHER REIMBURSABI	LE COST CENTER	3							<u> </u>
	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipm									96
97	Durable Medical Equipm									97
98	Other Reimbursable (spe									98
200	Total (sum of lines 50 thr	ough 199)								200

4090	(Cont.)		FORM CM	IS-2552-10				DR	AFT
	RTIONMENT OF MEDICAL AND OTHER			PROVIDER CCN	N:	PERIOD:		WORKSHEET D	),
HEAL	TH SERVICES COSTS					FROM		PART V	
				COMPONENT C		то			
Check	[ ] Title V - O/P		[] Hospital	[] Subprovi	ider (Other)	[] Swing Be			
applica			[ ] IPF	[ ] SNF		[] Swing Be	d NF		
boxes:	[] Title XIX - O/P		[ ] IRF	[] NF		[] ICF/ <mark>IID</mark>			
PART	V - APPORTIONMENT OF MEDICAL A	ND OTHER H	EALTH SERVI						
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Worksheet C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Part I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
	Operating Room								50
	Recovery Room								51
	Labor & Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope								56
57	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
	Laboratory								60
	PBP Clinical Laboratory ServPrgm. Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Transfusing								63
	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67 68
	Speech Pathology Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged To Patients								70
	Implantable Devices Charged to Patients								72
	Drugs Charged to Patients								73
	Renal Dialysis								74
	ASC (Non-Distinct Part)							+	75
	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								<u> </u>
	Rural Health Clinic (RHC)							1	88
	Federally Qualified Health Center (FQHC)			1	1	1		1	89
	Clinic							1	90
	Emergency							1	91
	Observation Bed							1	92
93	Other Outpatient Service (specify)							1	93
I	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
	Durable Medical Equipment-Sold								97
	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program								201
	Only Charges							L	
202	Net Charges (line 200 - line 201 )								202

DRAFT		FORM CMS-25	552-10		4090 (Co	ont.)
COMPUTATION OF I	NPATIENT		PROVIDER CCN.:	PERIOD:	WORKSHEET D-1,	
OPERATING COST				FROM	PART I	
			COMPONENT CCN.:	TO		
Check	[] Title V - I/P	[] Hospital	[] Subprovider (other)	[] ICF/IID	[] PPS	
applicable	[] Title XVIII, Part A	[] IPF	[] SNF		[] TEFRA	
boxes:	[] Title XIX - I/P	[] IRF			[] Other	
PART I - ALL PRO	VIDER COMPONENTS	•				-
		INPATIENT DAY	S			
1 Inpatient days (	including private room days and swi	ng-bed days, excluding	newborn)			1
2 Inpatient days (	including private room days, excludi	ng swing-bed and newb	orn days)			2
3 Private room da	ys (excluding swing-bed and observ	ation bed days). If you h	have only private room days, do not con	mplete this line.		3
	om days (excluding swing-bed and c		01 0.	•		4
		· · ·	ugh December 31 of the cost reporting	period		5
0			r December 31 of the cost reporting per			6
-	inter 0 on this line)	F				
		rivate room davs) throu	gh December 31 of the cost reporting p	eriod		7
			December 31 of the cost reporting period			8
-	nter 0 on this line)					-
		licable to the Program	(excluding swing-bed and newborn day	(5)		9
			private room days) through December			10
0	period (see instructions).	e ir i in only (merdanig	, private room aujoj anougn December	of of the		10
		e XVIII only (including	private room days) after December 3	1 of the		11
0	period (if calendar year, enter 0 on th		, private room days) after December 3	I OI UIC		11
			ing private room days) through Decem	her 31 of		12
the cost reporti		s v or XIX only (includ	ing private room days) through Decem	1001 51 01		12
		s V or XIX only (includ	ing private room days) after December	31 of the		13
0	eriod (if calendar year, enter 0 on thi		ing private room days) after December	51 01 110		15
	ssary private room days applicable to		g swing bod days)			14
	avs (title V or XIX only)	uie riogiani (excluding	g swilig-bed days)			14
	itle V or XIX only)					16
10 Indisely days (L		SWING BED ADJ	LICTMENIT			10
17 Medicara rata f	ar awing had SNE convices applicable		cember 31 of the cost reporting period			17
			1 01			17
	or swing-bed SNF services applicable		ember 31 of the cost reporting period			10
	or swing-bed NF services applicable					20
	0 11		ber 31 of the cost reporting period			20
	patient routine service cost (see instr		a cost reporting pariod (line F w line 15	7)		21
0		<u> </u>	e cost reporting period (line 5 x line 17	)		22
			ost reporting period (line 6 x line 18)			
			cost reporting period (line 7 x line 19)			24
	applicable to NF type services after	December 31 of the cos	t reporting period (line 8 x line 20)			25 26
	l cost (see instructions)	·	DC)			
27 General inpatie	nt routine service cost net of swing-b					27
20 Coursel tons it	at monthing complex channels (		DIFFERENTIAL ADJUSTMENT		T	20
	nt routine service charges (excluding	<u> </u>	uon ded charges)			28
	arges (excluding swing-bed charges)					29
	om charges (excluding swing-bed ch					30
	nt routine service cost/charge ratio (l	,				31
01	e room per diem charge (line 29 ÷ lin	/				32
	rivate room per diem charge (line 30		· · · · · ·			33
	m private room charge differential (		see instructions)			34
01	em private room cost differential (line	/				35
	st differential adjustment (line 3 x li			0)		36
37 General inpatie	nt routine service cost net of swing-b	ed cost and private roor	n cost differential (line 27 minus line 3	6)		37

4090 (Cont.)	Cont.) FORM CMS-2552-10							
COMPUTATION OF INPATIENT	_	PROVIDER CCN:		PERIOD:	WORKSHEET D-1,	RAFT		
OPERATING COST				FROM	PART II			
		COMPONENT CCN		то				
Check [] Title V	· I/P	[] Hospital	[]Subprovider (othe	er)	[] PPS			
applicable [] Title XV		[] IPF			[] TEFRA			
boxes: [] Title XI	X - I/P	[] IRF			[] Other			
PART II - HOSPITAL AND SUBPROVIDERS								
	PATIENT OPERATIN							
	HROUGH COST ADJU				1			
38 Adjusted general inpatient routine service c		tions)				38		
39 Program general inpatient routine service co	· /					39		
40 Medically necessary private room cost appl						40		
41 Total Program general inpatient routine ser	vice cost (line 39 + line 4	10)		1		41		
			Average					
	Total	Total	Per Diem	Program	Program Cost			
	Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2)	Days	(col. 3 x col. 4)			
	1	2	3	4	5	- 10		
42 Nursery (title V & XIX only) Intensive Care Type Inpatient						42		
51 1								
Hospital Units 43 Intensive Care Unit						43		
44 Coronary Care Unit						43		
45 Burn Intensive Care Unit						44		
46 Surgical Intensive Care Unit						45		
47 Other Special Care Unit (specify)						40		
4/ Ouler Special Care Onit (specify)					1			
48 Program inpatient ancillary service cost (W	orksheet D-3 column 3	line 200)			1	48		
49 Total Program inpatient costs (sum of lines						49		
is Total Program inpatient costs (sum of fines	11 unougn 10) (occ mou	ucuonoj						
PASS-TI	ROUGH COST ADJU	STMENTS						
50 Pass through costs applicable to Program in			n of Parts I and III)			50		
51 Pass through costs applicable to Program in	patient ancillary services	s (from Worksheet D, su	Im of Parts II and IV)			51		
52 Total Program excludable cost (sum of line	s 50 and 51)		· · · · ·			52		
53 Total Program inpatient operating cost excl	uding capital related, nor	nphysician anesthetist, a	and medical education	costs		53		
(line 49 minus line 52)								
						•		
TARGET AM	IOUNT AND LIMIT C	OMPUTATION						
54 Program discharges						54		
55 Target amount per discharge						55		
56 Target amount (line 54 x line 55)						56		
57 Difference between adjusted inpatient opera	ating cost and target amo	unt (line 56 minus line	53)			57		
58 Bonus payment (see instructions)						58		
59 Lesser of line 53 ÷ line 54 or line 55 from t				market basket		59		
60 Lesser of line 53 ÷ line 54 or line 55 from p						60		
61 If line 53 ÷ line 54 is less than the lower of			v 1	ating costs		61		
(line 53) are less than expected costs (lines	54 x 60), or 1 % of the ta	arget amount (line 56), o	otherwise enter zero.					
(see instructions)								
62 Relief payment (see instructions)						62		
63 Allowable Inpatient cost plus incentive pay	ment (see instructions)					63		
		WING BER COST						
	PATIENT ROUTINE S					1		
64 Medicare swing-bed SNF inpatient routine	costs through December	31 of the cost reporting	period (see instruction	s)		64		
(title XVIII only)	anata aftar D	of the cost series	wind (and instruction )					
65 Medicare swing-bed SNF inpatient routine	costs after December 31	or the cost reporting pe	rioa (see instructions)			65		
(title XVIII only)	uting goots (1 - CA - 1	line (F) (Titl- MATH	Lu Eas CALL	untions)				
66 Total Medicare swing-bed SNF inpatient ro						66		
67 Title V or XIX swing-bed NF inpatient rout 68 Title V or XIX swing-bed NF inpatient rout						67 68		
69 Total title V or XIX swing-bed NF inpatient rout		· ·	s periou (inite 15 x line	20)		68		
55 Trotar title v or ATA swing-bed for inpatient	rodune costs (nne 0/ +	mic 00)				09		

DRA	AFT		FOR	M CMS-2552-10	1		4090 (C	Cont.)	
	PUTATION OF	INPATIENT		PROVIDER CCN:		PERIOD:	WORKSHEET D-1,		
OPER	ATING COST			COMPONENT CCN:		FROM TO	PARTS III & IV		
Check applic boxes:	able :	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P		[ ] Hospital [ ] IPF [ ] IRF	[ ] Subprovider (other) [ ] SNF [ ] NF	[] ICF/IID	[ ] PPS [ ] TEFRA [ ] Other		
PART	TIII - SKILLEI	D NURSING FACILITY	Y, OTHER NURSING I	FACILITY, AND ICF/	ID ONLY			<del></del>	
70	Skilled nursing	facility/other nursing fac	cility/ICF/ <mark>IID</mark> routine serv	vice cost (line 37)				70	
71	Adjusted gener	ral inpatient routine servi	ice cost per diem (line 70	÷ line 2)				71	
72	Program routir	ne service cost (line 9 x li	ine 71)					72	
73	Medically nec	essary private room cost	applicable to Program (li	ne 14 x line 35)				73	
74	Total Program general inpatient routine service costs (line 72 + line 73)								
75	Capital-related	cost allocated to inpatie	nt routine service costs (i	from Worksheet B, Parts	II, column 26, line 45)			75	
76	Per diem capit	al-related costs (line 75 ÷	line 2)					76	
77	Program capita	al-related costs (line 9 x l	ine 76)					77	
78	Inpatient routine service cost (line 74 minus line 77)								
79	Aggregate cha	rges to beneficiaries for e	excess costs (from provid	er records)				79	
80	Total Program	routine service costs for	comparison to the cost li	mitation (line 78 minus	line 79)			80	
81	Inpatient routin	ne service cost per diem l	limitation					81	
82	Inpatient routi	ne service cost limitation	(line 9 x line 81)					82	
83	Reasonable in	patient routine service co	sts (see instructions)					83	
84	Program inpati	ent ancillary services (se	e instructions)					84	
85	Utilization rev	iew - physician compens	ation (see instructions)					85	
86	Total Program	inpatient operating costs	s (sum of lines 83 through	1 85)				86	
PART	IV - COMPU	TATION OF OBSERVA	ATION BED PASS-THI	ROUGH COST					
87	Total observat	ion bed days (see instruc	tions)					87	
88	Adjusted gener	ral inpatient routine cost	per diem (line 27 ÷ line 2	2)				88	
89	Observation be	ed cost (line 87 x line 88)	) (see instructions)					89	
		COMPUTATION OF	OBSERVATION BED	PASS THROUGH CO	ST		-		
						Total	Observation Bed		
				Routine Cost	column 1 ÷	Observation Bed Cost	Pass-Through Cost (col. 3 x col. 4)		
			Cost	(from line 27)	column 2	(from line 89)	(see instructions)		
			1	2	3	4	5		

90 Capital-related cost

91 Nursing School cost

92 Allied Health cost

93 All other Medical Education

90

91 92

93

	O (Cont.) FORM CMS-25 PRTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	DR WORKSHEET D-2,	111
	ICES RENDERED BY	PROVIDER CCN:	FROM	PARTS I-III	
	RNS AND RESIDENTS		TO		
	Γ I - NOT IN APPROVED TEACHING PROGRAM				
		Percent of	Expense	Total Inpatient Days	
	Cost Centers	Assigned Time	Allocation	All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			
2	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care) Intensive care unit				
4	Coronary care unit				
5					
6					
7	Other Special Care (specify)				
8					
9	Subtotal (sum of lines 2 through 8)				
10	IPF - Inpatient routine service				
	IRF - Inpatient routine service				:
	Subprovider (Other) - Inpatient routine service				
	Skilled Nursing Facility				
	Nursing Facility				
15	Other Long Term Care Home Health Agency				
16	Outpatient Rehabilitation Providers				
	Ambulatory Surgical Center				
	Hospice				
20	*				
				Total Charges	
				(from Worksheet C,	
				Part I, column 8,	
	Hospital Outpatient Services:			lines 88 through 93)	
21	Rural Health Clinic (RHC)				1
22	Federally Qualified Health Center (FQHC)				1
23	Clinic				1
24	Emergency				
25	Observation beds				1
26	Other Outpatient Service (specify)				
27	Subtotal (sum of lines 21 through 26)	100.00			
	Total (sum of lines 20 and 27) TII - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B I	100.00			1
AR	I II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART BT	Expenses Allocated	ISUNLY)		1
		to cost centers		Net Cost	
		on Worksheet B, Part I	Swing Bed	(column 1 plus	
		columns 21 and 22	Amount	column 2)	
	Hospital Inpatient Routine Services:	1	2	3	1
29	Adults & Pediatrics (general routine care)				
30	Swing Bed - SNF				
31	Swing Bed - NF				
32	Intensive care unit				
33	Coronary care unit				
34	Burn Intensive Care Unit				
35	-				
36					3
	Subtotal (sum of lines 28, and 29 through 36)				
	IPF - Inpatient routine service				
			1		
39	IRF - Inpatient routine service				
39 40	Subprovider (Other)- Inpatient routine service			_	
39 40 41	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility				
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)		(ED)		
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility	TH PARTS I AND II ARE US		d Teaching Program	
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	TH PARTS I AND II ARE US	Not In Approve	d Teaching Program	
39 40 41 42	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) F III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT	H PARTS I AND II ARE US		Amount	
39 40 41 42 <b>AR</b> T	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) TIII - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT Hospital	TH PARTS I AND II ARE US	Not In Approve (from Part I) 1		
39 40 41 42 PART	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) T III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT Hospital Inpatient	TH PARTS I AND II ARE US	Not In Approve (from Part I) 1 column 9, line 9	Amount	
39 40 41 42 <b>AR</b> 7 <b>AR</b> 7 43 44	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) TIII - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT Hospital Inpatient Outpatient	'H PARTS I AND II ARE US	Not In Approve (from Part I) 1	Amount	
39 40 41 42 <b>PAR</b> 7 43 43 44	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) T III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	TH PARTS I AND II ARE US	Not In Approve (from Part I) 1 column 9, line 9 column 9, line 27	Amount	
39 40 41 42 <b>PAR</b> 7 43 44 45 46	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) TIII - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT Hospital Inpatient Outpatient	TH PARTS I AND II ARE US	Not In Approve (from Part I) 1 column 9, line 9	Amount	
39 40 41 42 <b>PAR</b> 7 43 44 45 46 46 47	Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) <b>FIII - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOT</b> Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	TH PARTS I AND II ARE US	Not In Approve (from Part I) 1 column 9, line 9 column 9, line 27 column 9, line 10	Amount	

DRA	ΔFT			FORM CMS-2	552-10		4090 (0	Cont.)
APPO	RTIONMENT OF CO ICES RENDERED BY				PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-2, PARTS I-III (Cont.)	
	RNS AND RESIDENT					то		
PART	I - NOT IN APPRO							
	Average Cost		h Care Program Inpatie		Title V	Title XVIII	Title XIX	
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)	_
	4	5	6	7	8	9	10	-
1								1
2					-			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9 10
10 11								10
11								11
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20	Datia of Coat	Tiala	V and XIX Outration	t and	T;	lles V and XIX Outpatie	at and	20
	Ratio of Cost to Charges		es V and XIX Outpatien Title XVIII Part B Charg		11	Title XVIII Part B Co		
	(column 2 ÷	Title	Title XVIII	Title	Title	Title XVIII Tatt D Co	Title	-
	column 3)	V	Part B	XIX	V	Part B	XIX	
21	,							21
22								22
23								23
24								24
25								25
26 27								26 27
27								27
	' II - IN AN APPROV	I TED TEACHING PR	OGRAM (TITLE XV	III. PART B INPAT	IENT ROUTINE COS	TS ONLY)		20
		Average Cost		Expenses		1		
	Total	Per Day	Title XVIII	Applicable				
	Inpatient Days -	(column 3 ÷	Part B	to Title XVIII				
	All Patients	column 4)	Inpatient Days	(col. 5 x col. 6)				
	4	5	6	7				
29								29
30 31								30 31
32								32
33								33
34			1					34
35								35
36								36
37								37
38								38
39			-					39 40
40								40
41								41
	III - SUMMARY FO	OR TITLE XVIII (TO	D BE COMPLETED (	L DNLY IF BOTH PAU	RTS I AND II ARE US	ED)		72
		aching Program		XVIII Costs		, 		
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				
	3	4	5	6				
43	line 37							43
44			11					44
45 46	line 38		line 2 line 2					45 46
46	line 38		line 2					46
48	line 40		line 2					48
49	line 41		line 2					49

4090 (	(Cont.)		FORM CMS	5-2552-10		DR	RAFT
	ENT ANCILLAF	RY SERVICE	10101010	PROVIDER CCN:	PERIOD:	WORKSHEET D-3	<u> </u>
COST A	PPORTIONME	NT			FROM		
				COMPONENT CCN:	ТО		
Check		[] Title V	[] Hospital	[] Subprovidor (othor)	[] Swing-Bed SNF	[] PPS	
applicab	le	[] Title V [] Title XVIII, Part A	[] IPF	[ ] Subprovider (other) [ ] SNF	[] Swing-Bed NF	[] TEFRA	
boxes:	iic .	[] Title XIX	[] IRF	[] NF	[] ICF/IID	[] Other	
		[]	()	Ratio of Cost	Inpatient	Inpatient Program Costs	
С	COST CENTER	DESCRIPTION		to Charges	Program Charges	(col. 1 x col. 2)	
(A)				1	2	3	1
		TINE SERVICE COST CEN	TERS				
		rics (General Routine Care)					30
	Intensive Care Ur						31
	Coronary Care Ui Burn Intensive Ca						32 33
	Surgical Intensive						34
	Other Special Car						35
	Subprovider IPF	(dpeens)					40
	Subprovider IRF						41
42 S	Subprovider (Spe	cify)					42
43 N	Nursery						43
		RVICE COST CENTERS					
	Operating Room						50
	Recovery Room						51
	Labor Room and	Delivery Room					52
	Anesthesiology Radiology-Diagn	ontin					53 54
	Radiology-Diagn						55
	Radioisotope	Jeune					56
		raphy (CT) Scan					57
		nce Imaging (MRI)					58
	Cardiac Catheteri						59
60 I	Laboratory						60
		oratory Services-Prgm. Only					61
		Packed Red Blood Cells					62
		ocessing, & Trans.					63
	Intravenous Thera						64 65
	Respiratory Thera Physical Therapy	іру					66
	Occupational The	rany					67
	Speech Pathology						68
	Electrocardiology						69
	Electroencephalo						70
71 N	Medical Supplies	Charged to Patients					71
		ces Charged to Patients					72
	Drugs Charged to	Patients					73
	Renal Dialysis	et Daut)				+	74
	ASC (Non-Distin) Other Ancillary (s						75 76
		ERVICE COST CENTERS					- 10
	Rural Health Clin						88
		d Health Center (FQHC)				1	89
90 0		()					90
91 E	Emergency						91
		s (see instructions)					92
	Other Outpatient						93
		RSABLE COST CENTERS					
	Home Program D						94
	Ambulance Servi	ces Equipment-Rented					95 96
	Durable Medical						96
	Other Reimbursat						98
200 1	Fotal (sum of line	es 50-94 and 96-98)					200
		Laboratory Services-Program	only charges (line 61)				201
		200 minus line 201)	_ ` /				202

(A) Worksheet A line numbers

09-1	4		FORM	I CMS-	2552-10		4090 (0	Cont.)
COM	PUTATION OF ORGAN ACQ	UISITION COSTS A	ND CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR H	HOSPITALS WHICH ARE CE	RTIFIED TRANSPL	ANT CENTERS			FROM	PART I	
					OPO CCN:	то	—	
Check	:	[]HEART	[] LIVER	[] PAT	I ICREAS	[] ISLET		
	able box:	[] KIDNEY	[] LUNG		ESTINE	[]10221		
PART	I - COMPUTATION OF OF	RGAN ACQUISITIC		ROUTIN	E AND ANCILLARY S	ERVICES)		
			Inpatient			Organ		
	mputation of Inpatient		Routine Organ		Per Diem Costs	Acquisition	Cost	
	utine Service Costs		Charges		(from Wkst. D-1, Part II)		(col. 2 x col. 3)	-
	plicable to Organ Acquisition Adults and Pediatrics		1	D 38	2	3	4	1
				43				1 2
3				43				3
4	, , , , , , , , , , , , , , , , , , ,			44				4
5	Surgical Intensive Care Unit			46				5
6	Other Special Care (specify)			47				6
7	TOTAL (sum of lines 1-6)							7
	· · · · · · · · · · · · · · · · · · ·		· · ·			-		
					Ratio of Cost	Organ	Organ	
					to Charges	Acquisition	Acquisition	
	nputation of Ancillary				(from	Ancillary	Ancillary	
	vice Costs Applicable				Wkst. C)	Charges	Costs	
	Organ Acquisition			C	1	2	3	
	Operating Room			50				8
9				51 52				9 10
10	Anesthesiology			52				10
11	Radiology-Diagnostic			54				11
13				55				13
14	Radioisotope			56				14
15	Computed Tomography (CT)	Scan		57				15
16				58				16
17	Cardiac Catheterization	( )		59				17
18	Laboratory			60				18
19	PBP Clinical Laboratory Serv	ices-Program Only		61				19
20	Whole Blood & Packed Red I			62				20
21	Blood Storage, Processing, &	Transfusing		63				21
22	IV Therapy			64				22
23	1 3 15			65				23
24	Physical Therapy			66				24
25	Occupational Therapy			67				25
26	Speech Pathology Electrocardiology			68 69				26
27	Electrocardiology			70				27
20	Medical Supplies Charged to	Patients		70				20
30	Implantable Devices Charged			72				30
31	Drugs Charged to Patients			73				31
32	Renal Dialysis			74				32
	ASC (non-distinct part)			75				33
	Other Ancillary (specify)			76				34
35				88				35
36		nter (FQHC)		89				36
37	Clinic			90				37
38	Emergency Room			91				38
39	Observation Beds	e:fra)		92				39
40	Other Outpatient Service (spe	спуј		93				40
41	TOTAL (sum of lines 8-40)							41

C = Worksheet C line numbers

D = Worksheet D-1 line numbers

4090 (Cont.)	CMS-2552-10				
COMPUTATION OF ORGAN ACQUISITI	ON COSTS AND CHARGES	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR HOSPITALS WHICH ARE CERTIFIE	D TRANSPLANT CENTERS		FROM	PART II	
		OPO CCN:	ТО		
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE		

# PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICE COSTS)

	Computation of the Cost of Inpatient Services of Interns and Residents Not		Average Cost Per Day (from Wkst. D-2,	Organ	Organ Acquisition Costs	
	In Approved Teaching Program		Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)	
		D	1	2	3	
42	Adults & Pediatrics (General routine care)	2				42
43	Intensive Care Unit	3				43
44	Coronary Care Unit	4				44
45	Burn Intensive Care Unit	5				45
46	Surgical Intensive Care Unit	6				46
47	Other Special Care (specify)	7				47
48	TOTAL (sum of lines 42 through 47)					48

				Ratio of Cost	Organ	
	Computation of the Cost of Outpatient	Organ		to Charges	Acquisition	
	Services of Interns and Residents Not	Charges		from Wkst. D-2,	Costs	
	In Approved Teaching Program	(see instructions)		Part I, col. 4)	(col. 1 x col. 2)	
		1	D	2	3	
49	Rural Health Clinic (RHC)		21			49
50	Federally Qualified Health Center (FQHC)		22			50
51	Clinic		23			51
52	Emergency		24			52
53	Observation Beds		25			53
54	Other Outpatient Service (specify)		26			54
55	TOTAL (sum of lines 49 through 54)					55

D = Worksheet D-2, Part I, line numbers

09-14		FORM CMS-2	2552-10	4090 (Cont.)	
COMPUTATION OF ORGAN ACQUISITIO	N COSTS AND CHAI	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR HOSPITALS WHICH ARE CERTIFIED	TRANSPLANT CEN	TERS		FROM	PARTS III & IV
			OPO CCN:	то	
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE		

#### PART III - SUMMARY OF COSTS AND CHARGES

		C	ost	Cha	arges	
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and Ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct Organ Acquisition (see instructions)					59
60	Cost of physicians' services in a teaching					60
	hospital (see instructions)					
61	Total (sum of lines 56 thru 60)					61
62	Total Usable Organs (see instructions)					62
63	Medicare Usable Organs (see instructions)					63
64	Ratio of Medicare Usable Organs to Total Usable					64
	Organs (line 63 ÷ line 62)					
65	Medicare Cost/Charges (see instructions)					65
66	Revenue for Organs Sold					66
67	Subtotal (line 65 minus line 66)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69

## PART IV - STATISTICS

		Living Related	Cadaveric	Revenue	
		1	2	3	1
70	Organs Excised in Provider (1)				70
71	Organs Purchased from Other Transplant Hospitals (2)				71
72	Organs Purchased from Non-Transplant Hospitals				72
73	Organs Purchased from OPOs				73
74	Total (sum of lines 70 thru 73)				74
75	Organs Transplanted				75
76	Organs Sold to Other Hospitals				76
77	Organs Sold to OPOs				77
78	Organs Sold to Transplant Hospitals				78
79	Organs Sold to Military or VA Hospitals				79
80	Organs Sold Outside the U.S.				80
81	Organs Sent Outside the U.S. (no revenue received)				81
82	Organs Used for Research				82
83	Unusable/Discarded Organs				83
84	Total (sum of lines 75 through 83 should equal line 74)				84

Organs procured outside your center by a procurement team from your center are not included in the count.
 Organs procured outside your center by a procurement team from your center are included in the count.

