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

FORM APPROVED
OMB NO. 0938-0037
EXPIRES: 02/28/2020

COMMUNITY MENTAL HEALTH CENTER COST REPORT IDENTIFICATION DATA, CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report Date: Time:
2. [ ] Manually submitted cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report
4 [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received:_____
7. Contractor No.:_____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date:_____
11. Contractor's Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII PART B 1	
1	COMMUNITY MENTAL HEALTH CENTER		1

COST REPORT IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-1 PARTS I & II

PART I - IDENTIFICATION DATA

Community Mental Health Center Address:

	1	Provider CCN 2	CBSA 3	Date Certified 4	Type of control (see instructions) 5	
1	CMHC Name:					1
2	Street:	P.O. Box:				2
3	City:	State:	ZIP Code:	County:		3
4	Cost Reporting Period (mm/dd/yyyy) From:	To:				4
5	Is this CMHC part of a chain organization as defined in §2150 of CMS Pub. 15-1 that claims home office costs in a Home Office Cost Statement? Enter "Y for yes or "N" for no in column 1. If yes, enter the chain organization's information below.					5
6	Name of Chain Organization:					6
7	Street:	P.O. Box:		Home Office CCN:		7
8	City:	State:	Zip Code:			8

Medical Malpractice

9	Is this CMHC legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				9
10	If line 9 is "Y", is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				10
		Premiums	Paid Losses	Self Insurance	
11	Enter total malpractice premiums in column 1, total paid losses in column 2, and total self insurance in column 3				11
12	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? Enter "Y" for yes or "N" for no. (see instructions)				12

		Y/N 1	Demonstration Type 2	
13	Did this facility participate in any payment demonstration during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2. If the CMHC participated in more than one demonstration, subscript this line accordingly.			13

PART II - STATISTICAL DATA

	REIMBURSABLE COST CENTERS	Wkst. A	VISITS Medicare Patients 1	VISITS Other Patients 2	VISITS Total 3	PATIENT DAYS Medicare 4	PATIENT DAYS Other 5	PATIENT DAYS Total 6	
1	Drugs & Biologicals	23							1
2	Occupational Therapy	24							2
3	Behavioral Health Treatment/Services	25							3
4	Individual Therapy	26							4
5	Group Therapy	27							5
6	Activity Therapy	28							6
7	Family Therapy	29							7
8	Psychiatric Testing	30							8
9	Education Training	31							9
10	Other (specify)	32							10
11	TOTAL (sum of lines 1 through 10)								11
12	Unduplicated Census								12

	REIMBURSABLE COST CENTERS	Wkst. A	FTE ON PAYROLL Staff Therapists 7	Physicians 8	Social Workers 9	Others 10	
1	Drugs & Biologicals	23					1
2	Occupational Therapy	24					2
3	Behavioral Health Treatment/Services	25					3
4	Individual Therapy	26					4
5	Group Therapy	27					5
6	Activity Therapy	28					6
7	Family Therapy	29					7
8	Psychiatric Testing	30					8
9	Education Training	31					9
10	Other (specify)	32					10
11	TOTAL (sum of lines 1 through 10)						11
12	Unduplicated Census						12

COST REPORT REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-2

	PROVIDER ORGANIZATION AND OPERATION	Y/N 1	DATE 2	V/I 3	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, enter the date (mm/dd/yyyy) of the change in column 2. (see instructions)				1
2	Has the provider terminated participation in the Medicare Program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date (mm/dd/yyyy); and, enter in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that were related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter "Y" for yes or "N" for no in column 1. (see instructions)				3

	FINANCIAL DATA AND REPORTS	Y/N 1	A/C/R 2	DATE 3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter "Y" for yes or "N" for no. Column 2: If yes, enter in column 2: "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy of financial statements or enter date available (mm/dd/yyyy) in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

	BAD DEBTS	Y/N	
6	Is the provider seeking reimbursement for bad debts? Enter "Y" for yes or "N" for no. If yes, see instructions.		6
7	If line 6 is yes, did the provider's bad debt collection policy change during the cost reporting period? "Y" for yes or "N" for no. If yes, submit a copy.		7
8	If line 6 is yes, were patient deductibles and/or co-payments waived? Enter "Y" for yes or "N" for no. If yes, see instructions.		8

	PS&R REPORT DATA	Y/N 1	DATE 2	
9	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions.)			9
10	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions)			10
11	If line 9 or 10 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? Enter "Y" for yes or "N" for no. If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments:			13
14	Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTERS (Omit Cents)	SALARIES	OTHER	CON-TRACTED PURCHASED SERVICES	TOTAL (col. 1 through col. 3)	RECLASS. (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 4 ± col. 5)	ADJUSTMENTS (from Wkst. A-8)	NET EXPENSES FOR ALLOCATION (col. 6 ± col. 7)	
			1	2	3	4	5	6	7	8	
		GENERAL SERVICE COST CENTERS									
1	0100	Cap Rel Costs - Bldg & Fixt									1
2	0200	Cap Rel Costs - Mvble Equip									2
3	0300	Employee Benefits									3
4	0400	Administrative & General									4
5	0500	Maintenance & Repairs									5
6	0600	Operation of Plant									6
7	0700	Laundry & Linen Service									7
8	0800	Housekeeping									8
9	0900	Cafeteria									9
10	1000	Central Services & Supplies									10
11	1100	Medical Records & Library									11
12	1200	Pro Ed & Training (Approved)									12
13		Other (specify)									13
		REIMBURSABLE COST CENTERS									
23	2300	Drugs & Biologicals									23
24	2400	Occupational Therapy									24
25	2500	Behavioral Health Treatment/Services									25
26	2600	Individual Therapy									26
27	2700	Group Therapy									27
28	2800	Activity Therapy									28
29	2900	Family Therapy									29
30	3000	Psychiatric Testing									30
31	3100	Education Training									31
32		Other (specify)									32
		NONREIMBURSABLE COST CENTERS									
42	4200	Sheltered Workshops									42
43	4300	Recreational Programs									43
44	4400	Resident Day Camps									44
45	4500	Diagnostic Clinics									45
46	4600	Physicians' Private Offices									46
47	4700	Fund Raising									47
48	4800	Coffee Shops & Canteen									48
49	4900	Research									49
50	5000	Investment Property									50
51	5100	Advertising									51
52	5200	Franchise Fees and Other Assessments									52
53	5300	Pro Ed & Training (Not Approved)									53
54	5400	Meals & Transportation									54
55	5500	Activity Therapies									55
56	5600	Psychosocial Programs									56
57	5700	Vocational Training									57
58		Other (specify)									58