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4028.3)

409	0 (Cont.)	FG	ORM CMS-2552-	-10				09-14
	RTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING	HOSPITAL			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART I	
Check	applicable box: [] Hospital Staff [] Medie	al Staff					_	
	I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FO	R COST REPORTING P	ERIODS ENDING BEFO	ORE JUNE 30, 2014				
Line No.	<u>Specialty</u> Description/Physician Identifier 2	Total Remuneration 3	Professional Component 4	RCE Amount 5	Physician/ Professional Component Hours 6	Unadjusted RCE Limit 7	5 Percent of Unadjusted RCE Limit 8	
1	General Practitioner Family Practice Internal Medicine							1
3	Surgery Pediatrics Obstetrics-Gynecology							3 4 5
6								6
	Anesthesiology Pathology							8
10 11	All Other Total							10 11
Line	Specialty	Cost of Membership & Continuing	Professional Component	Cost of Physician Malpractice	Professional Component	Adjusted	Adjust Cost of Physician's Direct Medical &	
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	
9		11	12	13	14	15	16	1
2	Surgery							2
<u>4</u> 5	Pediatrics Obstetrics-Gynecology							4
6	Radiology Psychiatry							6
	Anesthesiology Pathology							8
10	All Other							10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)							11

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4029.1)

09-14		FORM CMS-2552-1		Cont.)		
APPOF	RTIONMENT OF COST FOR PHYSIC	CIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-5, PART II	
Check			[] IPF	то	_	
	hle herri	[] Hospital	[] IPF			
арриса	ble box:	[] IRF				
PART	II - APPORTIONMENT OF COST FO	R PHYSICIANS' SERVICES IN A TEACHING HO	SPITAL FOR COST RE	PORTING PERIODS E	NDING BEFORE JUNE 3	30 2014
				Medical School	Total	50,2014
			Hospital Staff	Faculty	(col 1 + col 2)	
			1	2	3	<u> </u>
1	Adjusted Cost of Physician's Direct M	edical and Surgical Services	_			1
	Total Inpatient Days and Outpatient V					2
3	Average Per Diem (line 1 ÷ line 2)	5				3
	HEALTH CARE PROGRAM REIMB	RURSABLE DAVS				
		OKSABLE DATS				
4	Title V - Inpatient					4
5	Title V - Outpatient					5
	Title XVIII - Part A					6
	Title XVIII - Part B					7
	Title XIX - Inpatient					8
	Title XIX - Outpatient					9
	Inpatient and Outpatient Kidney Acqu					10
	Inpatient and Outpatient Liver Acquis					11
	Inpatient and Outpatient Heart Acquis					12
	Inpatient and Outpatient Lung Acquisi					13
	Inpatient and Outpatient Pancreas Acq	1				14
	Inpatient and Outpatient Intestine Acq					15
	Inpatient and Outpatient Islet Acquisit	lon				16
17	Other Organ Acquisition					17
	HEALTH CARE PROGRAM REIMB	BURSABLE COST				
18	Title V - Inpatient (line 3 x line 4)					18
	Title V - Outpatient (line 3 x line 5)					19
	Title XVIII - Part A (line 3 x line 6)					20
	Title XVIII - Part B (line 3 x line 7)					21
22	Title XIX - Inpatient (line 3 x line 8)					22
23	Title XIX - Outpatient (line 3 x line 9	)				23
24	Inpatient and Outpatient Kidney Acqu	isition (line 3 x line 10)				24
25	Inpatient and Outpatient Liver Acquis	ition (line 3 x line 11)				25
26	Inpatient and Outpatient Heart Acquis	ition (line 3 x line 12)				26
	Inpatient and Outpatient Lung Acquisi					27
	Inpatient and Outpatient Pancreas Acq					28
	Inpatient and Outpatient Intestine Acq					29
	Inpatient and Outpatient Islet Acquisit					30
31	Inpatient and Outpatient Other Organ	Acquisition (line 3 x line 17)				31

Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII

Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate

Line 21 to Worksheet E, Part B

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4029.2)

40-583

## 4090 (Cont.)

## FORM CMS-2552-10

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD:	WORKSHEET D-5,
		FROM	PART III
		то	1

PART III - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ENDING ON OR AFTER JUNE 30, 2014

						Physician/		5 Percent	T
	Wkst. A		Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
	Line #	Cost Center / Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total							200

			Cost of		Cost of			Adjust Cost	
			Membership	Professional	Physician	Professional		of Physician's	
	Wkst. A		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
	Line #	Cost Center / Physician Identifier	Education	Share of Column 11	Insurance	Share of Column 13	RCE Limit	Surgical Services	
	9	10	11	12	13	14	15	16	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
200		Total (transfer the amount in column 16, line 200, to Part IV, line 1)							200

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4029.3)	1
40-583.1	

09-14			FORM CMS-25	52-10		4090 (Cont.)
APPORTIONMENT OF	COST FOR PHYSICIAN	NS' SERVICES IN A	TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5,
Check applicable box:	[] Hospital	[] IPF	[ ] IRF		•	
			ICES IN A TEACHING HOS	PITAL FOR COST REPOR	RTING PERIODS E	NDING ON OR AFTER JUNE 30, 20
	hysicians' direct medical and outpatient visit day					2
3 Average per diem		ys				3
J Average per utern	(mie 1 · mie 2)					5
HEALTH CARE 1	PROGRAM REIMBURS	SABLE DAYS				
4 Title V - Inpatient		STIBLE BITTO				4
5 Title V - Outpatie						5
6 Title XVIII - Part						6
7 Title XVIII - Part	В					7
8 Title XIX - Inpati	ent					8
9 Title XIX - Outpa						9
	atient kidney acquisition					10
	atient liver acquisition					11
12 Inpatient and outp						12
	atient lung acquisition					13
	atient pancreas acquisitio					14
	atient intestine acquisitio atient islet acquisition	n				15
16 Inpatient and autpa	atient islet acquisition					16
1/						1/
HEALTH CARE 1	PROGRAM REIMBURS	SABLE COST				
18 Title V - Inpatient		0.1111111 00001				18
19 Title V - Outpatie						19
20 Title XVIII - Part						20
21 Title XVIII - Part						21
22 Title XIX - Inpati	ent (line 3 x line 8)					22
	tient (line 3 x line 9)					23
	atient kidney acquisition					24
	atient liver acquisition (li					25
	atient heart acquisition (l					26
	atient lung acquisition (li					27
	atient pancreas acquisitio					28
	atient intestine acquisitio					29
	atient islet acquisition (li	ne 3 x line 16)				30
31						31

Transfer amounts as follows:

Add lines 18 and 19, and transfer to Worksheet E-3, Part VII, line 20 (title V hospital or component) Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF); Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (Cost reimbursement)

Line 21 to Worksheet E, Part B , line 23 (Medicare Part B Medical and Other Health Services)

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, line 20 (title XIX hospital or component) Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4029.4)

Rev. 6

40-583.2

4090 (Cont.)	FORM CMS-2552-10			09-14
CALCULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTLEMENT		FROM	PART A	
	COMPONENT CCN:	то		

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1.01     DRG       1.02     DRG       1.03     DRG       2     Outlid       2.01     Outlid       2.02     Outlid       3     Mana       4     Bed di       6     FTE di       6     FTE di       7     MMA       7.01     ACA       7.01     ACA       7.01     ACA       8.01     The a       8.02     The a       8.03     The a       8.04     FTE di       9     Sum di       10     FTE di       7     MMA       7.01     ACA       16     Adjus       8.01     The a       17     Adjus       16     Adjus       17     Adjus       18     Adjus       19     Curre       20     Prior       21     Enter       22     IME       23     Numit	amounts other than outlier payments amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions) amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions) for federal specific operating payment for Model 4 BPCI (see instructions) r payments for discharges (see instructions) r payments for discharges (see instructions) ged care simulated payments ged care simulated payments ays available divided by number of days in the cost reporting period (see instructions) ged care simulated payments ays available divided by number of days in the cost reporting period (see instructions) text Medical Education Adjustment Calculation for Hospitals oount for allopathic and osteopathic programs for the most recent cost reporting period ending on or 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) . Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Sectors 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 12 CFR 413.75(b), 413.79(c)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) out for residents in dental and podiatric programs the current year from your records count for residents in dental and podiatric programs the current year from your records count	grams in ams in accordance Federal Register,		1           1.01           1.02           1.03           2           2.01           2.02           3           4           5           6           7           7.01           8           8.01           8.02           9           10           11           12           13           14           15
1.02     DRG       1.03     DRG       2.01     Outlie       2.01     Outlie       3     Mana       4     Bed d       5     FTE d       before     before       6     FTE d       main     MMA       7     MMA       7     MMA       7.01     ACA       7.01     ACA       8.02     The a       8.03     The a       8.04     The a       9     Sum d       10     FTE d       11     FTE d       12     Curre       13     Total       14     Total       15     Sum d       16     Adjus       17     Adjus       18     Adjus       19     Curre       20     Prior       21     Enter       22     IME       23     Numin       24     IME l       25     If the	amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions for federal specific operating payment for Model 4 BPCI (see instructions) or payments for discharges (see instructions) re reconciliation amount re reconciliation amount and a standard payments ays available divided by number of days in the cost reporting period (see instructions) <b>ect Medical Education Adjustment Calculation for Hospitals</b> count for allopathic and osteopathic programs for the most recent cost reporting period ending on or e 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progra 2006, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) for allopathic and osteopathic programs in the current year from your records iount for relidents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year	grams in ams in accordance Federal Register,		1.02           1.03           2           1.03           2           3           4           5           6           7           7.01           8           8.01           8.01           11           12           13           14           15
1.03     DRG       2     Outlie       2.01     Outlie       2.02     Outlie       3     Mana       4     Bed d       -     Indir       5     FTE c       befor     in acc       6     FTE c       in acc     in acc       7     MAA       7.01     ACA       7.01     ACA       7.01     ACA       8.02     The a       9     Sum c       8.01     The a       8.02     The a       9     Sum c       10     FTE c       11     FTE c       12     Curre       13     Total       14     Total       15     Sum c       16     Adjus       18     Adjus       18     Adjus       19     Curre       20     Pior       21     Enter       22     IME       23     Numk       24     IME l       25     If the	for federal specific operating payment for Model 4 BPCI (see instructions) rr payments for discharges (see instructions) er reconciliation amount rr payment for discharges for Model 4 BPCI (see instructions) ged care simulated payments ays available divided by number of days in the cost reporting period (see instructions) <b>ect Medical Education Adjustment Calculation for Hospitals</b> count for allopathic and osteopathic programs for the most recent cost reporting period ending on or e 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro- ordance with 42 CFR 413.79(e) Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. timent (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progra 20069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) of allopathic and osteopathic programs in the current year from your records iount for relidents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 timent for residents in initial years of the program	grams in ams in accordance Federal Register,		1.03           2           2.01           2.02           3           4           5           6           7           7.01           8           8.01           8.01           111           12           13           14           15
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2.01     Outlie       2.02     Outlie       3     Mana       4     Bed de       5     FTE de       6     FTE de       7     MMA       7.01     ACA       7     If the       8.01     The a       8.01     The a       8.01     The a       8.02     The a       9     Sum de       10     FTE de       7.01     ACA       16     Adjus       17     Adjus       18     Adjus       19     Curre       13     Total       14     Total       15     Sum de       16     Adjus       17     Adjus       18     Adjus       19     Curre       20     Prior       21     Enter       22     IME j       23     Numk       24     IME j       25     If the	r reconciliation amount r reconciliation amount r reconciliation amount r payment for discharges for Model 4 BPCI (see instructions) ged care simulated payments ays available divided by number of days in the cost reporting period (see instructions) <b>etc Medical Education Adjustment Calculation for Hospitals</b> roount for allopathic and osteopathic programs for the most recent cost reporting period ending on or 12/31/1996 (see instructions) roount for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) . Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. thenet (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) sount for allopathic and osteopathic programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 thenet for residents in initial years of the program	ams in accordance Federal Register,		2.01 2.02 3 4 5 6 7 7.01 8.01 8.01 8.01 8.02 9 10 11 12 13 14 4 15
2.02 Outlie 3 Mana 4 Bed d 5 FTE c before 6 FTE c in acc 7 MMA 7.01 ACA 17 the 8 Adjus 8.01 The a 16 the 8.02 The a section 9 Sum c 10 FTE c 11 FTE c 11 FTE c 11 FTE c 11 FTE c 11 FTE c 12 Curre 13 Total 14 Total 15 Sum c 16 Adjus 17 Adjus 18 Adjus 19 Curre 20 Prior 21 Enter 22 IME 12 Curre 23 Num 14 Total 24 IME 1 24 IME 1 25 If the	rr payment for discharges for Model 4 BPCI (see instructions) ged care simulated payments ays available divided by number of days in the cost reporting period (see instructions) <b>ext Medical Education Adjustment Calculation for Hospitals</b> count for allopathic and osteopathic programs for the most recent cost reporting period ending on or e 12/31/1996 (see instructions) count for allopathic and osteopathic programs for the most recent cost reporting period ending on or e 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progra 2 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 threat for residents in initial years of the program	ams in accordance Federal Register,		2.02           3           4           5           6           7           7.01           8           8.01           8.01           100           111           12           13           14           15
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4         Bed d           Indir         FTE (           5         FTE (           6         FTE (           7         MMA           7         MMA           7         MMA           7         MMA           8         Adjus           with 4         page 4           9         Sum 0           8.001         The a           8.002         The a           8.010         The a           8.02         The a           9         Sum 0           10         FTE 0           11         FTE 0           12         Curre           13         Total           14         Total           15         Sum 0           16         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Numk	ays available divided by number of days in the cost reporting period (see instructions) ext Medical Education Adjustment Calculation for Hospitals count for allopathic and osteopathic programs for the most recent cost reporting period ending on or a 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. timent (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated prograves 22 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs in the current year from your records iount for residents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year if that year ended on or after September 30, 1997, otherwise fines 12 through 14 divided by 3 tment for residents in initial years of the program	ams in accordance Federal Register,		4           5           6           7           7.01           8           8.01           8.01           8.02           9           10           11           12           13           14           15
India           5         FTE c           before         in acc           6         FTE c           in acc         in acc           7         MAA           7.01         ACA           7.01         ACA           8.02         If the           8.01         The a           8.02         The a           9         Sum a           10         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           18         Adjus           19         Curre           20         Piora           21         Enter           22         IME j           23         Numk           24         IME j           25         If the	ect Medical Education Adjustment Calculation for Hospitals count for allopathic and osteopathic programs for the most recent cost reporting period ending on or e 12/31/1996 (see instructions) count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) . Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 22 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) oount for allopathic and osteopathic programs in tyear allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the prior year if that year ended on or after September 30, 1997, otherwise if lines 12 through 14 divided by 3 tment for residents in initial years of the program	ams in accordance Federal Register,		5 6 7 7.01 8 8.01 8.01 8.02 9 9 10 111 12 13 14 4 15
5         FTE of before           6         FTE of before           7         MMA           7.01         ACA           If the         Adjus           8         Adjus           8.01         The a section           9         Sum of a section           9         Sum of a section           9         Sum of a section           9         Sum of a section           10         FTE of a section           11         FTE of a section           12         Currer           13         Total           14         Total           15         Sum of a djus           16         Adjus           17         Adjus           18         Adjus           19         Currer           20         Prior           21         Enter           22         IME J           23         Numt           24         IME J           25         If the	ount for allopathic and osteopathic programs for the most recent cost reporting period ending on or 12/3/1/996 (see instructions) orunt for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro- ordance with 42 CFR 413.79(e) . Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. themet (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 12 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs in the current year from your records iount for allopathic and obticaprograms in the current year from your records iount for allopathic modiatric programs in the current year from your records iount for residents in dental and podiatric programs int year allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise in fines 12 through 14 divided by 3 thrent for residents in initial years of the program	ams in accordance Federal Register,		6 7 7.01 8 8.01 8.02 9 10 11 12 13 14 4 15
before           in acc           in AcA           fthe           Adjus           and           if the           and           and <tr tr="">     and</tr>	212/31/1996 (see instructions) 2000 For allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new proordance with 42 CFR 413.79(e) Section 422 CFR 413.79(e) Section 520 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs (2) CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) orount for allopathic and osteopathic programs in the current year from your records toount for relidents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the prior year if that year ended on or after September 30, 1997, otherwise if lines 12 through 14 divided by 3 tment for residents in initial years of the program	ams in accordance Federal Register,		6 7 7.01 8 8.01 8.02 9 10 11 12 13 14 4 15
6         FTE ( in acc in acc 7           7         MMA           7.01         ACA           8.01         If the           8.02         The a           8.01         The a           8.02         The a           9         Sum ( acc)           9         Sum ( acc)           10         FTE ( acc)           11         FTE ( acc)           12         Curree           13         Total           14         Total           15         Sum ( acc)           16         Adjus           17         Adjus           18         Adjus           19         Curree           20         Prior           21         Enter           22         IME           23         Numk           24         IME 1           25         If the	count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new pro ordance with 42 CFR 413.79(e) . Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progri 22 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 2 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise if lines 10 residents in initial years of the program	ams in accordance Federal Register,		7           7.01           8           8.01           8.02           9           10           11           12           13           14           15
in acc 7 MMA 7.01 ACA 8 Adjus with 4 page 8.01 The a sectio 9 Sum 0 16 FTE 0 10 FTE 0 10 FTE 0 11 FTE 0 11 FTE 0 11 Total 11 Total 11 Total 11 Adjus 11 Adjus 11 Adjus 11 Adjus 11 Adjus 12 Curre 13 Cotal 14 Adjus 19 Curre 10 Prior 20 Prior 21 Enter 22 IME 12 IME	ordance with 42 CFR 413.79(e) Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. timent (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 12 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 130069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs in the current year from your records iount for the prior year allowable FTE count for the prior year allowable FTE count for the prior year if that year ended on or after September 30, 1997, otherwise in fines 12 through 14 divided by 3 timent for residents in initial years of the program	ams in accordance Federal Register,		7           7.01           8           8.01           8.02           9           10           11           12           13           14           15
7         MMA           7.01         ACA           If the         Adjus           8.01         If the           8.01         The a           If the         If the           8.01         The a           9         Sum o           0         FTE o           10         FTE o           11         FTE o           12         Curre           13         Total           14         Total           15         Sum o           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME j           73         Numt           23         Numt	Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) sount for allopathic and osteopathic programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	Federal Register,		8.01 8.02 9 10 11 12 13 13 14 15
7.01         ACA           If the         If the           8         Adjus           8.01         The a           If the         If the           8.01         The a           sectio         Sectio           9         Sum a           10         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME 1           23         Numt           24         IME 1           25         If the	Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progra 2 CFR 413.75(b), 413.779(c)2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count of reidents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the prior year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	Federal Register,		8.01 8.02 9 10 11 12 13 13 14 15
If the           Adjus           with 4           page           8.01         The a           If the           8.02         The a           9         Sum a           10         FTE a           11         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Numk           24         IME 1           25         If the	cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 82 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise fi lines 12 through 14 divided by 3 tment for residents in initial years of the program	Federal Register,		8.01 8.02 9 10 11 12 13 13 14 15
If the           Adjus           with 4           page           8.01         The a           If the           8.02         The a           9         Sum a           10         FTE a           11         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Numk           24         IME 1           25         If the	cost report straddles July 1, 2011 then see instructions. tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progr. 82 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise fi lines 12 through 14 divided by 3 tment for residents in initial years of the program	Federal Register,		8.01 8.02 9 10 11 11 12 13 13 14 15
8         Adjus with 4 page 3           9         Sum 6           8.01         The a sectio           9         Sum 6           10         FTE 6           11         FTE 6           12         Curre           13         Total           14         Total           15         Sum 6           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME 1           23         Numt           24         IME 1           25         If the	tment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated progra 12 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records to year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise for sidents in initial years of the program	Federal Register,		8.01 8.02 9 10 11 11 12 13 13 14 15
with 4           page           8.01         The a           If the         section           9         Sum 0           0         FTE 0           10         FTE 0           11         FTE 0           12         Curre           13         Total           14         Total           15         Sum 0           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Numit           24         IME 1           25         If the	<sup>12</sup> CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 5069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records isount for allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise for lines 12 through 14 divided by 3 tment for residents in initial years of the program	Federal Register,		8.02 9 10 11 12 13 14 15
page 4           8.01         The a           If the         section           9         Sum a           10         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME 1           23         Num           24         IME 1           25         If the	50069, August 1, 2002. mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) fount for allopathic and osteopathic programs in the current year from your records iount for relidents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program			8.02 9 10 11 12 13 14 15
8.01         The a If the           8.02         The a If the           8.02         The a section           9         Sum of           10         FTE of           11         FTE of           12         Curre           13         Total           14         Total           15         Sum of           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           23         Numt           24         IME 1           25         If the	mount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise filmes 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		8.02 9 10 11 12 13 13 14 15
If the           8.02         The a section           9         Sum a           10         FTE a           11         FTE a           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME j           23         Num b           24         IME 1	cost report straddles July 1, 2011, see instructions. mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs in the current year from your records iount for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise fi lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		8.02 9 10 11 12 13 13 14 15
8.02         The a section           9         Sum (c)           10         FTE (c)           11         FTE (c)           12         Current           13         Total           14         Total           15         Sum (c)           16         Adjus           17         Adjus           18         Adjus           19         Current           20         Prior           21         Enter           22         IME 1           23         Num 4           24         IME 1           25         If the	mount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) rount for allopathic and osteopathic programs in the current year from your records outh for residents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		9 10 11 12 13 13 14 15
section           9         Sum of           10         FTE of           11         FTE of           12         Curre           13         Total           14         Total           15         Sum of           16         Adjus           17         Adjus           19         Curre           20         Prior           21         Enter           22         IME j           Tudir         Tadir           23         Numk           24         IME j           25         If the	n 5506 of ACA. (see instructions) of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) iount for allopathic and osteopathic programs in the current year from your records iount for residents in dental and podiatric programs int year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		9 10 11 12 13 13 14 15
9         Sum 6           10         FTE 6           11         FTE 6           12         Curre           13         Total           14         Total           15         Sum 6           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME 1           23         Num           24         IME 1           25         If the	of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions) count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		10 11 12 13 14 15
10         FTE c           11         FTE c           12         Curre           13         Total           14         Total           15         Sum c           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME j           73         Numt           24         IME j           25         If the	count for allopathic and osteopathic programs in the current year from your records count for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise files 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		10 11 12 13 14 15
11         FTE c           12         Curre           13         Total           14         Total           15         Sum a           16         Adjus           17         Adjus           19         Curre           20         Prior           21         Enter           22         IME j           3         Numk           23         Num L           24         IME 1           25         If the	count for residents in dental and podiatric programs nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		11 12 13 14 15
12         Curre           13         Total           14         Total           15         Sum of           16         Adjus           17         Adjus           19         Curre           20         Prior           21         Enter           22         IME           3         Numt           23         Numt           24         IME 1           25         If the	nt year allowable FTE (see instructions) allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		12 13 14 15
13         Total           14         Total           15         Sum of           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME I           23         Numl           24         IME I           25         If the	allowable FTE count for the prior year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		13 14 15
14         Total           15         Sum of           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           23         Numl           24         IME I           25         If the	allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		14 15
15         Sum of           16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Num           24         IME           25         If the	of lines 12 through 14 divided by 3 tment for residents in initial years of the program	e enter zero.		15
16         Adjus           17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME           23         Numb           24         IME           25         If the	tment for residents in initial years of the program			
17         Adjus           18         Adjus           19         Curre           20         Prior           21         Enter           22         IME I           23         Numb           24         IME I           25         If the				
18         Adjus           19         Curre           20         Prior           21         Enter           22         IME 1           23         Numb           24         IME 1           25         If the	tment for residents displaced by program or hospital closure			16
19Curre20Prior21Enter22IME JIndir23Numb24IME J25If the				17
20Prior21Enter22IME JIndir23Numb24IME J25If the	ted rolling average FTE count			18
21 Enter 22 IME j Indir 23 Numb 24 IME 1 25 If the	nt year resident to bed ratio (line 18 divided by line 4)			19
22 IME   Indir 23 Numb 24 IME   25 If the	year resident to bed ratio (see instructions)			20
India23Numbre24IME 125If the	the lesser of lines 19 or 20 (see instructions)			21
23 Numb 24 IME 1 25 If the	payment adjustment (see instructions)			22
24 IME 1 25 If the	ect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
25 If the	er of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C	. ).		23
	TE resident count over cap (see instructions)			24
	amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			25
26 Resid	ent to bed ratio (divide line 25 by line 4)			26
27 IME j	payments adjustment factor (see instructions)			27
28 IME a	add-on adjustment amount (see instructions)			28
29 Total	IME payment (sum of lines 22 and 28)			29
Dispr	oportionate Share Adjustment			
30 Perce	ntage of SSI recipient patient days to Medicare Part A patient days (see instructions)			30
	ntage of Medicaid patient days to total patient days (see instructions)			31
	of lines 30 and 31			32
	vable disproportionate share percentage (see instructions)			33
	oportionate share adjustment (see instructions)			34
	npensated Care Adjustment	Prior to October 1	On or after October 1	
	uncompensated care amount (see instructions)			35
	r 3 (see instructions)			35.01
	tal uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			35.02
-			1	35.02
55.05 110 16				55.05
36 Total	ta share of the hospital uncompensated care payment amount (see instructions)			

09-14	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT		FROM	PART A (Cont.)
	COMPONENT CCN:	то	

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	Additional payment for high percentage of ESRD beneficiary discharges	
	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	2
	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)	
	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see instructions)	41.
	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	2
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	4
	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	
	Average weekly cost for dialysis treatments (see instructions)	
46	Total additional payment (line 45 times line 44 times line 41.01)	
	Subtotal (see instructions)	
	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	
	Total payment for inpatient operating costs SCH and MDH only (see instructions)	
	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	Ę
	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)	Ę
	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).	[
	Nursing and allied health managed care payment	Ę
54	Special add-on payments for new technologies	
	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	2
	Cost of physicians' services in a teaching hospital (see instructions)	5
57	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).	
58	Ancillary service other pass through costs (from Worksheet D, Part IV, col. 11, line 200)	
59	Total (sum of amounts on lines 49 through 58)	!
60	Primary payer payments	
61	Total amount payable for program beneficiaries (line 59 minus line 60)	
62	Deductibles billed to program beneficiaries	
63	Coinsurance billed to program beneficiaries	
64	Allowable bad debts (see instructions)	
65	Adjusted reimbursable bad debts (see instructions)	
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	
68	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)	
70	Other adjustments (specify) (see instructions)	
	Bundled Model 1 discount amount	70.
	HVBP payment adjustment (see instructions)	70.
	Hospital readmissions reduction adjustment (see instructions)	70.
	Recovery of accelerated depreciation	70.
	Low volume adjustment for federal fiscal year (yyyy)	70.
	Low volume adjustment for federal fiscal year (yyyy)	70.
	Amount due provider (see instructions)	
	Sequestration adjustment (see instructions)	71.
	Interim payments	
	Tentative settlement (for contractor use only)	
-	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73	
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	
75	Tokested announts (nonanowable cost report nems) in accordance with CMD 1 do. 15-2, Chapter 1, 3115.2	
	TO BE COMPLETED BY CONTRACTOR	
	Operating outlier amount from Worksheet E, Part A line 2 (see instructions).	
	Capital outlier from Worksheet L, Part I, line 2	
	Operating outlier reconciliation adjustment amount (see instructions)	
-	Capital outlier reconciliation adjustment amount (see instructions)	
	The rate used to calculate the fime value of money (see instructions)	
95	Time value of money for operating expenses (see instructions)	
	Time value of money for capital related expenses (see instructions)	

4090	) (Cont.) FORM CMS-2552-10	)			09-14
	ULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
REIM	BURSEMENT SETTLEMENT		FROM	PART B	
		COMPONENT CCN:	то		
	applicable box: [] Hospital [] IPF [] IRF [] Subprovider (Oth	er) [] SNF			
	<sup>B</sup> - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)				1
	Medical and other services reimbursed under OPPS (see instructions).				2
	PPS payments				3
	Outlier payment (see instructions)				4
	Enter the hospital specific payment to cost ratio (see instructions)				5
	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line	200			9
	Organ acquisition				10
	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges				12
	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
15	Customary charges	aharga hasis			15
	Aggregate amount actually collected from patients liable for payment for services on a Amounts that would have been realized from patients liable for payment for services or				15
10	basis had such payment been made in accordance with 42 CFR §413.13(e)	i a chaige			10
17					17
	Total customary charges (see instructions)				18
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds lin	e 11) (see instructions)			19
	Excess of reasonable cost over customary charges (complete only if line 11 exceeds lin				20
	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	, (, -, -, -, -, -, -, -, -, -, -, -,			21
	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (see instructions)				25
	Deductibles and Coinsurance relating to amount on line 24 (see instructions)				26
27		(see instructions)			27
	Direct graduate medical education payments (from Worksheet E-4, line 50)				28
	ESRD direct medical education costs (from Worksheet E-4, line 36)				29
	Subtotal (sum of lines 27 through 29) Primary payer payments				30 31
	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(ICES)			- 32
33	Composite rate ESRD (from Worksheet I-5, line 11)				33
	Allowable bad debts (see instructions)				34
	Adjusted reimbursable bad debts (see instructions)				35
	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.98		5)			39.98
39.99					39.99
	Subtotal (see instructions)				40
	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	chapter 1 \$115.0			43
44	Frotested amounts (nonanowable cost report items) in accordance with CMS Pub. 15-2,	inuplet 1, 9115.2			44

10-12	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,
REIMBURSEMENT SETTLEMENT		FROM	PART B (Cont.)
	COMPONENT CCN	: TO	
Check applicable box [] Hospital [] IPF [] IRF	[ ] Subprovider(Other) [ ] SNF	·	
PART B - MEDICAL AND OTHER HEALTH SERVICES			
TO BE COMPLETED BY CONTRACTOR			
90 Original outlier amount (see instructions)			90
91 Outlier reconciliation adjustment amount (see instructi	ons)		91
92 The rate used to calculate the Time Value of Money			92
93 Time Value of Money (see instructions)			93
94 Total (sum of lines 91 and 93)			94

4090 (Cont.) FORM CMS-2552-10 10			10-12				
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN:	:		PERIOD: FROM TO	-	WORKSHEET E-1, PART I	
Check [] Hospital [] Subprovider (Other) applicable [] IPF [] SNF				patient art A		Part B	
box: [] IRF [] Swing-Bed SNF			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 or to be submitte for services rendered in the cost reporting period. If none, write "NONE" or en							2
3 List separately each retroactive		.01					3.01
lump sum adjustment amount based		.02					3.02
on subsequent revision of the	Program to	.03					3.03
interim rate for the cost reporting period.	Provider	.04					3.04
Also show date of each payment.		.05					3.05
If none, write "NONE" or enter a zero. (1)		.50					3.50
		.51					3.51
	Provider 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) (transfer to Wkst. E or Wkst. E-3, line							4
and column as appropriate)							
TO BE COMPLETED BY CONTRACTOR							
5 List separately each tentative settlement	Program to	.01					5.01
payment after desk review. Also show	Provider	.02					5.02
date of each payment.		.03					5.03
If none, write "NONE" or enter a zero. (1)		.50					5.50
	Provider to	.51					5.51
	Program	.52					5.52
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98)	0	.99					5.99
6 Determined 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			Contractor Number	•	NPR Date (Month/Day	/Year)	8

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

09-13		FORM CMS-2552-	-10		4090 (Cont.)
CALCULATION OF REIMBUR	SEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-1,
SETTLEMENT FOR HIT				FROM	PART II
			COMPONENT CCN:	то	
Check	[] Hospital	[ ] CAH			•
Applicable box:					

## TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAD COST REPORTS

## HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in ARRA §4102 from Wkst S-3, Part I, column 15, line 14	1
2	Medicare days from Wkst S-3, Part I, column 6, sum of lines 1, 8-12	2
3	Medicare HMO days from Wkst S-3, Part I, column 6, line 2	3
4	Total inpatient days from S-3, Part I, column 8, sum of lines 1, 8-12	4
5	Total hospital charges from Wkst C, Part I, column 8, line 200	5
6	Total hospital charity care charges from Wkst S-10, column 3, line 20	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part I line 168	7
8	Calculation of the HIT incentive payment (see instructions)	8
9	Sequestration adjustment amount (see instructions)	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	10

INPATIENT HOSPITAL	SERVICES	UNDER	PPS & CAH	

111171	TIENT HOST THE SERVICES UNDER IT'S & CAIL	 
30	Initial/interim HIT payment(s).	30
31	Initial/interim HIT payment adjustments (see instructions)	31
32	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32

4090(Cont.)	FORM CMS-2552-10				09-13
CALCULATION OF REIMBURSEMENT	P	PROVIDER CCN:	PERIOD:	WORKSHEET E-2	
SETTLEMENT - SWING BEDS	_		FROM		
	C	COMPONENT CCN:	то		

Check	[] Title V	[] Swing Bed - SNF		
applicable	[] Title XVIII	[] Swing Bed - NF		
boxes:	[] Title XIX		-	-
	·			

boxes:	[] Title XIX			
	COMPLETATION OF NET COST OF COMPLET CERTIFICES	PART A	PART B	_
	COMPUTATION OF NET COST OF COVERED SERVICES	1	2	
	Inpatient routine services - swing bed-SNF (see instructions)			1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V,			3
	columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days			5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			8
9	Primary payer payments (see instructions)			9
	Subtotal (line 8 minus line 9)			10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional			11
	services)			
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for			13
	physician professional services)			
	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			15
16	Other adjustments (specify) (see instructions)			16
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)			19
19.01	Sequestration adjustment (see instructions)			19.01
20	Interim payments			20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program line 19 minus lines 19.01, 20 and 21			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			23
	section 115.2			
_				

09-14	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART I
			то	

## PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER - TEFRA

1	Inpatient hospital services (see instructions)	1
2	Organ acquisition	2
3	Cost of physicians' services in a teaching hospital (see instructions)	3
4	Subtotal (sum of lines 1 thru 3)	4
5	Primary payer payments	5
6	Subtotal (line 4 less line 5).	6
7	Deductibles	7
8	Subtotal (line 6 minus line 7)	8
9	Coinsurance	9
10	Subtotal (line 8 minus line 9)	10
11	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11
12	Adjusted reimbursable bad debts (see instructions)	12
13	Allowable bad debts for dual eligible beneficiaries (see instructions)	13
14	Subtotal (sum of lines 10 and 12)	14
15	Direct graduate medical education payments (from Worksheet E-4, line 49)	15
16	Other pass through costs (see instructions). DO NOT USE THIS LINE.	16
17	Other adjustments (specify) (see instructions)	17
18	Total amount payable to the provider (see instructions)	18
18.01	Sequestration adjustment (see instructions)	18.01
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program line 18 minus lines 18.01, 19 and 20	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22

4090 (Cont.)	FORM CMS-2552-10		09-14
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
		FROM	PART II
	COMPONENT CCN:	то	

Check	[] Hospital		
applicable	[] Subprovider IPF		
box:			

## PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1
	Net IPF PPS Outlier payment	2
	Net IPF PPS ECT payment	3
	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)	4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure,	4.01
	that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	
5	New teaching program adjustment (see instructions)	5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period	6
	of a "new teaching program (see isntructions)	
7	Current year unweighted I&R FTE count for residents within the new program growth period	7
	of a "new teaching program (see isntructions)	
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)	8
9	Average daily census (see instructions)	9
10	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	10
	Teaching Adjustment (line 1 multiplied by line 10).	11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	12
13	Nursing and allied health managed care payment (see instruction)	13
14	Organ acquisition DO NOT USE THIS LINE	14
15	Cost of physicians' services in a teaching hospital (see instructions)	15
16	Subtotal (see instructions)	16
17	Primary payer payments	17
18	Subtotal (line 16 less line 17).	18
19	Deductibles	19
20	Subtotal (line 18 minus line 19)	20
21	Coinsurance	21
22	Subtotal (line 20 minus line 21)	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23
24	Adjusted reimbursable bad debts (see instructions)	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	25
26	Subtotal (sum of lines 22 and 24)	26
27	Direct graduate medical education payments (from Worksheet E-4, line 49) (For freestanding IPF only)	27
28	Other pass through costs (see instructions)	28
29	Outlier payments reconciliation	29
30	Other adjustments (specify) (see instructions)	30
31	Total amount payable to the provider (see instructions)	31
31.01	Sequestration adjustment (see instructions)	31.01
32	Interim payments	32
33	Tentative settlement (for contractor use only)	33
34	Balance due provider/program line 31 minus lines 31.01, 32 and 33	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	35

#### TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)	50
51	Outlier reconciliation adjustment amount (see instructions)	51
52	The rate used to calculate the Time Value of Money (see instructions)	52
53	Time Value of Money (see instructions)	53

09-14	
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4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN:

COMPONENT CCN: FROM \_ TO \_\_\_\_

PERIOD:

WORKSHEET E-3, PART III

Check	[] Hospital		
applicable	[ ] Subprovider IRF		
box:			

#### PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	Net Federal PPS payment (see instructions)	1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	2
3	Inpatient Rehabilitation LIP payments (see instructions)	3
4		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending	5
	on or prior to November 15, 2004 (see instructions)	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital	5.01
	closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2)	
6	New teaching program adjustment (see instructions)	6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period	7
	of a "new teaching program (see isntructions)	
8	Current year unweighted I&R FTE count for residents within the new program growth period	8
	of a "new teaching program (see isntructions)	
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	9
10	Average daily census (see instructions)	10
11	Teaching Adjustment Factor (see instructions)	11
12	Teaching Adjustment (see instructions)	12
13	Total PPS Payment (see instructions)	13
14	Nursing and allied health managed care payments (see instructions)	14
15	Organ acquisition DO NOT USE THIS LINE	15
16	Cost of physicians' services in a teaching hospital (see instructions)	16
17	Subtotal (see instructions)	17
18	Primary payer payments	18
19	Subtotal (line 17 less line 18).	19
20	Deductibles	20
21	Subtotal (line 19 minus line 20)	21
22	Coinsurance	22
23	Subtotal (line 21 minus line 22)	23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24
25	Adjusted reimbursable bad debts (see instructions)	25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	26
27	Subtotal (sum of lines 23 and 25)	27
28	Direct graduate medical education payments (from Worksheet E-4, line 49) (For free standing IRF only).	28
29	Other pass through costs (see instructions)	29
30	Outlier payments reconciliation	30
31	Other adjustments (specify) (see instructions)	31
32	Total amount payable to the provider (see instructions)	32
32.01	Sequestration adjustment (see instructions)	32.01
33	Interim payments	33
34	Tentative settlement (for contractor use only)	34
35	Balance due provider/program line 32 minus lines 32.01, 33 and 34	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	36

#### TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part III, line 4 (see instructions)	50
51	Outlier reconciliation adjustment amount (see instructions)	51
52	The rate used to calculate the Time Value of Money (see instructions)	52
53	Time Value of Money (see instructions)	53

4090 (Cont.)	FORM CMS-2552-10				09-14
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROV	/IDER CCN:	PERIOD:	WORKSHEET E-3,	
			FROM	PART IV	
			ТО		

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	1
2	Outlier payments	2
3	Total PPS payments (sum of lines 1 and 2)	3
4	Nursing and allied health managed care payments (see instructions)	4
5	Organ acquisition DO NOT USE THIS LINE	5
6	Cost of physicians' services in a teaching hospital (see instructions)	6
7	Subtotal (see instructions)	7
8	Primary payer payments	8
9	Subtotal (line 7 less line 8)	9
10	Deductibles	10
11	Subtotal (line 9 minus line 10)	11
12	Coinsurance	12
13	Subtotal (line 11 minus line 12)	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14
15	Adjusted reimbursable bad debts (see instructions)	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	16
17	Subtotal (sum of lines 13 and 15)	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)-	18
19	Other pass through costs (see instructions)	19
20	Outlier payments reconciliation	20
21	Other adjustments (specify) (see instructions)	21
22	Total amount payable to the provider (see instructions)	22
22.01	Sequestration adjustment (see instructions)	22.01
23	Interim payments	23
24	Tentative settlement (for contractor use only)	24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	26

#### TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Wkst. E-3, Pt. IV, line 3 (see instructions)	50
51	Outlier reconciliation adjustment amount (see instructions)	51
52	The rate used to calculate the Time Value of Money (see instructions)	52
53	Time Value of Money (see instructions)	53

09-14	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
		FROM	PART V
	COMPONENT CCN	ТО	

## PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

	1	
1	Inpatient services	1
2	Nursing and allied health managed care payment (see instruction)	2
3	Organ acquisition	3
4	Subtotal (sum of lines 1 thru 3)	4
5	Primary payer payments	5
6	Total cost (line 4 less line 5) (see instructions)	6
	COMPUTATION OF LESSER OF COST OR CHARGES	
	Reasonable charges	
7	Routine service charges	7
8	Ancillary service charges	8
9	Organ acquisition charges, net of revenue	9
10	Total reasonable charges	10
	Customary charges	
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	11
12	Amounts that would have been realized from patients liable for payment for services on	12
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	13
		14
		15
		16
17	Cost of physicians' services in a teaching hospital (see instructions)	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	Direct graduate medical education payments	18
19	Cost of covered services (sum of lines 6 and 17)	19
20	Deductibles (exclude professional component)	20
21	Excess reasonable cost (from line 16)	21
22	Subtotal (line 19 minus lines 20 and 21)	22
23	Coinsurance	23
24	Subtotal (line 22 minus line 23)	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25
26	Adjusted reimbursable bad debts (see instructions)	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	27
28	Subtotal (sum of lines 24 and 25 or 26)	28
29	Other adjustments (specify) (see instructions)	29
30	Subtotal (line 28, plus or minus line 29)	30
	Sequestration adjustment (see instructions)	30.01
	1 5	31
32	Tentative settlement (for contractor use only)	32
33	Balance due provider/program line 30 minus lines 30.01, 31, and 32	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chatper 1, §115.2	34

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4033.5)

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4090 (Cont.)	FORM CMS-2552-10		09-14
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
		FROM	PART VI
	COMPONENT CCN.	: TO	

## PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)	
1	Resource Utilization Group (RUGS) payment	1
2	Routine service other pass through costs	2
3	Ancillary service other pass through costs	3
4	Subtotal (sum of lines 1 through 3)	4
	COMPUTATION OF NET COST OF COVERED SERVICES	
5	Medical and other services. Do not use this line (see instructions).	5
6	Deductibles	6
7	Coinsurance	7
8	Allowable bad debts (see instructions)	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9
10	Adjusted reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (Sum of lines 4 and 5, minus 6 & 7 plus 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
15	Subtotal (line 12 minus 13 ± lines 14	15
15.01	Sequestration adjustment (see instructions)	15.01
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program line 15 minus 15.01, 16 and 17	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

DRAFT		FORM CMS-2552-1	0		4090 (Cont.)
CALCULATION OF REIMBURS	SEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
				FROM	PART VII
			COMPONENT CCN:	то	
Check	[] Title V	[] Hospital	[] NF	[] PPS	•
applicable	[] Title XIX	[] Subprovider	[] ICF/IID	[] TEFRA	
boxes:		[ ] SNF		[] Other	

## PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES

		Inpatient Title V or	Outpatient Title V or	
	COMPUTATION OF NET COST OF COVERED SERVICES	Title XIX	Title XIX	
1	Inpatient hospital/SNF/NF services			1
2				2
3				3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8 through 11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amounts that would have been realized from patients liable for payment for services			14
	on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15	Ratio of line 13 to line 14 (not to exceed 1.000000)			15
	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16			17
	exceeds line 4) (see instructions)			
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' service in a teaching hospital (see instructions)			20
	Cost of covered services (enter the lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (title V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			25
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34				34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	+		36
37	Other adjustments (specify) (see instructions)			37
38	Subtotal (line $36 \pm \text{line } 37$ )			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
40	Interim payments	+		40
41	Balance due provider/program (line 40 minus line 41)	+		41
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			42
43	riolesteu amounts (nonanowable cost report items) in accordance with Civis Pub. 15-2, Chapter 1, §115.2			43

DIREC	T GRADUATE MEDICAL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESR	D OUTPATIENT DIRECT MEDICAL		FROM	_	
EDUC	ATION COSTS		то	_	
Check	[] Title V			·	
applica	ble [] Title XVIII				
box:	[] Title XIX				
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost report	ing periods ending on or	before December 31, 19	96	1
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see ins	tructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413	.79 (m). (see instruction	15		3.01
	for cost reporting periods straddling 7/1/2011)				
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due	e to a Medicare GME			4
	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				
	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting per		/		4.01
	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost a	1 01	° ,		4.02
	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line				5
6		year from your records	(see instructions)	-	6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for				8
0	the current year				
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times				9
10	the result of line 5 divided by the amount on line 6				1(
	Weighted dental and podiatric resident FTE count for the current year Total weighted FTE count				10
	· · · · · · · · · · · · · · · · · · ·				11
	Total weighted resident FTE count for the prior cost reporting year (see instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instr.)				12
	Rolling average FTE count (sum of lines 11 through 13 divided by 3)				14
	Adjustment for residents in initial years of new programs				12
	Adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closure				10
	Adjusted rolling average FTE count				17
	Per resident amount				18
	Approved amount for resident costs				19
	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots r	Leceived under 42 8413 '			20
	Direct GME FTE unweighted resident count over cap (see instructions)				21
22					22
23					23
24					24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	-			26
27	Total inpatient days (see instructions)				27
28	Ratio of inpatient days to total inpatient days				28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	E XVIII ONLY (NURSI	NG SCHOOL AND		
	PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 2	3, lines 74 and 94)			32
33		ıd 94)			33
24	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
34 35	Medicare outpatient ESRD charges (see instructions)				35

09-14	FORM CMS-255	52-10		4090 (Cont.)
DIREC	GRADUATE MEDICAL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4
& ESRI	OUTPATIENT DIRECT MEDICAL	_ (Cont.)		
EDUCA	TION COSTS		то	_
Check	[] Title V			
applicat	le [] Title XVIII			
box:	[] Title XIX			
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs Wkst. D-4, Pt. III, col. 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A	AND PART B		
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instruction	ns)		49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instruction	s)		50

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4034) Rev. 6

40-599

4090	) (Cont.)	FOR	FORM CMS-2552-10			09-14	
	NCE SHEET		PROVIDER CCN: PERIOD:		WORKSHEET G		
(If you	are nonproprietary and do not maintain fund-type			FROM			
	nting records, complete the General Fund column			то			
			Specific				
		General	Purpose	Endowment	Plant		
	Assets	Fund	Fund	Fund	Fund		
	(Omit cents)	1	2	3	4		
	CURRENT ASSETS	•		•	•		
1	Cash on hand and in banks					1	
2	Temporary investments					2	
3	Notes receivable					3	
4	Accounts receivable					4	
5	Other receivables					5	
6	Allowances for uncollectible notes and					6	
	accounts receivable						
7	Inventory					7	
8	-FF					8	
9						9	
10						10	
11						11	
	FIXED ASSETS			-			
	Land					12	
13						13	
14	<b>F</b>					14	
	Buildings					15	
16	Accumulated depreciation					16	
17						17	
18	Accumulated depreciation					18	
19						19	
20	Accumulated depreciation					20	
21						21	
22	Accumulated depreciation					22	
	Major movable equipment					23	
24	······································	-		_		24	
	Minor equipment depreciable					25 26	
26	Accumulated depreciation HIT designated Assets					26	
27						27	
	Accumulated depreciation Minor equipment-nondepreciable					28	
		_				30	
30	OTHER ASSETS					30	
31						31	
32						31	
33				+	+	33	
34	Other assets			+		34	
35						35	
	Total assets (sum of lines 11, 30, and 35)					36	

10-1	2	FORM CMS-2	2552-10		4090 (0	Cont.)
(If you	NCE SHEET are nonproprietary and do not maintain fund-type nting records, complete the General Fund column o		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET G (CONT.)	
	Liabilities and Fund Balances (Omit cents) CURRENT LIABILITIES	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
38 39 40	Accounts payable					37 38 39 40 41
42 43 44	Accelerated payments Due to other funds Other current liabilities Total current liabilities (sum of lines 37 thru 44)					41 42 43 44 45
46	LONG TERM LIABILITIES					46
48 49	Unsecured loans Other long term liabilities Total long term liabilities (sum of					47 48 49 50
51						51
52 53 54	CAPITAL ACCOUNTS General fund balance Specific purpose fund Donor created - endowment fund balance - restricted					52 53 54
55 56						55 56
57 58	fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion					57 58
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 59)					59 60

4090 (Cont.)	FORM CMS-2552-10						10-12		
STATEMENT OF CHANGES IN FUND BALANCES				PROVIDER CCN	J:	PERIOD: FROM TO		WORKSHEE	ΓG-1
	GENER	AL FUND	SPECIFIC PU	JRPOSE FUND	ENDOWN	IENT FUND	PLANT I		
	1	2	3	4	5	6	7	8	
1 Fund balances at beginning of period									1
2 Net income (loss) (from Worksheet G-3, line 29)									2
3 Total (sum of line 1 and line 2)									3
4 Additions (credit adjustments) (specify)									4
5									5
6									6
7									7
8									8
9				-		-			9
10 Total additions (sum of lines 4-9)									10
11 Subtotal (line 3 plus line 10)							-		11
12 Deductions (debit adjustments) (specify)									12
13				-		-			13
14									14
15				-		-			15
16									16
17									17
18 Total deductions (sum of lines 12-17)									18
19 Fund balance at end of period per balance									19
sheet (line 11 minus line 18)									

10-12	FORM CMS-2552-10	4090 (Cont.)	
STATEMENT OF PATIENT REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-2,
AND OPERATING EXPENSES		FROM	PARTS I & II
		TO	

## PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	_
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES		I		
1	Hospital				1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)				10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive care unit				11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of				16
	of lines 11-15)				
	Total inpatient routine care services (sum of lines 10 and 16)				17
18	Ancillary services				18
19	Outpatient services				19
	Rural Health Clinic (RHC)				20
	Federally Qualified Health Center (FQHC)				21
	Home health agency				22
23	Ambulance				23
24					24
25					25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to				28
	Worksheet G-3, line 1)				

## PART II - OPERATING EXPENSES

		1	2	ĺ
29	Operating expenses (per Wkst. A, column 3, line 200)			29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)			43

4090 (Cont.)	FORM CMS-2552-10		10-1			
STATEMENT OF REVENUES	PROVIDER CCN: 1	PERIOD:	WORKSHEET G-3			
AND EXPENSES	1	FROM				
	· · · · · · · · · · · · · · · · · · ·	то				

1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1
2	Less contractual allowances and discounts on patients' accounts	2
3	Net patient revenues (line 1 minus line 2)	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	4
5	Net income from service to patients (line 3 minus line 4)	5

## OTHER INCOME

6	Contributions, donations, bequests, etc	6
7	Income from investments	7
8	Revenues from telephone and other miscellaneous communication services	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		14
15	Revenue from rental of living quarters	15
16	Revenue from sale of medical and surgical supplies to other than patients	16
17	Revenue from sale of drugs to other than patients	17
18	Revenue from sale of medical records and abstracts	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)	19
20	Revenue from gifts, flowers, coffee shops, and canteen	20
21	Rental of vending machines	21
22	Rental of hospital space	22
23	Governmental appropriations	23
24	Other (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	Total other expenses (sum of line 27 and subscripts)	28
29	Net income (or loss) for the period (line 26 minus line 28)	29

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS       PERIOD:       PERIOD:       WORKSHEET H         HOME HEALTH AGENCY COSTS       FROM	DR	AFT	FORM CMS-2552-10							4090 (C	ont.)		
HHA CCN:TO	ANALYSIS OF HOSPITAL-BASED							PROVIDER CCN:		PERIOD:		WORKSHEET H	
COST CENTER DESCRIPTIONS (omit cents)         SALARIES         EMPLOYEE BENEFITS         TRANSPOR- TATION         CONTRACTED/ PURCHASED (see instructions)         TOTAL (sum of cols.         RECLASS- (sum of cols.         RECLASS- (sum of cols.         RECLASS- (sum of cols.         NET FICATIONS         NET BLANCE (col. 6 + col. 7)         NET ADUSTMENTS         NET ALLCCATION           1         2         3         4         5         6         7         8         9         10           1         2         3         4         5         6         7         8         9         10           1         2         3         4         5         6         7         8         9         10           1         2         3         4         5         6         7         8         9         10           1         2         3         4         5         6         7         8         9         10           1         2         3         4         5         6         7         8         9         10           3         1         Maintistative and Genetal         1         1         1         1         1         1         1         1         1 <td colspan="2">HOME HEALTH AGENCY COSTS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>FROM</td> <td></td> <td></td> <td></td>	HOME HEALTH AGENCY COSTS									FROM			
SALARIES         EMPLOYEE BENEFITS         TATION (see Instructions)         PURCHASED SERVICS         TOTAL (sum of cols. SERVICS         TOTAL (sum of cols. Intructions)         TRIAL BALANCE (sum of cols. Intructions)         EXPENSES FOR ALLOCATION (sum of cols. Intructions)           1         2         3         4         5         6         7         8         9         10           2         Capital Related-Bidgs. and Fixtures								HHA CCN:		то			
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$					TRANSPOR-	CONTRACTED/				RECLASSIFIED		NET	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$			SALARIES	EMPLOYEE	TATION	PURCHASED		TOTAL		TRIAL		EXPENSES FOR	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		COST CENTER DESCRIPTIONS		BENEFITS	(see	SERVICES		(sum of cols.	RECLASS-	BALANCE		ALLOCATION	
1         2         3         4         5         6         7         8         9         10           GENERAL SERVICE COST CENTERS <td></td> <td>(omit cents)</td> <td></td> <td>-</td> <td>,</td> <td></td> <td>OTHER COSTS</td> <td></td> <td></td> <td>(col. 6 + col. 7)</td> <td>ADJUSTMENTS</td> <td>(col. 8 + col. 9)</td> <td></td>		(omit cents)		-	,		OTHER COSTS			(col. 6 + col. 7)	ADJUSTMENTS	(col. 8 + col. 9)	
GENERAL SERVICE COST CENTERSImage: constraint of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the ser			1	2	/	4		/		· /		· /	
2Capital Related-Movable EquipmentImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance3Plant Operation & MaintenanceImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance4Transportation (see instructions)Image: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance5Administrative and GeneralImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance6Skilled Nursing CareImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance7Physical TherapyImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance8Occupational TherapyImage: construction & Image: c		GENERAL SERVICE COST CENTERS	-	_	-		-	-		-	-		
2Capital Related-Movable EquipmentImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance3Plant Operation & MaintenanceImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance4Transportation (see instructions)Image: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance5Administrative and GeneralImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance6Skilled Nursing CareImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance7Physical TherapyImage: construction & MaintenanceImage: construction & MaintenanceImage: construction & Maintenance8Occupational TherapyImage: construction & Image: c	1	Capital Related-Bldgs, and Fixtures											1
3       Plant Operation & Maintenance       Image: Constructions of the structions of the	2												2
4Transportation (see instructions)Image: the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of th	3												3
5       Administrative and General       Image: Services       Ima	4												4
HHA REIMBURSABLE SERVICESImage: Construction of the servicesImage: Construct	5												5
7       Physical Therapy       Image: Comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of t													
7       Physical Therapy       Image: Comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of t	6	Skilled Nursing Care											6
8       Occupational Therapy       Image: Comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison													7
10       Medical Social Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Services       Image: Section Section Services       Image: Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section Section S													8
11       Home Health Aide       Image: See instructions)       Image: See instructinstructions)       Image: See instructions)       <	9	Speech Pathology											9
12       Supplies (see instructions)       Image: Construction of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the se	10	Medical Social Services											10
13       Drugs       Image: Constraint of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	11	Home Health Aide											11
14     DME     Image: Constraint of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of t	12	Supplies (see instructions)											12
HHA NONREIMBURSABLE SERVICES       Image: Constraint of the services       Image: Constrated of the services       Image: Cons	13	Drugs											13
15         Home Dialysis Aide Services         Image: Constraint of the services         Image: Constraint of	14	DME											14
16         Respiratory Therapy         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		HHA NONREIMBURSABLE SERVICES											
	15	Home Dialysis Aide Services											15
	16	Respiratory Therapy											16
17 Private Duty Nursing [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] _ ] [ ] [													17
18 Clinic Clinic	18	Clinic											18
19 Health Promotion Activities 10 10 10 10 10 10 10 10 10 10 10 10 10													19
20 Day Care Program													20
21 Home Delivered Meals Program Compared to the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco													21
22 Homemaker Service													22
23 All Others													23
24 Total (sum of lines 1-23)	24	Total (sum of lines 1-23)											24

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

4090 (Cont.)		FO	RM CMS-255	2-10				DR	RAFT
COST ALLOCATION - HHA GENERAL SERVICE COST				PROVIDER CCN:		PERIOD:		WORKSHEET H-1	
						FROM		PART I	
				HHA CCN:		то			
	NET EXPENSES	CAP	ITAL						
	FOR COST	RELATE	D COSTS						
	ALLOCATION			PLANT			ADMINIS-		
	(from Wkst.	BLDGS. &	MOVABLE	<b>OPERATION &amp;</b>	TRANS-	SUBTOTAL	TRATIVE	TOTAL	
	H, col. 10)	FIXTURES	EQUIPMENT	MAINTENANCE	PORTATION	(cols. 0-4)	& GENERAL	(cols. 4a + 5)	
	0	1	2	3	4	4a	5	6	1
GENERAL SERVICE COST CENTERS									
1 Capital Related-Bldgs. and Fixtures									1
2 Capital Related-Movable Equipment									2
3 Plant Operation & Maintenance									3
4 Transportation (see instructions)									4
5 Administrative and General									5
HHA REIMBURSABLE SERVICES									
6 Skilled Nursing Care									6
7 Physical Therapy									7
8 Occupational Therapy									8
9 Speech Pathology									9
10 Medical Social Services									10
11 Home Health Aide									11
12 Supplies (see instructions)									12
13 Drugs									13
14 DME									14
HHA NONREIMBURSABLE SERVICES									
15 Home Dialysis Aide Services									15
16 Respiratory Therapy									16
17 Private Duty Nursing									17
18 Clinic									18
19 Health Promotion Activities									19
20 Day Care Program									20
21 Home Delivered Meals Program									21
22 Homemaker Service									22
23 All Others									23
24 Totals (sum of lines 1-23)									24

09-13 FC	ORM CMS-255	2-10				4090 (0	Cont.)
COST ALLOCATION - HHA STATISTICAL BASIS		PROVIDER CCN:		PERIOD:		WORKSHEET H-1	L,
				FROM		PART II	
		HHA CCN:		то			
	-	PITAL					
		ED COSTS	PLANT			ADMINIS-	
	BLDGS. &	MOVABLE	OPERATION &			TRATIVE	
	FIXTURES	EQUIPMENT	MAINTENANCE	TRANS-		& GENERAL	
	(SQUARE	(DOLLAR	(SQUARE	PORTATION	RECONCIL-	(ACCUM.	
	FEET)	VALUE)	FEET)	(MILEAGE)	IATION	COST)	
	1	2	3	4	5a	5	
GENERAL SERVICE COST CENTERS							
1 Capital Related-Bldgs. and Fixtures							1
2 Capital Related-Movable Equipment							2
3 Plant Operation & Maintenance							3
4 Transportation (see instructions)							4
5 Administrative and General							5
HHA REIMBURSABLE SERVICES							
6 Skilled Nursing Care							6
7 Physical Therapy							7
8 Occupational Therapy							8
9 Speech Pathology	_						9
10 Medical Social Services							10
11 Home Health Aide							11
12 Supplies (see instructions)							12
13 Drugs							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 Home Dialysis Aide Services							15
16 Respiratory Therapy							16
17 Private Duty Nursing							17
18 Clinic							18
19 Health Promotion Activities	_						19
20 Day Care Program							20
21 Home Delivered Meals Program							21
22 Homemaker Service							22
23 All Others							23
24 Total (sum of lines 1-23)							24
25 Cost To Be Allocated (per Worksheet H-1, Part I)							25
26 Unit Cost Multiplier							26

4090	(Cont.)			FORM C	MS-2552-10						(	09-13
	CATION OF GENERAL SERVICE TO HHA COST CENTERS				PROVIDER CO	CN:	_	PERIOD: FROM		WORKSHEET H- PART I	2,	
					HHA CCN:			ТО				
				CAF	PITAL							
		From	HHA	RELATE	ED COSTS							
	HHA COST CENTER	Wkst. H-1	TRIAL			EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	& LINEN	
		col. 6,	(1)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	SERVICE	
		line	0	1	2	4	4A	5	6	7	8	1
	Administrative and General	5										1
	Skilled Nursing Care	6										2
	Physical Therapy	7										3
4	Occupational Therapy	8										4
	Speech Pathology	9										5
	Medical Social Services	10										6
7	Home Health Aide	11										7
	Supplies	12										8
	Drugs	13										9
	DME	14										10
11	Home Dialysis Aide Services	15										11
	Respiratory Therapy	16										12
	Private Duty Nursing	17										13
	Clinic	18										14
	Health Promotion Activities	19										15
	Day Care Program	20										16
	Home Delivered Meals Program	21										17
-	Homemaker Service	22										18
19	All Others	23										19
	Totals (sum of lines 1-19) (2)											20
	Unit Cost Multiplier: column 26, line 1 divided by		e, line 20									21
	minus column 26, line 1, rounded to 6 decimal place	ces.										

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4043.1)

10-1	2				FORM CM	IS-2552-10	)					4090 (C	ont.)
	CATION OF GENERAL SERVICE S TO HHA COST CENTERS					PROVIDER C	CCN:		PERIOD: FROM		WORKSHEET PART I (CON	· ·	
						HHA CCN:			то				
	HHA COST CENTER (omit cents)	HOUSE KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	
1	Administrative and General												1
2	Skilled Nursing Care												2
	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6													6
	Home Health Aide												7
	Supplies												8
	Drugs												9
-	DME												10
	Home Dialysis Aide Services												11
	Respiratory Therapy												12
	Private Duty Nursing												13
	Clinic												14
	Health Promotion Activities												15
	Day Care Program												16
	Home Delivered Meals Program												17
	Homemaker Service												18
	All Others												19
	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1 divided by minus column 26, line 1, rounded to 6 decimal place		1 26, line 20										21

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

4090	) (Cont.)		FOF	RM CMS-255	2-10					1	10-12
ALLC	CATION OF GENERAL SERVICE			PROVIDER CCN	:		PERIOD:		WORKSHEET H-	2,	
COST	S TO HHA COST CENTERS						FROM		PART I (CONT.)		
				HHA CCN:			то				
							INTERN &				
							RESIDENT		ALLOCATED		
	HHA COST CENTER		INTERNS &	RESIDENTS	PARAMEDICAL	SUBTOTAL	COST & POST		HHA		
	(omit cents)	NURSING	SALARY AND	PROGRAM	EDUCATION	(sum of cols.	STEPDOWN	SUBTOTAL	A&G (see	TOTAL	
		SCHOOL	FRINGES	COSTS	(SPECIFY)	4a-23)	ADJUSTMENTS	(cols. 23 ± 24)	Part II)	HHA COSTS	
		20	21	22	23	24	25	26	27	28	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	- injeren - inerepj										3
4	Occupational Therapy										4
5											5
6	Medical Social Services										6
7	Home Health Aide										7
8											8
9											9
10											10
	Home Dialysis Aide Services										11
	Respiratory Therapy										12
	Private Duty Nursing										13
	Clinic										14
-	Health Promotion Activities										15
	Day Care Program										16
	Home Delivered Meals Program										17
	Homemaker Service										18
	All Others										19
	Totals (sum of lines 1-19) (2)										20
21			n 26, line 20								21
	minus column 26, line 1, rounded to 6 decimal place	es.									

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4043.1)

09-13		FOF	RM CMS-2552-10				4090 (0	Cont.)
ALLOCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET H-2,	
COSTS TO HHA COST CENTERS					FROM		PART II	
STATISTICAL BASIS			HHA CCN:		то			
	CAP	ITAL						
	RELATI	ED COST	EMPLOYEE		ADMINIS-	MAIN-		
	BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
HHA COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT	
	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
	1	2	4	4A	5	6	7	
1 Administrative and General								1
2 Skilled Nursing Care								2
3 Physical Therapy								3
4 Occupational Therapy								4
5 Speech Pathology								5
6 Medical Social Services								6
7 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Home Dialysis Aide Services								11
12 Respiratory Therapy								12
13 Private Duty Nursing								13
14 Clinic								14
15 Health Promotion Activities								15
16 Day Care Program								16
17 Home Delivered Meals Program								17
18 Homemaker Service								18
19 All Others								19
20 Totals (sum of lines 1-19)								20
21 Total cost to be allocated								21
22 Unit Cost Multiplier								22

4090	) (Cont.)		FOF	M CMS-255	2-10					0	9-13
ALLO	CATION OF GENERAL SERVICE					PROVIDER CCN:		PERIOD:		WORKSHEET H	-2,
COST	S TO HHA COST CENTERS							FROM		PART II (CONT.)	)
STAT	ISTICAL BASIS			-		HHA CCN:		ТО			
	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1	Administrative and General		-							-	1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
	Drugs										9
	DME										10
	Home Dialysis Aide Services										11
	Respiratory Therapy										12
	Private Duty Nursing										13
	Clinic										14
	Health Promotion Activities										15
	Day Care Program										16
	Home Delivered Meals Program										17
	Homemaker Service										18
	All Others										19
	Totals (sum of lines 1-19)										20
	Total cost to be allocated										21
22	Unit Cost Multiplier										22

40-612

10-12		FOF	RM CMS-2552-10				4090 (0	Cont.)
ALLOCATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET H-2,	
COSTS TO HHA COST CENTERS					FROM		PART II (CONT.)	
STATISTICAL BASIS			HHA CCN:		то			
			NON-				PARA-	
			PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL	
	SOCIAL	OTHER	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	
HHA COST CENTER	SERVICE	GENERAL	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	
	(TIME	SERVICE	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED	
	SPENT)	(SPECIFY)	TIME)	TIME)	TIME)	TIME)	TIME)	
	17	18	19	20	21	22	23	7
1 Administrative and General								1
2 Skilled Nursing Care								2
3 Physical Therapy								3
4 Occupational Therapy								4
5 Speech Pathology								5
6 Medical Social Services								6
7 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Home Dialysis Aide Services								11
12 Respiratory Therapy								12
13 Private Duty Nursing								13
14 Clinic								14
15 Health Promotion Activities								15
16 Day Care Program								16
17 Home Delivered Meals Program								17
18 Homemaker Service								18
19 All Others								19
20 Totals (sum of lines 1-19)								20
21 Total cost to be allocated								21
22 Unit Cost Multiplier								22

4090 (Cont.)			FORM	CMS-2552-10			10-12
APPORTIONMENT OF PATIENT	SERVICE COST	S		PROVIDER CCN:	PERIOD:	WORKSHEET H-3,	
					FROM	Parts I & II	
				HHA CCN:	то		
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX				

#### PART I COMPLITATION OF THE ACCRECATE PROCRAM COST

PART I - COMPUTATION OF	THE AG	GREGATE F	ROGRAM	COST										
Cost Per Visit Computation								Program Visits			Cost of Services	5		
	From,	Facility	Shared			Average		Pa	rt B		Pai	t B		
	Wkst.	Costs	Ancillary	Total		Cost		Not			Not		Total	
	H-2,	(from	Costs	HHA		Per Visit		Subject to	Subject to		Subject to	Subject to	Program Cost	
Patient Services	Part I,	Wkst. H-2,	(from	Costs	Total	(col. 3		Deductibles	Deductibles		Deductibles	Deductibles	(sum of	
	col. 28,	Part I)	Part II)	cols. 1 + 2	Visits	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	& Coinsurance	& Coinsurance	cols. 9-10)	
	line	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Care	2													1
2 Physical Therapy	3													2
3 Occupational Therapy	4													3
4 Speech Pathology	5													4
5 Medical Social Service	6													5
6 Home Health Aide	7													6
7 Total (sum of lines 1-6	j)													7

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

Supplies and Drugs Cost							Prog	gram Covered Cl	harges		Cost of Service	s	
Computations		Facility	Shared					Pai	rt B		Pai	rt B	l i
	From	Costs	Ancillary	Total	Total			Not			Not		1
	Wkst. H-2	(from	Costs	HHA	Charges	Ratio		Subject to	Subject to		Subject to	Subject to	1
Other Patient Services	Part I,	Wkst. H-2,	(from	Costs	from HH/	(col. 3		Deductibles	Deductibles		Deductibles	Deductibles	1
	col. 28,	Part I)	Part II)	cols. 1 + 2	Record)	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	& Coinsurance	& Coinsurance	1
	line	1	2	3	4	5	6	7	8	9	10	11	1
15 Cost of Medical Supplies	8												15
16 Cost of Drugs	9												16

### PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

				Total			
			Cost	HHA Charges	HHA Shared	Transfer to	
		From Wkst. C,	to Charge	(from provider	Ancillary Costs	Part I	
		Part I, col. 9,	Ratio	records)	(col. 1 x col. 2)	as Indicated	
		line	1	2	3	4	
1	Physical Therapy	66				col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Cost of Medical Supplies	71				col. 2, line 15	4
5	Cost of Drugs	73				col. 2, line 16	5

DRAFT	FORM CMS-2	2552-10		4090 (Cont.)
CALCULATION OF HHA REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET H-4,
SETTLEMENT			FROM	Parts I & II
		HHA CCN:	то	
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX	

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

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

# PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

Description1210Total resonable cost (see instructions)11Total PPS Reimbursement - Full Episodes without Outliers12Total PPS Reimbursement - Full Episodes with Outliers13Total PPS Reimbursement - LUPA Episodes14Total PPS Reimbursement - PEP Episodes15Total PPS Reimbursement - Full Episodes with Outliers16Total PPS Outlier Reimbursement - Full Episodes17Total PPS Outlier Reimbursement - PEP Episodes18Total PPS Outlier Reimbursement - PEP Episodes19Oxygen Payments19Oxygen Payments20Prosthetic and Orthotic Payments21Part B deductibles billed to Medicare patients (exclude coinsurance)23Subtotal (sum of lines 10 thru 20 minus line 21) </th <th>10           11           12           13           14           15           16           17           18           19           20</th>	10           11           12           13           14           15           16           17           18           19           20
11       Total PPS Reimbursement - Full Episodes with Outliers         12       Total PPS Reimbursement - Full Episodes with Outliers         13       Total PPS Reimbursement - LUPA Episodes         14       Total PPS Reimbursement - LUPA Episodes         15       Total PPS Outlier Reimbursement - PEP Episodes         16       Total PPS Outlier Reimbursement - Full Episodes with Outliers         16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (time of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimburseline 20	11 12 13 14 15 16 17 17 18 19 20
12       Total PPS Reimbursement - Full Episodes with Outliers         13       Total PPS Reimbursement - LUPA Episodes         14       Total PPS Reimbursement - PEP Episodes         15       Total PPS Outlier Reimbursement - Full Episodes with Outliers         16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total PPS Outlier Reimbursement - PEP Episodes         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	12 13 14 15 16 17 18 19 20
13       Total PPS Reimbursement - LUPA Episodes         14       Total PPS Reimbursement - PEP Episodes         15       Total PPS Outlier Reimbursement - Full Episodes with Outliers         16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	13           14           15           16           17           18           19           20
14       Total PPS Reimbursement - PEP Episodes         15       Total PPS Outlier Reimbursement - Full Episodes with Outliers         16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimburseble bad debts (from your records)	14 15 16 17 18 19 20
15       Total PPS Outlier Reimbursement - Full Episodes with Outliers         16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	15 16 17 18 19 20
16       Total PPS Outlier Reimbursement - PEP Episodes         17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	16 17 18 19 20
17       Total Other Payments         18       DME Payments         19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	17 18 19 20
18       DME Payments       Image: Constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the	18 19 20
19       Oxygen Payments         20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	19 20
20       Prosthetic and Orthotic Payments         21       Part B deductibles billed to Medicare patients (exclude coinsurance)         22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	20
21       Part B deductibles billed to Medicare patients (exclude coinsurance)	
22       Subtotal (sum of lines 10 thru 20 minus line 21)         23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	
23       Excess reasonable cost (from line 8)         24       Subtotal (line 22 minus line 23)         25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	21
24       Subtotal (line 22 minus line 23)	22
25       Coinsurance billed to program patients (from your records)         26       Net cost (line 24 minus line 25)         27       Reimbursable bad debts (from your records)	23
26     Net cost (line 24 minus line 25)       27     Reimbursable bad debts (from your records)	24
27 Reimbursable bad debts (from your records)	25
	26
28 Reimbursable bad debts for dual eligible beneficiaries (see instructions)	27
	28
29 Total costs - current cost reporting period (line 26 plus line 27)	29
30 Other adjustments (see instructions) (specify)	30
31 Subtotal (line 29 plus/minus line 30)	31
31.01 Sequestration adjustment (see instructions)	31.01
32 Interim payments (see instructions)	32
33 Tentative settlement (for contractor use only)	33
34 Balance due provider/program line 31 minus lines 31.01, 32 and 33	34
35 Protested amounts (nonallowable cost report items) in accordance with CMS	35
Pub. 15-2, section 115.2	

40-615

4090 (Cont.	.)		FC	DRM CMS-2552	-10		D	RAFT
ANALYSIS OF	PAYMENTS TO HOSPITAL-				PROVIDER CCN:	PERIOD:	WORKSHEET H-5	
BASED HHAs F	FOR SERVICES					FROM	_	
RENDERED TO	PROGRAM BENEFICIARIES				HHA CCN:	то	_	
	Description			D	art A		Part B	
L	escription			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	_
				1	2	3	4	-
1 Total inte	erim payments paid to provider			-	-	5		1
	ayments payable on individual bills eith	er submitte	ed or					2
	mitted to the intermediary for services r							
cost repo	rting period. If none, write "NONE" or	enter a zei	ю.					
	rately each retroactive lump sum		.01					3.01
	nt amount based on subsequent revision		.02					3.02
of the int	erim rate for the cost reporting period.	Program	.03					3.03
	w date of each payment. If none, write	to	.04					3.04
"NONE"	or enter a zero.(1)	Provider	.05					3.05
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53 .54					3.53
6.1		Program	.54		-		_	3.54
	(sum of lines 3.01-3.49 minus sum		.99					1 2 00
	8.50-3.98) erim payments (sum of lines 1, 2, and 3.	00)	.99					3.99
	to Wkst. H-4, Part II, column as approp		201					1 4
(ualister	to wkst. 11-4, Fait II, column as approp	nate, inte .	<u>14)</u>					
	TO BE COMPLETED BY IN	FERMEDI	ARY					
5 List sepa	rately each tentative settlement paymen	Drogram	.01	1	1	1	1	5.01
· · · · · · · · · · · · · · · · · ·	k review. Also show date of each	to	.01			+	-	5.02
	If none, write "NONE" or enter	Provider	.02					5.03
a zero. (1		Provider	.50					5.50
u Leroi (1	-)	to	.50					5.51
		Program	.52					5.52
Subtotal	(sum of lines 5.01-5.49 minus sum	- 0 -	-					
of lines 5	5.50-5.98)		.99					5.99
6 Determin	ne net settlement amount (balance due)	Program						
based on	the cost report (see instructions)	to	.01					
		Provider						6.01
		Provider						
		to	.02					
		Program						6.02
-	MEDICARE PROGRAM LIABILITY							7
(see instr 8 Name of	uctions) Contractor	Contrac	<u> </u>	h	NPR Date: Month, Da			8
8 Name of	Contractor	Contrac	LOF IN	uniter	INPR Date: Month, Da	iy, i ear		8

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

09-1	4 FC	ORM CMS-255	4090 (Cont.)			
ANAI	YSIS OF RENAL DIALYSIS DEPARTMENT COSTS		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-1	
Check	applicable box: [] Renal Dialysis Department	[] Home Progra	m Dialysis			
		TOTAL			FTEs per	
		COSTS	BASIS	STATISTICS	2080 Hours	
		1	2	3	4	
1	Registered Nurses		Hours of Service			1
2	Licensed Practical Nurses		Hours of Service			2
3	Nurses Aides		Hours of Service			3
4	Technicians		Hours of Service			4
5	Social Workers		Hours of Service			5
6	Dieticians		Hours of Service			6
7	Physicians		Accumulated Cost			7
8	Non-patient Care Salary		Accumulated Cost			8
9	Subtotal (sum of lines 1-8)					9
10	Employee Benefits		Salary			10
11	Capital Related Costs-Bldgs. & Fixtures		Square Feet			11
12	Capital Related Costs-Mov. Equip.		Percentage of Time			12
13	Machine Costs & Repairs		Percentage of Time			13
14	Supplies		Requisitions			14
15	Drugs		Requisitions			15
16	Other		Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*					17
18	Capital Related Costs-Bldgs. & Fixtures		Square Feet			18
19	Capital Related Costs-Mov. Equip.		Percentage of Time			19
20	Employee Benefits Department		Salary			20
21	Administrative and General		Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping		Square Feet			22
23	Medical Education Program Costs		· 1· · · · · ·			23
24	Central Services & Supplies		Requisitions			24
25	Pharmacy		Requisitions			25
26	Other Allocated Costs		Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*					27
28	Laboratory (see instructions)		Charges			28
29	Respiratory Therapy (see instructions)		Charges			29
30	Other (see instructions)		Charges			30
31	Total costs (sum of lines 27-30)					31
						01

\* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 26 for line 74 or line 94 as appropriate.

4090 (Cont.)			FOR	M CMS-25	552-10						C	)9-14
ALLOCATION OF RENAL DEPARTMENT COSTS	5 TO TREATME	NT MODALITIE	ES			PROVIDER C	CCN:	PERIOD: FROM TO		WORKSHEET	I-2	
Check applicable box:	[] Renal Dia	lysis Department	[] Home	Program Dialy	sis			10				
OUTPATIENT SERVICES		J I	C · · ·	-0							1	
COMPOSITE PAYMENT RATE	RELATE	AL AND ED COSTS EQUIPMENT		PATIENT SALARY OTHER	EMPLOYEE BENEFITS DEPARTMENT	DRUGS	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)	
	1	2	3	4	5	6	7	8	9	10	11	1
1 Total Renal Department Costs											í	1
MAINTENANCE												
2 Hemodialysis											<u> </u>	2
3 Intermittent Peritoneal											<u> </u>	3
TRAINING												
4 Hemodialysis											L	4
5 Intermittent Peritoneal											L	5
6 CAPD											L	6
7 CCPD											i	7
HOME												
8 Hemodialysis											1	8
9 Intermittent Peritoneal											1	9
10 CAPD											í	10
11 CCPD											í	11
OTHER BILLABLE SERVICES												
12 Inpatient Dialysis											í	12
13 Method II Home Patient											í –	13
14 EPO (included in Renal Department)												14
15 ARENESP (included in Renal Department)												15
16 Other											[	16
17 Total (sum of lines 2 <i>through</i> 16)											í –	17
18 Medical Educational Program Costs											í	18
19 Total Renal Costs (line 17 + line 18)											í	19

DRAFT			FOR	M CMS-25	52-10						4090 (Co	ont.)
DIRECT AND INDIRECT RENAL DIALYSIS CO STATISTICAL BASIS	ST ALLOCATIO	- NC				PROVIDER C			PERIOD: FROM TO		WORKSHEET I-3	
Check applicable box:	[] Renal Dia	lysis Departmen	t [] Home	Program Dialys	is							
COMPOSITE PAYMENT SERVICES			AL AND ED COSTS EQUIPMENT (% OF TIME) 2	-	PATIENT SALARY OTHERS (HOURS) 4	EMPLOYEE BENEFITS DEPARTMENT (SALARY) 5	DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUB- TOTAL 9	OVERHEAD (ACCUM. COST) 10	
1 Total Renal Department Costs												1
MAINTENANCE												
2 Hemodialysis												2
3 Intermittent Peritoneal												3
TRAINING												i
4 Hemodialysis												4
5 Intermittent Peritoneal												5
6 CAPD												6
7 CCDP												7
HOME												<u> </u>
8 Hemodialysis												8
9 Intermittent Peritoneal												9
10 CAPD												10
11 CCDP											4	11
OTHER BILLABLE SERVICES											4	10
12 Inpatient Dialysis Treatments						-				-	4	12
13 Method II Home Patient 14 EPO											4	13
14 EPO 15 ARENESP											4	14
16 Other												15
16 Other 17 Total Statistical Basis												16 17
17 Total Statistical Basis 18 Unit Cost Multiplier (line 1 ÷ line 17)		+				+						17
10 Chit Cost multiplier (line 1 · lille 1/)		1	1	1	1	1		1	1			1 10

4090 (Cont.)	FORM	A CMS-25	552-10										DR.	AFT
COMPUTATION OF AVERAGE COST PER TREATMEN	NT							PROVIDER	CCN:		PERIOD: FROM		WORKSHEET I-	-4
FOR OUTPATIENT RENAL DIALYSIS								SATELLITE (	CN.		ТО			
Check applicable box: [] Renal Dialys	sis Department [] Ho	me Program D	Dialysis								10		<b>I</b>	
			Average Cost				Total					Average	Average	1
	Number of Total	Total Cost	of Program	Number	Number	Number	Program	Total	Total	Total	Average	Payment Rate	Payment Rate	1
	Treatments	(from Wkst.	Treatments (col. 2 ÷ col. 1)	of Program Treatments	of Program Treatments	of Program Treatments	Expenses (see instructions)	Program Payment	Program Payment	Program Payment	Payment Rate (col. 6 ÷ col. 4)		(col. 6.02 ÷ col. 4.02)	1
	1 reatments	1-2, col. 11)	(coi. 2 ÷ coi. 1) 3	1 reatments	4.01	4.02	(see instructions)	Payment	6.01	6.02	(COL 6 ÷ COL 4)	7.01	7.02	1
1 Maintenance - Hemodialysis		2	5	4	4.01	4.02	5	0	0.01	0.02	/	7.01	7.02	
2 Maintenance - Peritoneal Dialysis														2
3 Training - Hemodialysis														3
4 Training - Peritoneal Dialysis														4
5 Training - Continuous Ambulatory Peritoneal Dialys	is													5
6 Training - Continuous Cycling Peritoneal Dialysis														6
7 Home Program - Hemodialysis														7
8 Home Program - Peritoneal Dialysis														8
	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								
9 Home Program - Continuous Ambulatory Peritoneal														9
10 Home Program - Continuous Cycling Peritoneal Dia	lysis													10
11 Totals (sum of lines 1 through 8, columns 1 and 4)														11
(sum of lines 1-10, columns 2, 5 and 6)														<u> </u>
12 Total treatments (sum of lines 1 through 8 plus														12
(sum of lines 9 and 10 times 3))														

03-14	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSABLE	PROVIDER CCN:	PERIOD:	WORKSHEET I-5
BAD DEBTS - TITLE XVIII - PART B		FROM	
		ТО	

### Description

1	Total expenses related to care of program beneficiaries (see instructions)			1
		1	2	
2	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)			2
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments			2.04
2				3
	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.01				
	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
	Total deductibles billed to Medicare (Part B) patients (see instructions)	_		3.03
4	Coinsurance billed to Medicare (Part B) patients (see instructions)	_		4.01
	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
	Total coinsurance billed to Medicare (Part B) patients (see instructions) Bad debts for deductibles and coinsurance, net of bad debt recoveries			4.03
	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.01
5.01	services rendered on or after 1/1/2011 but before 1/1/2012			5.01
E 00				5.02
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.00	Services rendered on or after 1/1/2012 but before 1/1/2013 Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.03
5.03	services rendered on or after 1/1/2013 but before 1/1/2014			5.03
E 0.4	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for			5.04
5.04	services rendered on or after 1/1/2014			5.04
E 0E	Total bad debts (sum of line 5 through line 5.04)			5.05
	Allowable bad debts (see instructions)			5.03
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			7
/	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)			8
0 9	Program payment (see instructions)			9
10				10
	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	_		10

 PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE

 12
 Total allowable expenses (see instructions)
 12

 13
 Total composite costs (from Wkst. I-4, col. 2, line 11)
 13

 14
 Facility specific composite cost percentage (line 13 divided by line 12)
 14

4090	(Cont.)	FOR	M CMS-2	552-10						0	3-14
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVIDER	CCN:		PERIOD:		WORKSHEET	J-1,	
	JUNITY MENTAL HEALTH CENTERS						FROM		PART I	-	
				COMPONEN	IT CCN:		то				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENT	AL HEALTH CE	NTER COST								
		NET									
		EXPENSES	CAP	ITAL							i i
	COMPONENT COST CENTER	FOR COST	RELATE	D COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	i i
	(omit cents)	ALLOCATION	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE	OPERATION	& LINEN	i i
	()	(see instru.)			DEPARTMENT			& REPAIRS	OF PLANT	SERVICE	i i
		0	1	2	4	4A	5	6	7	8	i i
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

10-12			FOF	RM CMS-25	552-10						4090 (C	ont.)
ALLOCATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEE	Г Ј-1,	<u> </u>
COMMUNITY MENTAL HEALTH CENTERS								FROM		PART I (CON	Т.)	
					COMPONENT	Г ССN:		то				
PART I - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY M	ENTAL HEAL	TH CENTER C	COST CENTER	RS						
												I
				MAIN-		CENTRAL		MEDICAL			NON-	1
COMPONENT COST CENTER				TENANCE	NURSING	SERVICES		RECORDS		OTHER	PHYSICIAN	1
(omit cents)	HOUSE-			OF	ADMINIS-	&		&	SOCIAL	GENERAL	ANES-	1
	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	SERVICE	THETISTS	1
	9	10	11	12	13	14	15	16	17	18	19	L
1 Administrative and General												1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological Services												8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Therapies												11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)(1)												22
23 Unit Cost Multiplier (see instructions)												23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

4090 (Cont.)	FOI	RM CMS-25	52-10						1	10-12
ALLOCATION OF GENERAL SERVICE COSTS TO			PROVIDER CC	N:		PERIOD:		WORKSHEET	J-1,	
COMMUNITY MENTAL HEALTH CENTERS						FROM		PART I (CONT	.)	
			COMPONENT	CCN:		то		,	·	
PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUN	ITY MENTAL	HEALTH CENT						1		
						INTERN &				
				PARA-		RESIDENT		ALLOCATED		
COMPONENT COST CENTER		INTERNS &	RESIDENTS	MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
	SCHOOL	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	
	20	21	22	23	24	25	26	27	28	1
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)(1)										22
23 Unit Cost Multiplier (see instructions)										23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

09-13											
ALLOCATION OF GENERAL SERVICE COSTS TO			PROVIDER C	CN:		PERIOD:		WORKSHEET	J-1,		
COMMUNITY MENTAL HEALTH CENTERS						FROM		PART II			
			COMPONENT	Г CCN:		TO					
PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY	MENTAL HEAI	TH CENTER	COST CENTE	RS - STATISTI	ICAL BASIS	•					
		CAP	ITAL								
		RELAT	ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY		
		BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN		
CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT	r	GENERAL	REPAIRS	OF PLANT	SERVICE		
(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF		
		FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)		
	0	1	2	4	4A	5	6	7	8		
1 Administrative and General										1	
2 Skilled Nursing Care										2	
3 Physical Therapy										3	
4 Occupational Therapy										4	
5 Speech Pathology										5	
6 Medical Social Services										6	
7 Respiratory Therapy										7	
8 Psychiatric/Psychological Services										8	
9 Individual Therapy										9	
10 Group Therapy										10	
11 Individualized Activity Therapies										11	
12 Family Counseling										12	
13 Diagnostic Services										13	
14 Approved Patient Training & Education										14	
15 Prosthetic and Orthotic Devices										15	
16 Drugs and Biologicals										16	
17 Medical Supplies										17	
18 Medical Appliances										18	
19 Durable Medical Equipment-Rented										19	
20 Durable Medical Equipment-Sold										20	
21 All Others										21	
22 Totals (sum of lines 1-21)										22	
23 Total Cost to be Allocated										23	
24 Unit Cost Multiplier (see instructions)										24	

4090 (Cont.)				FORM CM	IS-2552-10						0	9-13
ALLOCATION OF GENERAL S	RVICE COSTS TO				PROVIDER C	CN:		PERIOD:		WORKSHEET	ſ J-1,	
COMMUNITY MENTAL HEAL	'H CENTERS							FROM		PART II (CON	√T.)	
					COMPONENT	Г ССN:		то				
PART II - ALLOCATION OF G	ENERAL SERVICE COSTS TO C	OMMUNITY N	IENTAL HEAI	TH CENTER	COST CENTE	RS - STATISTI	CAL BASIS					
				MAIN-							NON-	
				TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
	HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
CORF COST	CENTER KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
(omit ce	nts) (HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
	9	10	11	12	13	14	15	16	17	18	19	
1 Administrative and Genera												1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological 9	ervices											8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Th	rapies											11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training												14
15 Prosthetic and Orthotic De	rices											15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment												19
20 Durable Medical Equipment	t-Sold											20
21 All Others												21
22 Totals (sum of lines 1-21)												22
23 Total Cost to be Allocated												23
24 Unit Cost Multiplier (see i	istructions)											24

10-1	2		4090 (Cont.)								
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CCI	N:	_	PERIOD:		WORKSHEET .	J-1,	
COMI	IUNITY MENTAL HEALTH CENTERS						FROM		PART II (CONT	ī.)	
				COMPONENT (	CCN:	_	то				
PART	TII - ALLOCATION OF GENERAL SERVICE COST	5 TO COMMUNITY	Y MENTAL HEA	LTH CENTER C	OST CENTERS ·	STATISTICA	BASIS		•		
					PARA-						
			INTERNS &	RESIDENTS	MEDICAL						
		NURSING	SALARY &	PROGRAM	EDUCATION						
	CORF COST CENTER	SCHOOL	FRINGES	COSTS	(SPECIFY)						
	(omit cents)	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED						
		TIME)	TIME)	TIME)	TIME)						
		20	21	22	23	24	25	26	27	28	
	Administrative and General										1
	Skilled Nursing Care										2
	Physical Therapy										3
4	Occupational Therapy										4
	Speech Pathology										5
	Medical Social Services										6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
12	Family Counseling										12
	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)										22
23	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

4090 (Cont.)		FOI	RM CMS-255	2-10					1	10-12
COMPUTATION OF COMMUNITY MENTAL HEALTH CENT	TER PROVIDER CO	OSTS		PROVIDER CC	N:		PERIOD:		WORKSHEET J	J-2,
				COMPONENT (	CCN:	_	FROM TO		PART I	
PART I - APPORTIONMENT OF CMHC COST CENTERS							•		•	
	(From		Ratio of		Title V		Title XVIII		Title XIX	
	Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
	Part I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
	col. 28)	Charges	(col. 1 ÷ col. 2)	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	
	1	2	3	4	5	6	7	8	9	1
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapy										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 All Others (1)										19
20 Totals (sum of lines 1-19)										20

(1) Enter amount in column 1 from Worksheet J-1, Part I, column 28, line 21.

FORM CMS-2552-10(10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4054.1) 40-628

09-13	FORM CMS-2552-10		4090 (Cont.)
COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-2,
		FROM	PART II
	COMPONENT CCN:	то	

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

	(From				Title V		Title XVIII		Title XIX	T
	Wkst. J-1,	Total	Ratio of	Title V	Component	Title XVIII	Component	Title XIX	Component	
	Part I,	Component	Costs to	Component	costs (col. 3	Component	costs (col. 3	Component	costs (col. 3	
	col. 29)	Charges	Charges (1)	Charges (2)	x col. 4)	Charges (2)	x col. 6)	Charges (2)	x col. 8)	
	1	2	3	4	5	6	7	8	9	1
21 Respiratory Therapy										21
22 Physical Therapy										22
23 Occupational Therapy										23
24 Speech Pathology										24
25 Medical Supplies Charged to Patients										25
26 Implantable Devices Charged to Patients										26
27 Drugs Charged to Patients										27
28 Total (sum of lines 21-28)										28
29 Total component costs. Add the amount from Part I, line 20										25
and the amounts from line 28, columns 5, 7, and 9. (3)										

(1) From Worksheet C, Part I, column 9, lines as appropriate

(2) Charges for columns 4 and 8 are obtained from your records.

(3) Transfer the amounts on line 28, columns 5, 7, and 9, as appropriate, to Worksheet J-3, line 1.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4054.2)

4090 (Cont.)	FORM CMS-2552-10			09-13
CALCULATION OF REIMBURSEMENT SETTLEMENT COMMU	JNITY PROVIDER CCN	PERIOD:	WORKSHEET J-3	
MENTAL HEALTH CENTER PROVIDER SERVICES		FROM		
	COMPONENT CO	CN: TO		

Check					
applicable	[] Title V	[] Title XVIII	[] Title XIX		
boxes:					
				PROGRAM	
				COST	
	es (from Worksheet J-2, Part II,	line 29)			1
2 PPS payments received ex	xcluding outliers				2
3 Outlier payments					3
4 Primary payer payments					4
5 Total reasonable cost (see	,				5
6 Total charges for program					6
CUSTOMARY CHARGE					
	ly collected from patients liable				7
	been realized from patients liabl		a charge		8
	een made in accordance with 42				8
	not to exceed 1.000000) (see ins	structions)			9
10 Total customary charges					10
	ges over reasonable cost (see in				11
	over customary charges (see in				12
COMPUTATION OF RE	IMBURSEMENT SETTLEME	NT			
13 Total reasonable cost (fro	m line 5)				13
14 Part B deductible billed to	o program patients				14
15 Net cost (line 13 minus lin	ne 14)				15
16 Excess of reasonable cost	over customary charges (from l	line 12)			16
17 Subtotal (line 15 minus li	ne 16)				17
18 80 percent of costs (80%	of line 17) (see instructions)				18
19 Actual coinsurance billed	to program patients (from provi	ider records)			19
20 Net cost less actual billed	coinsurance (line 17 minus line	e 19)			20
21 Allowable bad debts (from	n provider records) (see instruc	rtions)			21
22 Adjusted reimbursable ba	d debts (see instructions)				22
23 Allowable bad debts for d	lual eligible beneficiaries (see in	nstructions)			23
24 Net reimbursable amount	(see instructions)				24
25 Other adjustments (see in	structions) (specify)				25
26 Total cost (line 24 plus or					26
26.01 Sequestration adjustment	(see instructions)				26.01
27 Interim payments (see in:	structions)				27
28 Tentative settlement (for					28
29 Balance due component/p	program line 26 minus lines 26.0	)1, 27 and 28			29
30 Protested amounts (nonal	lowable cost report items in acco	ordance with CMS Pub. 15-2,	section 115.2)		30

DRAFT

# FORM CMS-2552-10

4090 (Cont.)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH	PROVIDER CCN:	PERIOD:	WORKSHEET J-4
CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		FROM	
	COMPONENT COMPONENT	ТО	

Check applicable	[] Title XVIII					
oxes:						
			L	Part		
DESCRIPTIO	N			1	2	_
				mm/dd/yyyy	Amount	
1 Total interim payme	nts paid to providers					
	yable on individual bills, either					
	ibmitted to the intermediary, for					
	the cost reporting periods. If					
none, write "NONE"						
List separately each			.01			3.0
lump sum adjustmer		Program	.02			3.0
based on subsequent		to	.03			3.0
the interim rate for		Provider	.04			3.0
cost reporting period			.05			3.0
date of each paymer			.50			3.50
If none, write "NON	Е",	Provider	.51			3.53
or enter zero (1).		to	.52			3.52
		Program	.53			3.5
			.54			3.5
Subtotal (sum of line	es 3.01-3.49					
minus sum of lines 3	5.50-3.98)		.99			3.9
Total interim payme	nts (sum of lines 1, 2, and 3.99)					4
(transfer to Workshe	et J-3, line 27)					
D BE COMPLETED BY IN List separately each		Program	.01			5.0
settlement payment		to	.01			5.02
Also show date of ea		Provider	.02			5.02
		Provider	.03			5.50
If none, write "NON	E,"					
or enter zero (1).		to	.51			5.5
		Program	.52			5.52
Subtotal (sum of line						
sum of lines 5.50-5.			.99			5.99
Determine net settle		Program				
(balance due) based		to				
report (see instructio	ns). (1)	Provider	.01			6.0
		to				
		Program	.02			6.02
Total Medicare liabi	lity (see instructions)					
3 Name of Contractor			NPR D	ate (Month, Day, Year)		8

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

4090 (Cont.)			FOF	RM CMS-255	2-10					DI	RAFT
ANALYSIS OF HOSPITAL-BASED					PROVIDER CCI	N:	_	PERIOD:		WORKSHEET	K
HOSPICE COSTS								FROM			
					HOSPICE CCN:		_	то			
		EMPLOYEE		CONTRACTED							
	SALARIES	BENEFITS	TRANSPOR-	SERVICES				SUBTOTAL		TOTAL	
COST CENTER DESCRIPTIONS	(from	(from	TATION	(from		TOTAL	RECLASSI-	(col. 6	ADJUST-	(col. 8	
	Wkst. K-1)	Wkst. K-2)	(see inst.)	Wkst. K-3)	OTHER	(cols. 1-5)	FICATION	± col. 7)	MENTS	± col. 9)	
	1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Bldg and Fixt.											1
2 Capital Related Costs-Movable Equip.											2
3 Plant Operation and Maintenance											3
4 Transportation - Staff											4
5 Volunteer Service Coordination											5
6 Administrative and General											6
INPATIENT CARE SERVICE											
7 Inpatient - General Care											7
8 Inpatient - Respite Care											8
VISITING SERVICES											
9 Physician Services											9
10 Nursing Care											10
11 Nursing Care-Continuous Home Care											11
12 Physical Therapy											12
13 Occupational Therapy											13
14 Speech/ Language Pathology											14
15 Medical Social Services											15
16 Spiritual Counseling											16
17 Dietary Counseling											17
18 Counseling - Other											18
19 Home Health Aide and Homemaker											19
20 HH Aide & Homemaker - Cont. Home Care											20
21 Other											21
OTHER HOSPICE SERVICE COSTS											
22 Drugs, Biological and Infusion Therapy											22
23 Analgesics											23
24 Sedatives / Hypnotics											25
25 Other - Specify											25
26 Durable Medical Equipment/Oxygen											26
27 Patient Transportation											27
28 Imaging Services											28
29 Labs and Diagnostics											29
30 Medical Supplies											30
31 Outpatient Services (including E/R Dept.)											31
32 Radiation Therapy											32
33 Chemotherapy											33
34 Other											34
HOSPICE NONREIMBURSABLE SERVICE											
35 Bereavement Program Costs											35
36 Volunteer Program Costs											36
37 Fundraising											37
38 Other Program Costs											38
39 Total (sum of lines 1 thru 38)											39

DRAFT	FORM CMS	5-2552-10	4090 (Cont.)							
HOSPICE COMPENSATION ANALYSIS				PROVIDER CCN	J:	_	PERIOD:		WORKSHEET K	(-1
SALARIES AND WAGES							FROM			
				HOSPICE CCN:		_	то			
			MEDICAL							1
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	1
GENERAL SERVICE COST CENTERS										
<ol> <li>Capital Related Costs-Bldg and Fixt.</li> </ol>										1
2 Capital Related Costs-Movable Equip.										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff										4
5 Volunteer Service Coordination										5
6 Administrative and General										6
INPATIENT CARE SERVICE										<u> </u>
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										11
13 Occupational Therapy										13
14 Speech/ Language Pathology										13
15 Medical Social Services							_			14
16 Spiritual Counseling										15
17 Dietary Counseling										17
17 Dietary Counseling 18 Counseling - Other							_			17
19 Home Health Aide and Homemaker										10
20 HH Aide & Homemaker - Cont. Home Care							_			20
										20
21 Other OTHER HOSPICE SERVICE COSTS										21
										22
22 Drugs, Biological and Infusion Therapy						-				
23 Analgesics										23 24
24 Sedatives / Hypnotics						-				
25 Other - Specify										25
26 Durable Medical Equipment/Oxygen						-	-			26 27
27 Patient Transportation									+	
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										<u> </u>
35 Bereavement Program Costs					ļ					35
36 Volunteer Program Costs			ļ							36
37 Fundraising										37
38 Other Program Costs										38
39 Total (sum of lines 1 thru 38) (1) Transfer the amount in column 9 to Wkst K, column 1										39

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

4090 (Cont.)	FORM CMS		DRAFT							
HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)				PROVIDER CC	N:	_	PERIOD: FROM		WORKSHEET K-2	
DENEFITS (FATROLL RELATED)				HOSPICE CCN:			TO			
COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS 4	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER 8	TOTAL (1)	
GENERAL SERVICE COST CENTERS	1	2	3	4	5	6	/	8	9	
1 Capital Related Costs-Bldg and Fixt.										1
2 Capital Related Costs-Didg and Fixt.										2
3 Plant Operation and Maintenance						-	-		-	3
4 Transportation - Staff									+	4
5 Volunteer Service Coordination										5
6 Administrative and General										6
INPATIENT CARE SERVICE										0
7 Inpatient - General Care										7
8 Inpatient - Respite Care										8
VISITING SERVICES										0
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care-Continuous Home Care										10
12 Physical Therapy										11
13 Occupational Therapy										12
14 Speech/ Language Pathology										13
14 Speech Language Pathology 15 Medical Social Services									-	14
16 Spiritual Counseling										
										16
17 Dietary Counseling										17 18
18 Counseling - Other 19 Home Health Aide and Homemaker										-
										19
20 HH Aide & Homemaker - Cont. Home Care				_						20
21 Other										21
OTHER HOSPICE SERVICE COSTS										22
22 Drugs, Biological and Infusion Therapy										22
23 Analgesics										23
24 Sedatives / Hypnotics										24
25 Other - Specify										25
26 Durable Medical Equipment/Oxygen										26
27 Patient Transportation										27
28 Imaging Services										28
29 Labs and Diagnostics										29
30 Medical Supplies										30
31 Outpatient Services (including E/R Dept.)										31
32 Radiation Therapy										32
33 Chemotherapy										33
34 Other										34
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										35
36 Volunteer Program Costs										36
37 Fundraising										37
38 Other Program Costs										38
39 Total (sum of lines 1 thru 38) (1) Transfer the amount in column 9 to Wkst K column 2										39

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

09-13	FORM CMS	S-2552-10		4090 (Cont.)							
HOSPICE COMPENSATION ANALYSIS				PROVIDER CCN	N:		PERIOD:		WORKSHEET K-3		
CONTRACTED SERVICES/PURCHASED SERVICES							FROM				
				HOSPICE CCN:			то				
			MEDICAL								
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL					
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)		
	1	2	3	4	5	6	7	8	9		
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Bldg and Fixt.									1	1	
2 Capital Related Costs-Movable Equip.										2	
3 Plant Operation and Maintenance										3	
4 Transportation - Staff										4	
5 Volunteer Service Coordination										5	
6 Administrative and General										6	
INPATIENT CARE SERVICE											
7 Inpatient - General Care										7	
8 Inpatient - Respite Care										8	
VISITING SERVICES											
9 Physician Services										9	
10 Nursing Care										10	
11 Nursing Care-Continuous Home Care										11	
12 Physical Therapy									-	11	
13 Occupational Therapy										13	
14 Speech/ Language Pathology										13	
15 Medical Social Services										14	
16 Spiritual Counseling										15	
17 Dietary Counseling										10	
17 Dietary Counseling 18 Counseling - Other										17	
										18	
19 Home Health Aide and Homemaker											
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		L								28	
29 Labs and Diagnostics									-	29	
30 Medical Supplies										30	
31 Outpatient Services (including E/R Dept.)										31	
32 Radiation Therapy										32	
33 Chemotherapy										33	
34 Other										34	
HOSPICE NONREIMBURSABLE SERVICE											
35 Bereavement Program Costs										35	
36 Volunteer Program Costs										36	
37 Fundraising										37	
38 Other Program Costs										38	
39 Total (sum of lines 1 thru 38)										39	

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

4090 (0	Cont.)			FORM CMS	5-2552-10						09-13
COST AL	LOCATION - HOSPICE GENERAL SERVICE COST				PROVIDER CC	N:	_	PERIOD: FROM		WORKSHEET PART I	'К-4,
					HOSPICE CCN:		_	TO			
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION 0	CAPITAL RE BUILDINGS & FIXTURES 1	LATED COST MOVABLE EQUIPMENT 2	PLANT OPERATION & MAINT. 3	TRANS- PORTATION 4	VOLUNTEER SERVICES COORDI- NATOR 5	SUBTOTAL (cols. 0 - 5) 5A	ADMINIS- TRATIVE & GENERAL 6	TOTAL (col. 5 ± col. 6) 7	
GI	ENERAL SERVICE COST CENTERS	0	1		5	-	5	5/1	0	,	_
	apital Related Costs-Bldg and Fixt.										1
	apital Related Costs-Movable Equip.										2
	ant Operation and Maintenance										3
	ansportation - Staff										4
	olunteer Service Coordination										5
	dministrative and General										6
	IPATIENT CARE SERVICE										+
	patient - General Care										7
	patient - Respite Care										8
	ISITING SERVICES										Ť
	hysician Services										9
	ursing Care										10
	ursing Care-Continuous Home Care										11
	nysical Therapy										12
	ccupational Therapy										13
	peech/ Language Pathology										13
	edical Social Services										15
	piritual Counseling										16
	ietary Counseling										10
	punseling - Other										18
	ome Health Aide and Homemaker										10
	H Aide & Homemaker - Cont. Home Care										20
21 Ot											21
	THER HOSPICE SERVICE COSTS										
	rugs, Biological and Infusion Therapy							-			22
	nalgesics										23
	edatives / Hypnotics										24
	ther - Specify				1						25
	urable Medical Equipment/Oxygen										26
	tient Transportation	1						1		1	27
	haging Services										28
	abs and Diagnostics										29
	edical Supplies									1	30
	utpatient Services (including E/R Dept.)										31
	adiation Therapy										32
	nemotherapy										33
34 Ot											34
	OSPICE NONREIMBURSABLE SERVICE										
	ereavement Program Costs										35
	olunteer Program Costs									1	36
	Indraising									1	37
	ther Program Costs							1			38
	otal (sum of lines 1 thru 38)				1						39

09-13		FORM CMS-2552-10							
COST ALLOCATION - HOSPICE STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET K-4	4,	
					FROM		PART II		
			HOSPICE CCN:		TO	_			
		LATED COST	PLANT		VOLUNTEER		ADMINIS-		
	BUILDINGS	MOVABLE	OPERATION	TRANS-	SERVICES		TRATIVE &		
COST CENTER DESCRIPTIONS	& FIXTURES	EQUIPMENT	& MAINT.	PORTATION	COORDINATOR	RECONCIL-	GENERAL		
	(SQ. FT.)	(\$ VALUE)	(SQ. FT.)	(MILEAGE)	(HOURS)	IATION	(ACC. COST)	_	
GENERAL SERVICE COST CENTERS	1	2	3	4	5	6A	6	-	
1 Capital Related Costs-Bldg and Fixt.								1	
2 Capital Related Costs-Movable Equip.								2	
3 Plant Operation and Maintenance								3	
4 Transportation - Staff								5	
5 Volunteer Service Coordination								5	
6 Administrative and General								6	
INPATIENT CARE SERVICE								+	
7 Inpatient - General Care								7	
8 Inpatient - Respite Care								8	
VISITING SERVICES								- 0	
9 Physician Services								9	
10 Nursing Care								10	
10 Nursing Care-Continuous Home Care								10	
12 Physical Therapy								11	
13 Occupational Therapy								12	
14 Speech/ Language Pathology								13	
15 Medical Social Services								14	
16 Spiritual Counseling								15	
								16	
17 Dietary Counseling								17	
<ul><li>18 Counseling - Other</li><li>19 Home Health Aide and Homemaker</li></ul>								10	
20     HH Aide & Homemaker - Cont. Home Care       21     Other								20	
								21	
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy								22	
23 Analgesics									
24 Sedatives / Hypnotics								24	
25 Other - Specify								25 26	
26 Durable Medical Equipment/Oxygen									
27 Patient Transportation								27 28	
28 Imaging Services								28	
29 Labs and Diagnostics			+						
30 Medical Supplies			+					30	
31 Outpatient Services (including E/R Dept.)								31	
32 Radiation Therapy								32	
33 Chemotherapy								33	
34 Other HOSPICE NONREIMBURSABLE SERVICE								34	
								- 25	
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, Part I)								39	
40 Unit Cost Multiplier								40	

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4061)

	(Cont.) CATION OF GENERAL SERVICE		FC	ORM CMS-2	PROVIDER CCN: PERIOD: WORKSH						
	S TO HOSPICE COST CENTERS				PROVIDER CC	_IN				PART I	
0.0313	5 TO HOSPICE COST CENTERS				HOSDICE CON	I:		FROM TO	PARII		
DADT	I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSP	CE COST CENT	TDC		HUSPICE CCN			10			
PARI	1- ALLOCATION OF GENERAL SERVICE COS15 TO HOSPI	ICE COST CENT	EKS	1						1	
		From	HOSPICE	CAL	PITAL						
	HOSPICE COST CENTER	Wkst. K-4	TRIAL		D COSTS	EMPLOYEE		ADMINIS-	MAIN-		1
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	1
	(onit cents)	col. 7,	(1)	FIXTURES		DEPARTMENT		GENERAL	REPAIRS	OF PLANT	1
		line	0	1	2	4	4A	5	6	7	ł
1	Administrative and General	6	0	1	2	4	4A	5	0	/	
	Inpatient - General Care	7									
	Inpatient - Respite Care	8									
	Physician Services	9									
	Nursing Care	10	+					+	+	+	
	Nursing Care-Continuous Home Care	10									6
	Physical Therapy	11									
	Occupational Therapy	12									
	Speech/ Language Pathology	13									
	Medical Social Services	14									10
	Spiritual Counseling	15									11
	Dietary Counseling	16									12
											12
	Counseling - Other Home Health Aide and Homemaker	18									13
	Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care	19									12
		20									19
	Other	21									17
	Drugs, Biological and Infusion Therapy	22									
	Analgesics	23									18
19	Sedatives / Hypnotics	24									19
	Other - Specify	25									20
	Durable Medical Equipment/Oxygen	26									2
	Patient Transportation	27									22
	Imaging Services	28									23
	Labs and Diagnostics	29									24
	Medical Supplies	30									25
	Outpatient Services (including E/R Dept.)	31									20
	Radiation Therapy	32									2
	Chemotherapy	33		ļ				ļ			2
	Other	34									29
	Bereavement Program Costs	35									3
	Volunteer Program Costs	36									3
	Fundraising	37	ļ	ļ	1			ļ	l		3
	Other Program Costs	38							L		3
	Totals (sum of lines 1-33) (2)										34
35	Unit Cost Multiplier (see instructions)										35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

	2			FC	ORM CMS-2	552-10	4090 (Cont.)					
ALLO	CATION OF GENERAL SERVICE					PROVIDER CC	N:		PERIOD:		WORKSHEET K-5,	
COST	S TO HOSPICE COST CENTERS								FROM		PART I (Cont.)	)
						HOSPICE CCN	:		то			
PART	I - ALLOCATION OF GENERAL SERVICE C	OSTS TO HOSPIC	E COST CENT	ERS							•	
												T
	HOSPICE COST CENTER	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
	(omit cents)	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
		SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
		8	9	10	11	12	13	14	15	16	17	7
	Administrative and General											1
2	Inpatient - General Care											2
	Inpatient - Respite Care											3
	Physician Services											4
	Nursing Care											5
	Nursing Care-Continuous Home Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech/ Language Pathology											9
	Medical Social Services											10
11	Spiritual Counseling											11
	Dietary Counseling											12
	Counseling - Other											13
14	Home Health Aide and Homemaker											14
15	HH Aide & Homemaker - Cont. Home Care											15
	Other											16
17	Drugs, Biological and Infusion Therapy											17
	Analgesics											18
19	Sedatives / Hypnotics											19
	Other - Specify											20
	Durable Medical Equipment/Oxygen											21
22	Patient Transportation											22
23	Imaging Services											23
	Labs and Diagnostics											24
	Medical Supplies											25
	Outpatient Services (including E/R Dept.)											26
	Radiation Therapy											27
	Chemotherapy											28
	Other									1		29
	Bereavement Program Costs											30
	Volunteer Program Costs									1		31
	Fundraising											32
	Other Program Costs				1			1		1	1	33
	Totals (sum of lines 1-33) (2)											34
	Unit Cost Multiplier (see instructions)											35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

4090 (Cont.) ALLOCATION OF GENERAL SERVICE				FU	RM CMS-2		CN:		PERIOD:	10-12 WORKSHEET K-5.		
COSTS TO HOSPICE COST CENTERS						PROVIDER C	CN:		FROM		PART I (Cont.)	
COSTS TO HOSPICE COST CENTERS						HOSPICE CC	NT.		TO	PARTI (Coll.)		
PART I - ALLOCATION OF GENERAL SERVIC		SDICE COST (	ENTEDS			HUSPICE CC.	N		10			
PART I - ALLOCATION OF GENERAL SERVIC		SPICE COST C	ENTERS	r –		1		INTERN &	r –			
		NON-				PARA-		RESIDENT		ALLOCATED	TOTAL	Í
HOSPICE COST CENTER	OTHER	PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL		COST & POST	-	HOSPICE	HOSPICE	Í
(omit cents)	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	-	SUBTOTAL			A&G (see	COSTS	Í
(onit cents)	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)	ADJUST.	$(cols. 24 \pm 25)$	Part II)	$(cols. 26 \pm 27)$	1
	`8	19	20	21	22	23	24	25	26	27	28	ł
1 Administrative and General	0	15	20	21		23	24	25	20	2/	20	1
2 Inpatient - General Care												2
3 Inpatient - Respite Care												3
4 Physician Services												4
5 Nursing Care												5
6 Nursing Care-Continuous Home Care												6
7 Physical Therapy												7
8 Occupational Therapy												8
9 Speech/ Language Pathology												9
10 Medical Social Services												10
11 Spiritual Counseling												10
12 Dietary Counseling									-			11
13 Counseling - Other												12
14 Home Health Aide and Homemaker				-					-			13
15 HH Aide & Homemaker - Cont. Home Care												15
16 Other												16
17 Drugs, Biological and Infusion Therapy												17
18 Analgesics												18
19 Sedatives / Hypnotics												19
20 Other - Specify												20
21 Durable Medical Equipment/Oxygen												21
22 Patient Transportation												22
23 Imaging Services												23
24 Labs and Diagnostics												23
25 Medical Supplies												25
26 Outpatient Services (including E/R Dept.)												26
27 Radiation Therapy												20
28 Chemotherapy									1			28
29 Other												29
30 Bereavement Program Costs												30
31 Volunteer Program Costs												31
32 Fundraising												32
33 Other Program Costs												33
34 Totals (sum of lines 1-33) (2)												34
35 Unit Cost Multiplier (see instructions)												35

Column 0, line 34 must agree with Wkst. A, column 7, line 116.
 Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

09-1	3	FORM CMS-						4090 (Cont.		
	CATION OF GENERAL SERVICE COSTS TO ICE COST CENTERS STATISTICAL BASIS			PROVIDER CCN:	·	PERIOD: FROM TO		WORKSHEET K-5, PART II		
PART	II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	ENTERS - STATISTI	CAL BASIS	HOSTICE CON.						
1/11/1	HOSPICE COST CENTER	CAP	TTAL ED COST EQUIPMENT (DOLLAR VALUE) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 5A	ADMINIS- TRATIVE & GENERAL (ACCUM. COST) 5	MAIN- TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7		
1	Administrative and General	1	2	4	ЪА	5	0	/	1	
	Inpatient - General Care					+			2	
	Inpatient - Respite Care								3	
	Physician Services					+		1	4	
	Nursing Care					+	1	1	5	
	Nursing Care-Continuous Home Care						1		6	
	Physical Therapy								7	
	Occupational Therapy								8	
9	Speech/ Language Pathology								9	
10	Medical Social Services								10	
	Spiritual Counseling								11	
	Dietary Counseling								12	
	Counseling - Other								13	
	Home Health Aide and Homemaker								14	
	HH Aide & Homemaker - Cont. Home Care								15	
16	Other								16	
17	Drugs, Biological and Infusion Therapy								17	
									18	
	Sedatives / Hypnotics								19	
20	Other - Specify								20	
21	Durable Medical Equipment/Oxygen								21	
	Patient Transportation								22	
23	Imaging Services								23	
24	Labs and Diagnostics								24	
25	Medical Supplies								25	
26	Outpatient Services (including E/R Dept.)								26	
27	Radiation Therapy								27	
	Chemotherapy								28	
29	Other								29	
	Bereavement Program Costs								30	
									31	
	Fundraising								32	
	Other Program Costs								33	
	Totals (sum of lines 1-33) (2)								34	
35	Total cost to be allocated								35	
36	Unit Cost Multiplier (see instructions)								36	

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

4090	(Cont.)			FO	RM CMS-255	2-10		09-13			
ALLO	CATION OF GENERAL SERVICE COSTS TO					PROVIDER CCN		PERIOD:		WORKSHEET K-	-5,
HOSP	ICE COST CENTERS STATISTICAL BASIS							FROM		PART II (Cont.)	
						HOSPICE CCN: _		ТО			
PART	II - ALLOCATION OF GENERAL SERVIC	E COSTS TO HOSE	PICE COST CENT	TERS - STATISTI	CAL BASIS			-			
	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	-
1	Administrative and General										1
2	Inpatient - General Care										2
3	Inpatient - Respite Care										3
	Physician Services										4
	Nursing Care										5
	Nursing Care-Continuous Home Care										6
	Physical Therapy										7
	Occupational Therapy										8
	Speech/ Language Pathology										9
	Medical Social Services										10
	Spiritual Counseling										11
	Dietary Counseling										12
	Counseling - Other										13
	Home Health Aide and Homemaker										14
	HH Aide & Homemaker - Cont. Home Care										15
	Other										16
	Drugs, Biological and Infusion Therapy										17
	Analgesics										18
	Sedatives / Hypnotics										19
	Other - Specify										20
	Durable Medical Equipment/Oxygen										21
	Patient Transportation										22
	Imaging Services										23
	Labs and Diagnostics										24
	Medical Supplies										25
	Outpatient Services (including E/R Dept.)										26
	Radiation Therapy										27
	Chemotherapy										28
	Other										29
	Bereavement Program Costs										30
	Volunteer Program Costs					l					31
	Fundraising										32
	Other Program Costs										33
	Totals (sum of lines 1-33) (2)										34
	Total cost to be allocated										35
- 36	Unit Cost Multiplier (see instructions)										36

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS       PROVIDER CCN:	4090 (Cont. WORKSHEET K-5, PART II (Cont.) PARA- MEDICAL EDUCATION
PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS         NON-         INTERNS & RESIDENTS           HOSPICE COST CENTER         SOCIAL         OTHER         ANES-         THURSING         SALARY & PROGRAM           HOSPICE COST CENTER         SERVICE         GENERAL         THETISTS         SCHORD         (ASSIGNED)         (AS	MEDICAL EDUCATION
HOSPICE COST CENTER         SOCIAL SERVICE SPENT)         OTHER GENERAL SERVICE SPENT)         OTHER ANES- GENERAL (ASSIGNED (ASSIGNED)         INTERNS & RESIDENTS SALARY & PROGRAM FRINCES           1         Administrative and General         INTERNS & RESIDENTS         SCHOOL (ASSIGNED)         FRINCES (ASSIGNED)         COSTS (ASSIGNED)           1         Inpatient - General Care         INTERNS & RESIDENTS         TIME)         TIME)         TIME)           1         Inpatient - Respice Care         Inpatient - General Care         INTERNS & RESIDENTS         COSTS           4         Physican Services         Inpatient - General Care         INTERNS & RESIDENTS         COSTS           4         Physican Services         INTERNS & RESIDENTS         INTERNS & RESIDENTS         COSTS           5         Nursing Care-Continuous Home Care         INTERNS & RESIDENTS         INTERNS & RESIDENTS           9         Speech / Language Pathology         INTERNS & RESIDENTS         INTERNS & RESIDENTS           10         Medical Services         INTERNS & RESIDENTS         INTERNS & RESIDENTS           10         Medical Services         INTERNS & RESIDENTS         INTERNS & RESIDENTS           11         Sprintul Counseling         INTERNS & RESIDENTS         INTERNS & RESIDENTS           12         Diteary Counseling         INTER	MEDICAL EDUCATION
Hospice cost center         SOCIAL SERVICE SERVICE         OTHER GENERAL SERVICE SERVICE         OTHER ANESS GENERAL SERVICE         OTHER ANESS CHOL SERVICE         INTENSIS SCHOL (ASSIGNED         INTENSIS SCHOL (ASSIGNED         INTENSIS SCHOL (ASSIGNED           1         Administrative and General         17         18         19         20         21         22           2         Inpatient - General Care         1         1         19         20         21         21           3         Inpatient - General Care         1         1         1         19         20         21         21           4         Physical Services         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1	MEDICAL EDUCATION
1Administrative and GeneralImage: Ceneral CareImage: Ceneral CareImage: Ceneral Care3Inpatient - Respite CareImage: CareImage: CareImage: Care4Physician ServicesImage: CareImage: CareImage: Care5Nursing Care-Continuous Home CareImage: CareImage: CareImage: Care6Nursing Care-Continuous Home CareImage: CareImage: CareImage: Care7Physical TherapyImage: CareImage: CareImage: Care8Occupational TherapyImage: CareImage: CareImage: Care9Speech/ Language PathologyImage: CareImage: CareImage: Care10Medical Social ServicesImage: CareImage: CareImage: Care11Spiritual CounselingImage: CareImage: CareImage: Care12Dietary CounselingImage: CareImage: CareImage: Care13Counseling - OtherImage: CareImage: CareImage: Care14Home Health Aide and HomemakerImage: CareImage: CareImage: Care15HH Aide & HomemakerImage: CareImage: CareImage: Care16OtherImage: CareImage: CareImage: Care19Sedatives / HypoticsImage: CareImage: CareImage: Care20Other - SpecifyImage: CareImage: CareImage: Care21Durable Medical Equipment/OxygenImage: CareImage: CareImage: Care22Patie	(SPECIFY) (ASSIGNED TIME)
2Inpatient - General CareImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care3Inpatient - Respite CareImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care4Physician ServicesImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care5Nursing CareImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care6Nursing Care-Continuous Home CareImpatient - Respite CareImpatient - Respite Care7Physical TherapyImpatient - Respite CareImpatient - Respite Care8Occupational TherapyImpatient - Respite CareImpatient - Respite Care9Speech/ Language PathologyImpatient - Respite CareImpatient - Respite Care10Medical Social ServicesImpatient - Respite CareImpatient - Respite Care11Spiritual CounselingImpatient - Respite CareImpatient - Respite Care12Dietary CounselingImpatient - Respite CareImpatient - Respite Care13Counseling - OtherImpatient - Respite CareImpatient - Respite Care14Home Health Aide and HomemakerImpatient - Respite CareImpatient - Respite Care15HH Aide & Homemaker - Cont. Home CareImpatient - Respite CareImpatient - Respite Care16OtherImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care13Spite CareImpatient - Respite CareImpatient - Respite CareImpatient - Respite Care <td>23</td>	23
3Inpatient - Respite Care </td <td></td>	
4Physician ServicesImage: ConstructionImage:	
5Nursing CareImage: Continuous Home CareImage: Continuous Home CareImage: Continuous Home Care7Physical TherapyImage: Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Content of Con	
6Nursing Care-Continuous Home CareImage CareIm	
7Physical TherapyImage: Comparison of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of	
8       Occupational Therapy       Image Pathology       Image Pathology         9       Speech/ Language Pathology       Image Pathology       Image Pathology         10       Medical Social Services       Image Pathology       Image Pathology         11       Medical Social Services       Image Pathology       Image Pathology         12       Dietary Counseling       Image Pathology       Image Pathology         13       Spiritual Counseling       Image Pathology       Image Pathology         14       Home Health Aide and Homemaker       Image Pathology       Image Pathology         14       Home Health Aide and Homemaker       Image Pathology       Image Pathology       Image Pathology         15       HH Aide & Homemaker - Cont. Home Care       Image Pathology       Image Pathology       Image Pathology       Image Pathology         16       Other       Image Pathology       Ima	
9Speech/ Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology10Medical Social ServicesImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology11Spiritual CounselingImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology12Dietary CounselingImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology13Durable Medical Equipment/OxygenImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology14Home Health Aide and HomemakerImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology14Home Health Aide and HomemakerImage: Speech / Language PathologyImage: Speech / Language PathologyImage: Speech / Language Pathology15HH Aide & Homemaker - Cont. Home CareImaging ServicesImaging ServicesImaging Services16OtherImaging ServicesImaging ServicesImaging ServicesImaging Services	8
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11Spiritual CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: CounselingImage: Counsel	10
12Dietary CounselingImage: Conseling - OtherImage: Conseling - OtherImage: Conseling - Other13Counseling - OtherImage: Conseling - OtherImage: Conseling - OtherImage: Conseling - Other14Home Health Aide and HomemakerImage: Conseling - OtherImage: Conseling - OtherImage: Conseling - Other16OtherImage: Conseling - OtherImage: Conseling - OtherImage: Conseling - Other17Drugs, Biological and Infusion TherapyImage: Conseling - OtherImage: Conseling - Other18AnalgesicsImage: Conseling - OtherImage: Conseling - Other19Sedatives / HypnoticsImage: Conseling - OtherImage: Conseling - Other20Other - SpecifyImage: Conseling - OtherImage: Conseling - Other21Durable Medical Equipment/OxygenImage: Conseling - OtherImage: Conseling - Other23Imaging ServicesImaging ServicesImage: Conseling - OtherImage: Conseling - Other	1
13Counseling - OtherImage: Counseling - OtherImage: Counseling - Other14Home Health Aide and HomemakerImage: Counseling - OtherImage: Counseling - Other16OtherImage: Counseling - OtherImage: Counseling - Other17Drugs, Biological and Infusion TherapyImage: Counseling - OtherImage: Counseling - Other18AnalgesicsImage: Counseling - OtherImage: Counseling - Other19Sedatives / HypnoticsImage: Counseling - OtherImage: Counseling - Other20Other - SpecifyImage: Counseling - OtherImage: Counseling - Other21Durable Medical Equipment/OxygenImage: Counseling - OtherImage: Counseling - Other23Imaging ServicesImage: Counseling - OtherImage: Counseling - Other	12
14Home Health Aide and HomemakerImage: Cont. Home CareImage: Cont. Home CareImage: Cont. Home Care15HH Aide & Homemaker - Cont. Home CareImage: Cont. Home CareImage: Cont. Home Care16OtherImage: Cont. Home CareImage: Cont. Home Care17Drugs, Biological and Infusion TherapyImage: Cont. Home CareImage: Cont. Home Care18AnalgesicsImage: Cont. Home CareImage: Cont. Home Care19Sedatives / HypnoticsImage: Cont. Home CareImage: Cont. Home Care20Other - SpecifyImage: Cont. Home CareImage: Cont. Home Care21Durable Medical Equipment/OxygenImage: Cont. Home CareImage: Cont. Home Care22Patient TransportationImage: Cont. Home CareImage: Cont. Home Care23Imaging ServicesImage: Cont. Home CareImage: Cont. Home Care	1
15HH Aide & Homemaker - Cont. Home CareImage: Content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the c	14
16OtherImage: Constraint of the systemImage:	1
17Drugs, Biological and Infusion TherapyImage of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	10
18     Analgesics     Images in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	1
19       Sedatives / Hypnotics       Image: Constraint of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the sys	18
20       Other - Specify       Image: Constraint of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specif	19
21       Durable Medical Equipment/Oxygen       Imaging Services       Imaging Services         22       Patient Transportation       Imaging Services       Imaging Services	20
22         Patient Transportation	2
23 Imaging Services	22
	2
24 Labs and Diagnostics	24
25 Medical Supplies	2
25 Middau Supplies	20
20 Radiatin Strategy Including Dir Dept.)	2
28 Chemotherapy	20
29 Other Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Constant Con	29
30     Bereavement Program Costs	30
31 Volunteer Program Costs	3:
2 Fundraising 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	33
33 Other Program Costs	33
34 Totals (sum of lines 1-33) (2)	34
35 Total cost to be allocated	3
36 Unit Cost Multiplier (see instructions)	30

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

4090	(Cont.)	FORM CMS-2	4 CMS-2552-10								
APPO	RTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: _		PERIOD:		WORKSHEET K-5	j,				
				FROM		PART III					
		HOSPICE CCN:		то							
PART	<b>III - COMPUTATION OF TOTAL HOSPICE SHAP</b>	RED COSTS				•					
			Wkst. C, Part I,	Cost to	Total Hospice Charges	Hospice Shared Ancillary					
	COCECENTER	col. 9,	Charge	(Provider	Costs						
	COST CENTER	line 0	Ratio	Records)	(cols. 1 x 2)	4					
	ANCILLARY SERVICE COST CENTERS		0	1	2	5					
1	Physical Therapy		66				1				
2	Occupational Therapy		67				2				
3	Speech/ Language Pathology		68				3				
4	Drugs, Biological and Infusion Therapy		73				4				
5	Durable Medical Equipment/Oxygen		96				5				
6	Labs and Diagnostics		60				6				
	Medical Supplies		71				7				
	Outpatient Services (including E/R Dept.)		93				8				
	Radiation Therapy		55				9				
10	Other		76				10				
11	Totals (sum of lines 1-10)						11				

03-1	4	FORM C	CMS-2552-10		4090 (Con		
CALC	ULATION OF HOSPICE PER DIEM COST	PROVIDER CCN:		PERIOD: FROM		WORKSHEET K-	6
		HOSPICE CCN:		TO			
						1	
	COMPUTATION OF PER DIEM COST		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
			1	2	3	4	
1	Total cost (see instructions)						1
2	Total unduplicated days (Worksheet S-9, column 6					2	
3	Average cost per diem (line 1 divided by line 2)						3
4	Unduplicated Medicare days (Worksheet S-9, colur	nn 1, line 5)					4
5	Aggregate Medicare cost (line 3 times line 4)						5
6	Unduplicated Medicaid days (Worksheet S-9, colu	nn 2, line 5)					6
7	Aggregate Medicaid cost (line 3 times line 6)						7
8	Unduplicated SNF days (Worksheet S-9, column 3,	line 5)					8
9	Aggregate SNF cost (line 3 times line 8)						9
10	Unduplicated NF days (Worksheet S-9, column 4, l	ine 5)					10
11	Aggregate NF cost (line 3 times line 10)						11
12	Other Unduplicated days (Worksheet S-9, column 5	5, line 5)					12
13	Aggregate cost for other days (line 3 times line 12)						13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

4090 (Cont.)		FORM	FORM CMS-2552-10							
CALCULATION OF C	APITAL PAYMENT	PROVIDER CCN	:	PERIOD: FROM		WORKSHEET L				
		COMPONENT CO	CN:	то						
Check	[] Title V		[] Hospital		[] PPS					
applicable	[] Title XVIII,	Part A	[] Subprovider (or	ther)	[] Cost Method					
boxes:	[] Title XIX		[] ===F====(=	)	[]					
	OSPECTIVE METHOD									
	ERAL AMOUNT									
1 Capital DRG of							1			
1	Capital DRG other than outlier						1.01			
2 Capital DRG ou							2			
	Capital DRG outlier payments						2.01			
	lays divided by number of day	s in the cost reporting p	eriod (see instructions)				3			
<b>.</b>	ns & residents (see instruction	1 01	(				4			
5 Indirect medical	education percentage (see ins	tructions)					5			
	education adjustment (multip		ines 1 and 1.01)				6			
	SI recipient patient days to Me	5	/	line 30) (see instru	(ctions)		7			
	ledicaid patient days to total da		, , , , , , , , , , , , , , , , , , , ,				8			
9 Sum of lines 7 a		J- ()					9			
	oportionate share percentage	see instructions)					10			
	e share adjustment (line 10 tim		d 1.01)				11			
	e capital payments (sum of lin						12			
PART II - PAYMENT	UNDER REASONABLE C	OST	,							
1 Program inpatie	nt routine capital cost (see ins	tructions)					1			
2 Program inpatie	nt ancillary capital cost (see in	structions)					2			
3 Total inpatient p	orogram capital cost (line 1 plu	s line 2)					3			
4 Capital cost pay	ment factor (see instructions)	· · · · · · · · · · · · · · · · · · ·					4			
5 Total inpatient p	orogram capital cost (line 3 x l	ne 4)					5			
PART III - COMPUT	ATION OF EXCEPTION P.	AYMENTS				•				
1 Program inpatie	nt capital costs (see instructio	ns)					1			
2 Program inpatie	nt capital costs for extraordina	ry circumstances (see in	nstructions)				2			
3 Net program inp	atient capital costs (line 1 min	us line 2)					3			
4 Applicable exce	ption percentage (see instruct	ons)					4			
	comparison to payments (line						5			
6 Percentage adju	stment for extraordinary circui	nstances (see instructio	ns)				6			
7 Adjustment to c	apital minimum payment leve	for extraordinary circu	mstances (line 2 x line 6	)			7			
8 Capital minimu	m payment level (line 5 plus li	ne 7)		_			8			
9 Current year cap	oital payments (from Part I, lin	e 12 as applicable)					9			
	nparison of capital minimum J			e 9)			10			
11 Carryover of ac	cumulated capital minimum pa	yment level over capita	l payment				11			
	Worksheet L, Part III, line 14									
	of capital minimum payment						12			
	ception payment (if line 12 is p						13			
	cumulated capital minimum pa						14			
	g period (if line 12 is negative,									
	owable operating and capital J	v .	ns)				15			
	erating and capital costs (see i						16			
17 Current year exe	ception offset amount (see ins	ructions)					17			

FORM CMS-2552-10 (03-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4064.1 - 4064.3)

09-1	3	5-2552-10			4090 (Cont.)					
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET I PART I	L-1,
		EXTRA- ORDINARY		PITAL ED COSTS		_				
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0			211	4		0	/	<u> </u>
	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits Department						1			4
5	Administrative and General									5
6	Maintenance and Repairs									6
	Operation of Plant									7
8	Laundry and Linen Service									8
	Housekeeping									9
	Dietary									10
	Cafeteria									11
	Maintenance of Personnel									12
	Nursing Administration									13
	Central Services and Supply									14
										15
	Medical Records & Medical Records Library									16
										17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing School									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Ed. Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									<b></b>
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit Burn Intensive Care Unit		l							32 33
	Surgical Intensive Care Unit Other Special Care Unit (specify)		-							34 35
										40
	Subprovider IPF Subprovider IRF									40
										41 42
	Subprovider									42
	Skilled Nursing Facility									43
	Nursing Facility									44
										45
40	Other Long Term Cale									40

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1)

4690	(Cont.)	5-2552-10	10					9-13		
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM		WORKSHEET L PART I (Cont.)	1,
EAIR	AORDINART CIRCOMSTANCES						TO		PARTI (Cont.)	
		EXTRA-	CAP	ITAL						
		ORDINARY	RELATE	D COSTS						
		CAPITAL			SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION OF PLANT	
		COSTS 0	FIXTURES 1	EQUIPMENT 2	cols. 0-2) 2A	DEPARTMENT 4	GENERAL 5	REPAIRS 6	OF PLANT 7	4
	ANCILLARY SERVICE COST CENTERS	0	1	2	ZA	4	5	0	7	<u> </u>
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
53	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
57	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catherization									59
	Laboratory									60
	PBP Clinical Laboratory Service-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65 66
	Physical Therapy Occupational Therapy									65
	Speech Pathology									68
	Electrocardiology									69
	Electrocardiology									70
	Medical Supplies Charged to Patients									70
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									<u> </u>
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient (specify)									93

09-1	3	8-2552-10			4090 (Cont.					
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET I PART I (Cont.)	1,
		EXTRA- ORDINARY		PITAL ED COSTS						
	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	7	<u> </u>
	Home Program Dialysis									94
	Ambulance Services									94
	Durable Medical Equipment-Rented									95
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									97
	Outpatient Rehabilitation Provider (specify)									90
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									100
	SPECIAL PURPOSE COST CENTERS									0
	Kidney Acquisition									105
	Heart Acquisition									105
	Liver Acquisition	-								100
	Liver Acquisition									107
	Pancreas Acquisition	-								100
110	Intestinal Acquisition	-								110
110	Islet Acquisition	-								110
	Other Organ Acquisition (specify)									111
	Ambulatory Surgical Center (Distinct Part)									112
	Hospice									115
	Other Special Purpose (specify)									110
	SUBTOTALS (sum of lines 1-117)									117
110	SOBIOTALS (suil of lines 1-117)									110
	NONREIMBURSABLE COST CENTERS									<u> </u>
	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
	Negative Cost Centers									200
	Total (sum of line 118 and lines190-201)									201
	Total Statistical Basis									202
	Unit Cost Multiplier									203
204	One Cost multiplier						1		1	204

4090 (Cont.)							09-13				
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES						PROVIDER C		PERIOD: FROM TO		WORKSHEE PART I (Cont	
Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS	0	5	10			10	11	10	10	17	
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment											2
4 Employee Benefits Department											4
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria						1					11
12 Maintenance of Personnel											12
13 Nursing Administration								-			13
14 Central Services and Supply											14
15 Pharmacy 16 Medical Records & Medical Records Library										+	15 16
17 Social Service										<u> </u>	16
18 Other General Service (specify)										<u> </u>	17
19 Nonphysician Anesthetists										<u> </u>	10
20 Nursing School						+				<b> </b>	20
21 Intern & Res. Service-Salary & Fringes (Approved)										<u> </u>	20
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Ed. Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit						1					33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility										<b></b>	45
46 Other Long Term Care											46

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1)

10-12				FORM CM	4S-2552-10				4090 (Cont.)			
	NOF ALLOWABLE COSTS FOR NARY CIRCUMSTANCES			1	1		PROVIDER 0	CCN:	PERIOD: FROM TO		WORKSHEET L-1 PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
ANCILI	ARY SERVICE COST CENTERS		5	10			10		10	10		
50 Operati		-					-					50
51 Recover												51
	Room and Delivery Room											52
53 Anesthe	esiology			-								53
	gy-Diagnostic			-								54
	gy-Therapeutic											55
56 Radiois												56
	ted Tomography (CT) Scan											57
	ic Resonance Imaging (MRI)											58
	Catherization											59
60 Laborat												60
	inical Laboratory Service-Program Only											61
	Blood & Packed Red Blood Cells	-					-					62
	storing, Processing, & Trans.											63
	nous Therapy											64
	tory Therapy											65
66 Physica												66
	tional Therapy											67
68 Speech												68
69 Electroo												69
	encephalography											70
	l Supplies Charged to Patients											71
	able Devices Charged to Patients											72
	Charged to Patients	1										73
74 Renal D		1										74
75 ASC (N	Ion-Distinct Part)	1										75
	ncillary (specify)		İ		1				1			76
	TIENT SERVICE COST CENTERS											
	ealth Clinic (RHC)											88
89 Federal	ly Qualified Health Center (FQHC)	1										89
90 Clinic		1										90
91 Emerge	ncy	1										91
	ation Beds											92
93 Other O	Outpatient (specify)											93

4090	) (Cont.)						10-12					
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES			-	-		PROVIDER C	CCN:	PERIOD: FROM TO		WORKSHEET PART I (Cont.	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS	0	5	10		12	15	14	15	10	17	<u> </u>
94	Home Program Dialysis											94
	Ambulance Services											95
	Durable Medical Equipment-Rented											96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)											98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											100
101	SPECIAL PURPOSE COST CENTERS											101
105	Kidney Acquisition								-			105
	Heart Acquisition											105
	Liver Acquisition											100
	Lung Acquisition											107
	Pancreas Acquisition											100
	Intestinal Acquisition								ł			110
	Islet Acquisition											110
	Other Organ Acquisition (specify)											112
	Ambulatory Surgical Center (Distinct Part)											112
	Hospice											115
	Other Special Purpose (specify)											110
	SUBTOTALS (sum of lines 1-117)											117
110	SOBTOTALS (sum of lines 1-117)											110
	NONREIMBURSABLE COST CENTERS											<u> </u>
190	Gift, Flower, Coffee Shop, & Canteen											190
	Research											191
	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
	Cross Foot Adjustments											200
	Negative Cost Centers											200
	Total (sum of line 118 and lines190-201)											201
	Total Statistical Basis						1		-			202
	Unit Cost Multiplier								<u> </u>			203
204	Cont Cost multiplier											204

4090	) (Cont.)		S-2552-10	0					09-13		
	OCATION OF ALLOWABLE COSTS FOR					PROVIDER CC	N:	PERIOD:		WORKSHEET	L-1,
EXTR	AORDINARY CIRCUMSTANCES							FROM		PART I (Cont.)	
		1	1		1		-	то	INTERN &		
			NON-		INTERNS &	INTERNS &	PARA-		RESIDENT		
		OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	MEDICAL		COST & POST		
	Cost Center Descriptions	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION		STEPDOWN		
	Cost Center Descriptions	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	-
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment	1									2
	Employee Benefits Department	1									4
	Administrative and General	1									5
6	Maintenance and Repairs	1									
	Operation of Plant	]									7
	Laundry and Linen Service										8
	Housekeeping										9
	Dietary										10
	Cafeteria										11
	Maintenance of Personnel										12
	Nursing Administration										13
	Central Services and Supply										14
	Pharmacy										15
	Medical Records & Medical Records Library										16
	Social Service										17
	Other General Service (specify)										18
	Nonphysician Anesthetists										19
	Nursing School					4					20
	Intern & Res. Service-Salary & Fringes (Approved)						1				21
	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Ed. Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit										31
	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	Subprovider IPF										40
	Subprovider IRF										41
	Subprovider										42
	Nursery										43
	Skilled Nursing Facility	+									44 45
	Nursing Facility										
46	Other Long Term Care										46

# FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1)

4690	K690 (Cont.) FORM CMS-2552-10							09-13			
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET L-1, PART I (Cont.)	
	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHY SICIAN ANESTHETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10	15	20	21		25	24	20	20	<u> </u>
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
											55
	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catherization										59
	Laboratory										60
	PBP Clinical Laboratory Service-Program Only										61
											62
	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65											65
											66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										0
	Rural Health Clinic (RHC)										88
											89
90	Clinic										90
	- 82										91
											92
93	Other Outpatient (specify)										93

10-12								4090 (Cont.)			
	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	
	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
0	THER REIMBURSABLE COST CENTERS	10	15	20	21	22	25	24	23	20	
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Dutpatient Rehabilitation Provider (specify)										99
	ntern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										101
	PECIAL PURPOSE COST CENTERS										
	idney Acquisition										105
	eart Acquisition										106
	iver Acquisition										107
	ung Acquisition										108
	ancreas Acquisition										109
	itestinal Acquisition										110
	let Acquisition										111
	ther Organ Acquisition (specify)										112
	mbulatory Surgical Center (Distinct Part)										115
116 H	ospice										116
	ther Special Purpose (specify)										117
	UBTOTALS (sum of lines 1-117)										118
	· · · · · · · · · · · · · · · · · · ·		4								
N	ONREIMBURSABLE COST CENTERS										
190 G	ift, Flower, Coffee Shop, & Canteen										190
	esearch										191
	hysicians' Private Offices										192
193 N	onpaid Workers										193
	ther Nonreimbursable (specify)										194
	ross Foot Adjustments										200
	egative Cost Centers										201
202 T	otal (sum of line 118 and lines190-201)		1						1		202
	otal Statistical Basis										203
204 U	nit Cost Multiplier										204

4090	0 (Cont.) IPUTATION OF PROGRAM INPATIENT ROUTINE SERVICE			FORM CMS-25	52-10					10-12
	PUTATION OF PROGRAM INPA TAL COSTS FOR EXTRAORDIN				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET L-1, PART II	
Check applical box:	ble [	] Title V ] Title XVIII, Part A ] Title XIX								
(A)	Cost Center Description		Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) 1	Swing Bed Adjustment 2	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2) 3	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4) 5	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6) 7	
(A)	INPATIENT ROUTINE SERVI	CE	1	2						
30	Adults & Pediatrics (General Ro	utine Care)								30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify	)								35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (Other)									42
43	Nursery									43
200	Total (sum of lines 30-199)									200

(A) Worksheet A line numbers

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.2)

10-12		FORM CMS-2552-10						
COMPUTATION OF PROGRAM IN		Έ			PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
CAPITAL COSTS FOR EXTRAORI	DINARY CIRCUMSTANCES					FROM	PART III	
					COMPONENT CCN:	ТО		
	•							
Check	[] Hospital	[] Title V						
applicable	[] Subprovider	[] Title XVIII, Part A	-					
boxes:		[] Title XIX					-	
			Capital Cost for					
			Extraordinary				Program	
			Circumstances	Total Charges	Ratio of Cost		Extraordinary	
Cost Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
			Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)			1	2	3	4	5	
ANCILLARY SERVICE COS	T CENTERS							
50 Operating Room								50
51 Recovery Room								51
52 Labor Room and Delivery Ro	oom							52
53 Anesthesiology								53
54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT)	Scan							57
58 Magnetic Resonance Imaging	(MRI)							58
59 Cardiac Catherization								59
60 Laboratory								60
61 PBP Clinical Laboratory Serv								61
62 Whole Blood & Packed Red E								62
63 Blood Storing, Processing, &	Trans.							63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged to								71
72 Implantable Devices Charged	to Patients							72
73 Drugs Charged to Patients	·							73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76

(A) Worksheet A line numbers

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4065.3)

4090 (Cont.)		FORM CMS-255	2-10					10-12
COMPUTATION OF PROGRAM II	NPATIENT ANCILLARY SERVICE				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
CAPITAL COSTS FOR EXTRAOR	DINARY CIRCUMSTANCES					FROM	PART III (CONT.)	
					COMPONENT CCN:	то		
Check	[] Hospital	[] Title V						
applicable	[] Subprovider	[] Title XVIII, Part A						
boxes:		[] Title XIX						
			Capital Cost for					
			Extraordinary				Program	
			Circumstances	Total Charges	Ratio of Cost		Extraordinary	
Cost Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
			Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)			1	2	3	4	5	
OUTPATIENT SERVICE C	OST CENTERS							_
88 Rural Health Clinic (RHC)								88
89 Federally Qualified Health Co	enter (FQHC)							89
90 Clinic								90
91 Emergency								91
92 Observation Beds								92
93 Other Outpatient (specify)								93
OTHER REIMBURSABLE C	LOST CENTERS							0.1
94 Home Program Dialysis								94
95 Ambulance Services								95
96 Durable Medical Equipment-								96
97 Durable Medical Equipment-								97
98 Other Reimbursable (specify)								98
200 Total (sum of lines 50 throug	n 199)							200

(A) Worksheet A line numbers

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4065.3)

DRAFT	
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	

[] Hospital-based RHC

[] Hospital-based FQHC

Check applicable box:

## FORM CMS-2552-10

PROVIDER CCN: PERIOD: FROM\_ COMPONENT CCN: то\_

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

4090	(Cont.)	FOR	M CMS-2	552-10		DRAFT		
ALLO	CATION OF OVERHEAD			PROVIDER CCN:	PERIOD:	WORKSHEET M-2		
TO H	OSPTIAL-BASED RHC/FQHC SERVICES				FROM	_		
				COMPONENT CCN:	то	_		
	applicable box:	[] Hospital-ba	<mark>sed</mark> RHC	[] Hospital-based FQHC				
VISIT	S AND PRODUCTIVITY							
		Number			Minimum	Greater of		
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or		
		Personnel	Visits	Standard (1)	x col. 3)	col. 4		
	Positions	1	2	3	4	5		
1	Physicians						1	
2	Physician Assistants						2	
3	Nurse Practitioners						3	
4	Subtotal (sum of lines 1-3)						4	
5	Visiting Nurse						5	
6	Clinical Psychologist						6	
7	Clinical Social Worker						7	
7.01	Medical Nutrition Therapist (FQHC only)						7.01	
7.02	Diabetes Self Management Training (FQHC only)						7.02	
8	Total FTEs and Visits (sum of lines 4-7)						8	
9	Physician Services Under Agreements						9	
DETE	RMINATION OF ALLOWABLE COST APPLICA	ABLE TO RHC/	FQHC SERV	ICES				
10	Total costs of health care services (from Worksheet M	A-1, column 7, lir	ne 22)				10	
11	Total nonreimbursable costs (from Worksheet M-1, o	olumn 7, line 28)	l .				11	
12	Cost of all services (excluding overhead) (sum of line	es 10 and 11)					12	
13	Ratio of hospital-based RHC/FQHC services (line 10	divided by line 12	2)				13	
14	Total hospital-based RHC/FQHC overhead (from Wo	rksheet M-1, colu	ımn 7, line 31)				14	
15	Parent provider overhead allocated to facility (see in	structions)					15	
16	Total overhead (sum of lines 14 and 15)				16			
17	Allowable Direct GME overhead (see instructions)						17	
18	Enter the amount from line 16						18	
19	Overhead applicable to hospital-based RHC/FQHC se	ervices (line 13 x l	line 18)			19		
20	Total allowable cost of hospital-based RHC/FQHC se	ervices (sum of lin	es 10 and 19)				20	

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals "Y"), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

DRAFT		FORM CMS-255	2-10		4090	(Cont.)
CALCULATION OF REIMBUR	SEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET M-3	<u>,                                     </u>
	-BASED RHC/FQHC SERVICES			FROM		
			COMPONENT CCN:	то		
Check	[] Hospital-based RHC	[] Title V	[] Title XIX			
applicable boxes:	[] Hospital-based FQHC	[] Title XVIII				
DETERMINATION OF RATE	FOR HOSPITAL-BASED RHC/FQHC S	SERVICES				
1 Total allowable cost of ho	spital-based RHC/FQHC services (from W	orksheet M-2, line 20)				1
2 Cost of vaccines and their	administration (from Worksheet M-4, line	15)				2
3 Total allowable cost exclu	uding vaccine (line 1 minus line 2)					3
4 Total visits (from Worksh						4
	reement (from Worksheet M-2, column 5,	line 9)				5
6 Total adjusted visits (line	1 /					6
7 Adjusted cost per visit (lir	ne 3 divided by line 6)					7
						_
					ion of Limit (1)	
				Prior to	On or after	
				January 1	January 1	
				1	2	
	rom CMS Pub. 100-04, chapter 9, §20.6 or	your contractor)				8
9 Rate for Program covered						9
CALCULATION OF SETTLE						
Ŭ	cluding mental health services (from contr	/				10
	osts for mental health services (line 9 x line					11
	r mental health services (from contractor re	ecords)				12
	m mental health services (line 9 x line 12)					13
	tal health services (see instructions)					14
	ion pass-through cost (see instructions)					15
	of lines 11, 14, and 15, columns 1, 2 and 3)	1				16
	ee instructions)(from contractor's records)					16.01
	charges (see instructions)(from provider's	records)				16.02
16.03 Total program preventive						16.03
	ntive costs (see instructions)					16.04
16.05 Total program cost (see in	nstructions)					16.05
17 Primary payer amounts						17
	ible for RHC only (see instructions) (from					18
	rance for RHC/FQHC services (see instruc	tions) (from contractor record	15)			19
20 Net Medicare cost exclude 21 Program cost of vaccines	and their administration (from Worksheet 1	M 4 line 10)				20
	am cost (line 20 plus line 21)	M-4, IIIe 18)				21
22 Total reimbursable Progra 23 Allowable bad debts (see	· · · · · · · · · · · · · · · · · · ·					22
23.01 Adjusted reimbursable bad						23.01
	lual eligible beneficiaries (see instructions)					23.01
25 Other adjustments (specify	, , , , , , , , , , , , , , , , , , ,					24
26 Net reimbursable amount						25
26.01 Sequestration adjustment	· · · · · · · · · · · · · · · · · · ·					26.01
20.01 Sequestration adjustment ( 27 Interim payments	(see instructions)					20.01
28 Tentative settlement (for c	contractor use only)					28
	program line 26 minus lines 26.01, 27 and 2	18				20
	lowable cost report items) in accordance w					30
Pub. 15-2, chapter 1, secti	· ,					
1 ub. 15 2, enapter 1, seeu				1		

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

4090	)(Cont.)	FORM	CMS-2552-1	0		DI	RAFT
	PUTATION OFHOSPITAL-BASE CINE COST	D RHC/FQHC PNEUMOCOCCAL A	ND INFLUENZA		PERIOD: FROM	WORKSHEET M-4	
				COMPONENT CCN:	то		
Check		[] Hospital-based RHC [] Title		[] Title XIX			
applic	able boxes:	[] Hospital-based FQHC [] Title	e XVIII		i		
					PNEUMOCOCCAL	INFLUENZA	_
					1	2	<u> </u>
	Health care staff cost (from Wor						1
2	Ratio of pneumococcal and influ health care staff time	enza vaccine staff time to total					2
		cine health care staff cost (line 1 x line	- 2)				3
	Medical supplies cost - pneumoc		2)				4
4	(from your records)	occai and influenza vaccine					4
5		influenza vaccine (line 3 plus line 4)					5
		ased RHC/FQHC (from Worksheet M	I-1 column 7 line 7	(2)			6
7			r i, column /, mic 2	-2)			7
- 8		enza vaccine direct cost to total direct					8
	cost (line 5 divided by line 6)						
9		nd influenza vaccine (line 7 x line 8)					9
	Total pneumococcal and influenz						10
	administration costs (sum of line	s 5 and 9)					
11	Total number of pneumococcal a	nd influenza vaccine injections					11
	(from your records)	-					
12	Cost per pneumococcal and influ	enza vaccine injection (line 10/line 11)	)				12
13	Number of pneumococcal and in	fluenza vaccine injections administered	d				13
	to Program beneficiaries						
14	Program cost of pneumococcal a	nd influenza vaccines and their					14
	administration costs (line 12 x lin						
15		influenza vaccines and their administra	ation costs (sum of o	columns			15
	1 and 2, line 10) (transfer this an						$\perp$
16	<b>U U</b>	ccal and influenza vaccines and their a		(sum			16
	of columns 1 and 2 line 14) (tra	nsfer this amount to Worksheet M-3 li	ine 21)				

DRAFT	FORM CMS-25	52-10			4090 (0	Cont.)
ANALYSIS OF PAYMENTS		PROVIDER O	CCN:	PERIOD:	WORKSHEET M-5	,
RHC/FQHC FOR SERVICES	RENDERED			FROM		
TO PROGRAM BENEFICIAR	RIES	COMPONEN	T CCN:	то		
Check applicable box:	[] Hospital-based RHC [] Hospital-base	d FOHC				
Спеск аррпсаве вох.	[] Hospital-based RHC [] Hospital-base	u runu		1	Part B	-
DESCRIPTION				1	2	-
DESCINI HOIV				mm/dd/yyyy	Amount	-
1 Total interim payments	paid to hospital-based RHC/FQHC					1
2 Interim payments paya	ble on individual bills, either					2
submitted or to be subr	nitted to the intermediary, for					
services rendered in the	e cost reporting periods. If					
none, write "NONE", o	or enter zero.					
3 List separately each ret	roactive		.01			3.01
lump sum adjustment a	mount	Program	.02			3.02
based on subsequent re	vision of	to	.03			3.03
the interim rate for the		Provider	.04			3.04
cost reporting period. A	Also show		.05			3.05
date of each payment.			.50			3.50
If none, write "NONE"	·	Provider	.51			3.51
or enter zero (1).		to	.52			3.52
		Program	.53			3.53
		, in the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se	.54			3.54
Subtotal (sum of lines 3	3.01-3.49 minus sum of lines 3.50-3.98)	L	.99			3.99
4 Total interim payments	s (sum of lines 1, 2, and 3.99)					4
(transfer to Worksheet	M-3, line 27)					
TO BE COMPLETED	BY CONTRACTOR					
5 List separately each ter		Program	.01			5.01
settlement payment after	er desk review.	to	.02			5.02
Also show date of each	n payment.	Provider	.03			5.03
If none, write "NONE,"	л <i>ч</i> П	Provider	.50			5.50
or enter zero (1).		to	.51			5.51
		Program	.52			5.52
Subtotal (sum of lines 5	5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6 Determine net settleme	ent amount	Program				
(balance due) based on	the cost	to				
report (see instructions	). (1)	Provider	.01			6.01
		Provider				
		to				
		Program	.02			6.02
7 Total Medicare liability	y (see instructions)					7
8 Name of Contractor			Cont	ractor Number	NPR Date (Month/Day/Ye	ea 8
						1

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

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4070)

Rev.

4090	(Cont.)	FORM CMS	CMS-2552-10						
	ASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE IOSPITAL-BASED FQHC	OF EXPENSES				PERIOD: FROM: TO:	_	WORKSHEET N-1	
	COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
GENE	RAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg and Fix								1
2	Cap Rel Costs-Mvble Equip								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation and Maintenance								5
6	Janitorial								6
7	Medical Records								7
8	Subtotal - Administrative Overhead								8
9	Pharmacy								9
	Medical Supplies								10
	Transportation								11
	Other General Service								12
	Subtotal - Total Overhead								13
	CT CARE COST CENTERS								
	Physician								23 24
	Physican Services Under Agreement								24
	Physician Assistant								25
	Nurse Practitioner								26
27	Visiting Registered Nurse								27
28	Visiting Licensed Practical Nurse								28
	Certified Nurse Midwife								29
	Clinical Psychologist								30
	Clinical Social Worker								31
	Laboratory Technician								32
	Reg Dietician/Cert DSMT/MNT Educator								33
	Physical Therapist								34 35
35	Occupational Therapist								
36	Other Allied Health Personnel								36
37	Subtotal - Direct Patient Care Services								37

FORM CMS-2552-10 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4071) 40-664

DRAFT	FORM CM				<b>I</b> S-2552-10				
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANC FOR HOSPITAL-BASED FOHC	E OF EXPENSES		PROVIDER CCN:		PERIOD:		WORKSHEET N-1		
			COMPONENT CCN	<i>ī</i> :	FROM TO	_			
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. $3 \pm$ col. 4)	ADJUSTMENTS 6	$\begin{array}{c} NET\\ EXPENSES FOR\\ ALLOCATION\\ (col. 5 \pm col. 6)\\ \hline 7\end{array}$		
REIMBURSABLE PASS THROUGH COSTS	1	2	3	4	5	0	/	1	
47 Pneumococcal Vaccines & Med Supplies								47	
48 Influenza Vaccines & Med Supplies								48	
49 Subtotal - Reimbursable Pass through Costs								49	
OTHER FQHC SERVICES									
60 Medicare Excluded Services								60	
61 Diagnostic & Screening Lab Tests								61	
62 Radiology - Diagnostic								62	
63 Prosthetic Devices								63	
64 Durable Medical Equipment								64	
65 Ambulance Services								65	
66 Telehealth								66	
67 Other								67	
68 Subtotal - Other FQHC Services								68	
NONREIMBURSABLE COST CENTERS									
78 Other Nonreimbursable								78	
100 TOTAL (sum of lines 13, 37, 49, 68 and 78)								100	

FORM CMS-2552-10 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4071) Rev.

4090 (Cont.)			FOR	M CMS-25	52-10								DR	RAFT
CALCULATION OF HOSPITAL-BASED FQHC CO	ST PER VIS	T						PROVIDER C	C <b>N:</b>		PERIOD:		WORKSHEET N	√-2
											FROM:			
								COMPONENT	CCN:		TO:			
								Total	Visits	Title XV	TII Visits	Title X	VIII Costs	<u> </u>
														1
		Direct Cost	Total Medical		General									
	From	- 2	& Mental Health		Service Cost	Total Costs	Average		Mental		Mental		Mental	
	Wkst. N-1,	Practitioner	Visits	(see	(see	by		Medical Visits					Health Cost	
	col. 7,	from Wkst. N-1	by Practitioner				by Practitioner	by Practitioner						4
Positions	line:	1	2	3	4	5	6	7	8	9	10	11	12	
1 Physician	23													1
2 Physican Services Under Agreement	24													2
3 Physician Assistant	25													3
4 Nurse Practitioner	26													4
5 Visiting Registered Nurse	27													5
6 Visiting Licensed Practical Nurse	28													6
7 Certified Nurse Midwife	29													7
8 Clinical Psychologist	30													8
9 Clinical Social Worker	31													9
10 Reg Dietician/Cert DSMT/MNT Educator	33													10
11 Totals														11
12 Unit Cost Multiplier														12
13 Total Cost Per Visit														13

FORM CMS-2552-10 (DRAFT)	INSTRUCTIONS FOR THIS	5 WORKSHEET ARE	E PUBLISHED IN CMS P	UB. 15-2, SECTION 4071.1)
40-666				

DRAFT	FORM CMS-2552-10	FORM CMS-2552-10				
COMPUTATION OF HOSPITAL-BASED FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET N-3	<u>,</u>		
		PNEUMOCOCCAL	INFLUENZA 2			
1 Health care staff cost (from Worksheet N-1, column 7, sum of li	ines 23, and 25 through 36)	1	2	1		
2 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time				2		
3 Pneumococcal and influenza vaccine health care staff cost (line				3		
4 Vaccines and related medical supplies cost (from Worksheet N-				4		
5 Direct cost of pneumococcal and influenza vaccine (line 3 + lin				5		
6 Total direct cost of the hospital-based FQHC (from Worksheet . 7 Total administrative overhead (from Worksheet N-1, column 7,				6		
<ul> <li>8 Ratio of pneumococcal and influenza vaccine direct cost to tota</li> </ul>				- / 8		
cost (line 5 / line 6)	i di ect			0		
9 Overhead cost - pneumococcal and influenza vaccine (line 7 x l	line 8)			9		
10 Total cost of pneumococcal and influenza vaccine and their				10		
administration (sum of lines 5 and 9)						
11 Total number of pneumococcal and influenza vaccine injections	5			11		
(from your records)						
12 Cost per pneumococcal and influenza vaccine injection (line 10				12		
13 Number of pneumococcal and influenza vaccine injections adm	inistered			13		
to Medicare beneficiaries				14		
14 Cost of pneumococcal and influenza vaccines and their administration costs furnished to Medicare beneficiaries (line 1	2 x line 12)			14		
15 Total cost of pneumococcal and influenza vaccines and their ad				15		
(sum of columns 1 and 2, line 10)						
16 Total Medicare cost of pneumococcal and influenza vaccines an	nd their administration costs (sum		T	16		
of columns 1 and 2, line 14) (transfer this amount to Workshee	t N-4, line 2)					

4090 (Cont.)	FORM CMS-2552-10	DR
CALCULATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN:         PERIOD:	WORKSHEET N-4

1	FQHC PPS Amount (see instructions)	
2	Medicare cost of pneumococcal and influenza vaccine and administration (From Worksheet N-3, line 16)	
3	Medicare advantage supplemental payments (for information only)	
4	Total (sum of lines 1 through 2)	
5	Primary payer payments	
6	Total amount payable for program beneficiaries (line 4 minus line 5)	
7	Coinsurance billed to program beneficiaries	
8	Net Medicare reimbursement excluding bad debts (line 6 minus line 7)	
9	Allowable bad debts (see instructions)	
10	Adjusted reimbursable bad debts (see instructions)	
11	Allowable bad debts for dual eligible beneficiaries (see instructions)	
12	Subtotal (line 8 plus line 10)	
13	Other adjustments (specify) (see instructions)	
14	Amount due hospital-based FQHC prior to the sequestration adjustment (see instructions)	
15	Sequestration adjustment (see instructions)	
16	Amount due hospital-based FQHC after sequestration adjustment (see instructions)	
17	Interim payments (from Worksheet N-5, column 2, line 4)	
18	Tentative settlement (for contractor use only)	
19	Balance due hospital-based FQHC/program (line 16 minus lines 17 and 18)	
20	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	

# $\begin{array}{c} 1\\ 2\\ 3\\ 4\\ 5\\ 6\\ 7\\ 7\\ 8\\ 9\\ 10\\ 11\\ 12\\ 13\\ 14\\ 15\\ 16\\ 17\\ 18\\ 19\\ 20\\ \end{array}$

AFT

DRAFT		4090 (Con			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERED	PROVIDER CCN: 		D: :	WORKSHEET N-5	<u> </u>
Description		-	P mm/dd/yyyy 1	art B Amount 2	
Total interim payments paid to hospital-based FQHC     Interim payments payable on individual bills, either submitted or to be submitted to the contractor     for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		-	1		1 2
3 List separately each retroctive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment.	Program to Provider	.01 .02 .03 .04 .05			3.01 3.02 3.03 3.04 3.05
If none, write "NONE" or enter a zero. (1)	Provider to Program	.50 .51 .52 .53 .54			3.50 3.51 3.52 3.53 3.54
Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98) 4 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. N-4, line 17)		.99			3.99
TO BE COMPLETED BY CONTRACTOR 5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider Provider to Program	.01 .02 .03 .50 .51 .52			5.01 5.02 5.03 5.50 5.51 5.52
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98) 6 Determine net settlement amount (balance due) based on the cost report (1) 7 Total Medicare program liability (see instructions)	Program to provider Provider to program	.99 .01 .02			5.99 6.01 6.02 7

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

FORM CMS-2552-10 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4071.4)

Rev.

4090 (Cont.)		FORM	1 CMS-2552-10				D	RAFT
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM: TO	WORKSHEET O	
	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	_
GENERAL SERVICE COST CENTERS	-	_				, , , , , , , , , , , , , , , , , , ,	· · ·	
1 0100 Cap Rel Costs-Bldg & Fixt*								1
2 0200 Cap Rel Costs-Myble Equip*								2
3 0300 Employee Benefits Department*								3
4 0400 Administrative & General *								4
5 0500 Plant Operation and 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*								15
16 1600 Other General Service*								16
17 1700 Patient/Residential Care Services								17
DIRECT PATIENT CARE SERVICE COST CENTERS								
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 3300 Medical Social Services**								33
34 3400 Spiritual Counseling**								34
35 3500 Dietary Counseling**								35
36 3600 Counseling - Other**								36
37 3700 Hospice Aide and Homemaker Services**								37
38 3800 Durable Medical Equipment/Oxygen**								38
39 3900 Patient Transportation**								39

\* 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-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2	, SECTION 4072)			
40-670				Rev.
DRAFT	FORM CMS-2552-10			4090 (Cont.)
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET O
		HOSPICE CCN:	FROM TO	
		HOST ICE CON.		

	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	$\Box$
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)	1	2	5	+	5	0	/	<u> </u>
40 4000 Imaging Services**								40
41 4100 Labs and Diagnostics**								41
42 4200 Medical Supplies-Non-routine**								42
43 4300 Outpatient Services**								43
44 4400 Palliative Radiation Therapy**								44
45 4500 Palliative Chemotherapy**								45
46 Other Patient Care Services**								46
NONREIMBURSABLE COST CENTERS								
60 6000 Bereavement Program *								60
61 6100 Volunteer Program *								61
62 6200 Fundraising*								62
63 6300 Hospice/Palliative Medicine Fellows*								63
64 6400 Palliative Care Program*								64
65 6500 Other Physician Services*								65
66 6600 Residential Care *								66
67 6700 Advertising*								67
68 6800 Telehealth/Telemonitoring*								68
69 6900 Thrift Store*								69
70 7000 Nursing Facility Room & Board*								70
71 7100 Other Nonreimbursable*								71
100 Total								100

\* Transfer the amounts in column 7 to Wkst. O-5, Part I, column 0, line as appropriate. \*\* See instructions. Do not transfer the amounts in column 7 to Wkst. O-5, Part I.

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072) Rev.

4090 (Cont.)		FORM	1 CMS-2552-10				DI	RAFT
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE CONTINUOUS HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-1	
	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6) 7	
DIRECT PATIENT CARE SERVICE COST CENTERS	1	2	5	7		0	/	<u> </u>
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								46
100 Total *								100

DRAFT		FORM	1 CMS-2552-10				4090 (0	Cont.)
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE ROUTINE HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-2	<u> </u>
	SALARIES	OTHER	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 )	
DIDECT DATIENT CARE CEDUICE COST CENTERS	1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS								- 25
25 Inpatient Care - Contracted 26 Physician Services								25
26 Physician Services 27 Nurse Practitioner								26 27
28 Registered Nurse								27
29 LPN/LVN								20
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								46
100 Total *								100

4090 (Cont.)		FORM	I CMS-2552-10				DI	RAFT
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE INPATIENT RESPITE CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-3	
	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 ) 7	
DIRECT PATIENT CARE SERVICE COST CENTERS	1	4	5	7		0	/	<u> </u>
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								46
100 Total *								100

DRAFT		FORM	I CMS-2552-10				4090 (0	Cont.)
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET O-4	
					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	
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								46
100 Total *								100

4090 (Cont.)	FORM CM	DRAFT		
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE	PROVIDER CCN:	PERIOD:	WORKSHEET O-5	
NET EXPENSES FOR ALLOCATION	HOSPICE CCN:	FROM TO		
	HOSPICE CCN.	10		
		GENERAL		
	HOSPICE	SERVICE		
	DIRECT	EXPENSES	TOTAL	
	EXPENSES	FROM WKST B PART I	EXPENSES	
	( see instructions )	( see instructions )	( sum of cols. $1 + 2$ $)$	
Descriptions	1	2	3	
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				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 Advertising				67
68 Telehealth/Telemonitoring				68
69 Thrift Store				69
70 Nursing Facility Room & Board				70
71 Other Nonreimbursable				71
99 Negative Cost Center				99
100 Total				100

DRA					M CMS-2552	-10					4090 (0	
COST	" ALLOCATION - HOSPITAL-BASED H	OSPICE GENERAI	L SERVICE COST.	S			PROVIDER CCN: HOSPICE CCN: _		_ PERIOD: _ FROM TO		WORKSHEET O PART I	-6
		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	ЗА	4	5	6	7	8	
GEN	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip				7							2
3	Employee Benefits											3
	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	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											<u>16</u>
	Patient/Residential Care Services											17
	L OF CARE											
	Hospice Continuous Home Care											50
	Hospice Routine Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care											53
	REIMBURSABLE 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
68	Telehealth/Telemonitoring	T										68
69	Thrift Store	1										69
	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
	Negative Cost Center											99
-	Total			1								100
100				1	1					I		100

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN C	MS PUB. 15-2, SECTION 4072.3)			
Rev.				40-677
4090 (Cont.)	FORM CMS-2552-10			DRAFT
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET O-6
		HOSPICE CCN:	FROM	Part I
			ТО	

	NURSING ADMINIS-	ROUTINE MEDICAL	MEDICAL RECORDS	STAFF TRANS-	VOLUNTEER SVC COOR-	PHARMACY	PHYSICIAN ADMINISTRA-	OTHER GENERAL	PATIENT / RESIDENTIAL	TOTAL	Τ
	TRATION	SUPPLIES	RECORDS	PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS		
Descriptions	9	10	11	12	13	14	15	16	17	18	-
GENERAL SERVICE COST CENTERS	-										
1 Cap Rel Costs-Bldg & Fixt											1
2 Cap Rel Costs-Myble 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		1									9
10 Routine Medical Supplies			1								10
11 Medical Records											11
12 Staff Transportation											12
13 Volunteer Service Coordination						1					13
14 Pharmacy							1				14
15 Physician Administrative Services											15
16 Other General Service (specify)									-		16
17 Patient/Residential Care Services											17
LEVEL OF CARE											
50 Continuous Home Care											50
51 Routine Home Care											51
52 Inpatient Respite Care											52
53 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 Advertising											67
68 Telehealth/Telemonitoring											68
69 Thrift Store											69
70 Nursing Facility Room & Board											70
71 Other Nonreimbursable (specify)											71
99 Negative Cost Center	1						1				99
100 Total											100

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072.3) 40-678

DRAFT		FOI	RM CMS-2552-	-10					4090 (0	Cont.
COST ALLOCATION - HOSPITAL-BASED HOSPICE GE	NERAL SERVICE COST.	S STATISTICAL E	BASIS		PROVIDER CCN:		_ PERIOD: _ FROM TO		WORKSHEET O 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 )	4
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										ļ
3 Employee Benefits 4 Administrative & General										
5 Plant Operation and Maintenance							-			
6 Laundry & Linen Service										
7 Housekeeping					+				-	
8 Dietary										8
9 Nursing Administration									+	
10 Routine Medical Supplies										10
11 Medical Records									_	1
12 Staff Transportation										1
13 Volunteer Service Coordination										13
14 Pharmacy										14
15 Physician Administrative Services										15
16 Other General Service										10
17 Patient/Residential Care Services										1
LEVEL OF CARE										
50 Hospice Continuous Home Care										50
51 Hospice Routine Home Care										5
52 Hospice Inpatient Respite Care										52
53 Hospice General Inpatient Care										- 53
NONREIMBURSABLE COST CENTERS										
60 Bereavement Program										60
61 Volunteer Program										6
62 Fundraising										62
63 Hospice/Palliative Medicine Fellows										63
64 Palliative Care Program										64
65 Other Physician Services										6
66 Residential Care										66
67 Advertising										62
68 Telehealth/Telemonitoring										68
69 Thrift Store										69
70 Nursing Facility Room & Board										7(
71 Other Nonreimbursable										7
99 Negative Cost Center										9
100 Total (sum of lines 1 through 99)										100
101 Cost to be allocated (per Wkst. O-6, Part I)										10
102 Unit cost multiplier										102
202 Chie cost multiplier	I									102

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072.3)

Rev.

FORM CMS-2552-10

4090 (Cont.) FORM C COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

PROVIDER CCN:	PERIOD:	WORK
HOSPICE CCN:	FROM	Part II

DRAFT KSHEET O-6

40-679

								ТО			
	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		
	( Direct	( Patient	( Patient		( Hours of		(Patient	( Specify	(In-Facility		
	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											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		1									9
10 Routine Medical Supplies			-								10
11 Medical Records				1							11
12 Staff Transportation				-							12
13 Volunteer Service Coordination						1					13
14 Pharmacy							4				14
15 Physician Administrative Services								+			15
16 Other General Service											15
17 Patient/Residential Care Services											10
LEVEL OF CARE											1/
50 Continuous Home Care											50
51 Routine Home Care					-						51
52 Inpatient Respite Care											52
53 General Inpatient Care											53
NONREIMBURSABLE COST CENTERS											
60 Bereavement Program			-	-							60
61 Volunteer Program											61
62 Fundraising											62
63 Hospice/Palliative Medicine Fellows											63
63 Hospice/Panlative Medicine Penows 64 Palliative Care Program											64
65 Other Physician Services											65
<u> </u>											
66 Residential Care			-								66
67 Advertising			-								67
68 Telehealth/Telemonitoring											68
69 Thrift Store											69
70 Nursing Facility Room & Board											70
71 Other Nonreimbursable											71
99 Negative Cost Center											99
100 Total (sum of lines 1 through 99)											100
101 Cost to be allocated (per Wkst. O-6, Part	l)										101
102 Unit cost multiplier											102

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072.3)

40-680

DRAFT				FORM CMS-	2552-10					4090 (C	lont.)
APPORTIONMENT OF HOSPITAL-BASED HOSI	ERVICE COSTS	S BY LEVEL OF C	CARE		PROVIDER CCN HOSPICE CCN:		PERIOD:           FROM		WORKSHEET O-7	7	
	Wkst. C,	Cost to		Charges by LOC (fr	om Provider Recor	ds)		Shared Service	e Costs by LOC		
	Pt. I, col. 9,	Charge					HCHC	HRHC	HIRC	HGIP	1
	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	66										1
2 Occupational Therapy	67										2
3 Speech/ Language Pathology	68										3
4 Drugs, Biological and Infusion Therapy	73										4
5 Durable Medical Equipment/Oxygen	96										5
6 Labs and Diagnostics	60										6
7 Medical Supplies	71										7
8 Outpatient Services (including E/R Dept.)	93										8
9 Radiation Therapy	55										9
10 Other	76										10
11 Totals (sum of lines 1 through 10)											11

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST       PROVIDER CCN:       PEROD:	4090 (Cont.)	FORM CMS-2552-10	FORM CMS-2552-10						
HOSPICE CCN:         TO           ITTLE XVIII         TITLE XVIII           MEDICARE         MEDICARE           1         Total cost (Wst. O-6, Part 1, col 18, line 50 plus Wst. O-7, col. 6, line 11)         1           2         Total unduplicated days (Wst. S-9, col. 4, line 10)         1           2         Total unduplicated days (Wst. S-9, col. 4, line 10)         1           4         Unduplicated program days (Wst. S-9, col. 3, appropriate, line 10)         4           5         Program cost (line 3 times line 4)         5           1         Total cost (Wst. O-6, Part 1, col. 18, line 51 plus Wst. O-7, col. 7, line 11)         6           6         Total average cost per diem (line 6 divided by line 2)         4           4         Duduplicated program days (Wst. S-9, col. 3, appropriate, line 10)         4           6         Total average cost per diem (line 6 divided by line 2)         7           6         Total average cost per diem (line 6 divided by line 7)         8           7         8         Total average cost per diem (line 6 divided by line 7)         8           10         Program cost (line 8 times line 9)         10         10           11         Total average cost per diem (line 1 divided by line 12)         11         111           12         Total unduplicated	CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM CO	ST PROVIDER CCN:							
Instrume         Instrume           HOSE/CE         CONTINUOUS HOME CARE         I           1         Total cost (Wst. 0-6, Part I, col 18, line 50 plus Wst. 0-7, col. 6, line 11)         1         2         3           1         Total cost (Wst. 0-6, Part I, col 18, line 51 plus Wst. 0-7, col. 6, line 10)         2         1         2         3           2         Total average cost per diem (line 1 divided by line 2)         1         2         3         3           4         Unduplicated days (Wst. S-9, col. 4, line 10)         2         3         3         4           4         Unduplicated days (Wst. S-9, col. 4, line 10)         3         4         4         4           5         Program cost (line 3 dires line 4)         1         2         5           6         Total average cost per diem (line 1 divided by line 2)         3         4         4           6         Total average cost per diem (line 6 divided by line 7)         4         5         5           7         Total average cost per diem (line 6 divided by line 7)         8         10         10           10         Program cost (line 8 divided by line 7)         8         10         11           11         Total average cost per diem (line 11 divided by line 7)         10			FROM						
$\frac{MEDICARE}{1} \frac{MEDICALD}{2} \frac{TOTAL}{3}$		HOSPICE CCN:	ТО						
$\frac{MEDICARE}{1} \frac{MEDICALD}{2} \frac{TOTAL}{3}$									
I         2         3           HOSRICE CONTINUOUS HOME CARE         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1									
HOSRICE CONTINUOUS HOME CARE       1         I Total cost (Wkst. 0-6, Part I, col 18, line 50 plus Wkst. 0-7, col. 6, line 11)       1         2 Total unduplicated days (Wkst. S-9, col. 4, line 10)       2         3 Total average cost per diem (line 1 divided by line 2)       4         4 Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)       4         5 Program cost (line 3 times line 4)       4         6 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)       6         7 Total unduplicated days (Wkst. S-9, col. 4, line 11)       6         9 Unduplicated program days (Wkst. S-9, col. 4, line 11)       6         10 Program cost (line 8 times line 9)       9         11 Total average cost per diem (line 52 plus Wkst. 0-7, col. 8, line 11)       9         11 Total average cost per diem (line 52 plus Wkst. 0-7, col. 8, line 11)       9         11 Total average cost per diem (line 52 plus Wkst. 0-7, col. 8, line 11)       10         11 Total average cost per diem (line 13 line 52 plus Wkst. 0-7, col. 8, line 11)       11         12 Total average cost per diem (line 13 line 53 plus Wkst. 0-7, col. 8, line 11)       11         12 Total average cost per diem (line 14)       11         13 Total average cost per diem (line 153 plus Wkst. 0-7, col. 9, line 11)       11         14 Unduplicated program days (Wkst. S-9, col. 4, line 12)       11		MEDICARE							
1       Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 11)       1         2       Total unduplicated days (Wkst. S-9, col. 4, line 10)       2         3       Total average costs per diem (line 1 divided by line 2)       3         4       Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)       4         5       Program cost (line 3 times line 4)       5         6       Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)       6         7       Total anduplicated days (Wkst. S-9, col. 4, line 11)       6         7       Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 7, line 11)       7         8       Total cost (Wkst. S-9, col. 4, line 11)       7         9       Unduplicated program days (Wkst. S-9, col. 3 appropriate, line 11)       7         10       Program cost (line 8 times line 9)       10         11       Total cost (Wkst. O-6, Part I, col. 18, line 12)       11         12       Total unduplicated days (Wkst. S-9, col. 4, line 12)       12         13       Total cost (Wkst. O-6, Part I, col. 18, line 12)       12         14       Unduplicated pays (Wkst. S-9, col. 4, line 12)       13         15       Total cost (Wkst. O-6, Part I, col. 18, line 12)       14         14       U		1	2	3					
2       Total unduplicated days (Wkst. S-9, col. 4, line 10)       2         3       Total average cost per diem (line 1 divided by line 2)       3         4       Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)       4         5       Program cost (line 3 times line 4)       5         6       Total cost (Wks. O-6, Part1, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)       6         6       Total average cost per diem (line 6 divided by line 7)       6         9       Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)       7         7       8       Total average cost per diem (line 6 divided by line 7)       8         9       Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)       9       9         10       Program cost (line 8 times line 9)       10       10         11       Total cost (Wkst. O-6, Part1, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11       11         12       Total and cost (Wkst. O-6, Part1, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11       12         13       Total average cost per diem (line 11 divided by line 12)       12       13         14       Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)       13       14         15       Foral average cost per diem (line 16 divided by lin									
3       Total average cost per diem (line 1 divided by line 2)       3         4       Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)       4         5       Program cost (line 3 times line 4)       5         HOSH ICE: ROUTINE HOME: CARE       6         6       Total anduplicated days (Wkst. S-9, col. 4, line 11)       6         7       Total anduplicated days (Wkst. S-9, col. 4, line 11)       7         8       Total anduplicated days (Wkst. S-9, col. 4, line 11)       7         9       Unduplicated program days (line 8 times line 9)       8         9       Unduplicated program days (line 8 times line 9)       9         10       Program cost (line 8 times line 9)       9         11       Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11         12       Total anduplicated days (Wkst. S-9, col. 4, line 12)       11         11       Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11         12       Total anduplicated days (Wkst. S-9, col. 4, line 12)       11         13       Total out-like 11 divided by line 12)       11         14       Unduplicated days (Wkst. S-9, col. 4, line 13)       11         15       Frogram cost (line 13 times line 14)       16		6, line 11)			1				
4       Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)       4         5       Program cost (line 3 times line 4)       5         HOSHICE ROUTINE HOME CARE       6         6       Total oxingte cost per diem (line 6 divided by line 7)       6         7       7         8       Total average cost per diem (line 6 divided by line 7)       8         9       Unduplicated program days (Wkst. S-9, col. 4, line 11)       9         9       Unduplicated program days (Wkst. S-9, col. 4, line 11)       9         10       Program cost (line 8 divided by line 7)       9         11       Total average cost per diem (line 52 plus Wkst. O-7, col. 8, line 11)       9       10         11       Total over (Wkst. S-9, col. 4, line 12)       10       11         12       Total unduplicated days (Wkst. S-9, col. 4, line 12)       11       11         12       Total unduplicated days (Wkst. S-9, col. 4, line 12)       12       12         13       Total average cost per diem (line 11 divided by line 12)       12       13         14       Unduplicated program days (Wkst. S-9, col. 9, line 11)       13       14         15       Program cost (line 13 times line 14)       15       15         16       Total unduplicated days (Wkst. S-9, col. 9, lin					_				
5       Program cost (line 3 times line 4)       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       11       10       10       10       10       10       10       10       11       10       10       11       10       10       11       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       10       11       11       11       11 </td <td></td> <td></td> <td></td> <td></td> <td></td>									
HOSH ICE ROUTINE HOME CARE		10)							
6       Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)       6         7       Total unduplicated days (Wkst. S-9, col. 4, line 11)       7         8       Total average cost per diem (line 6 divided by line 7)       8         9       Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)       9         10       Program cost (line 8 times line 9)       10         11       Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11         12       Total unduplicated days (Wkst. S-9, col. 4, line 12)       11         13       Total average cost per diem (line 11 divided by line 12)       11         14       Unduplicated program days (Wkst. S-9, col. 4, line 12)       11         15       Program cost (line 13 times line 14)       11         16       Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)       11         15       Program cost (Wkst. S-9, col. 4, line 13)       15         16       Total cost (Wkst. S-9, col. 4, line 13)       16         17       Total unduplicated days (Wkst. S-9, col. 4, line 13)       16         16       Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)       17         17       Total unduplicated days (Wkst. S-9, col. 4, line 13)       16 <td></td> <td></td> <td></td> <td></td> <td>5</td>					5				
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8       Total average cost per diem (line 6 divided by line 7)       8         9       Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)       9         10       Program cost (line 8 times line 9)       10         HOSFICE INPATIENT RESPITE CARE       10         11       Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)       11         12       Total unduplicated days (Wkst. S-9, col. 4, line 12)       11         13       Total overage cost per diem (line 11 divided by line 12)       11         14       Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)       12         13       Total average cost per diem (line 16 divided by line 12)       11         14       Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)       14         15       Program cost (line 13 times line 14)       11         16       Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)       16         17       Total unduplicated days (Wkst. S-9, col. 4, line 13)       11         18       Total average cost per diem (line 16 divided by line 17)       17         19       Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)       19         20       Program cost (line 18 times line 19)       19         20		. 7, line 11)			6				
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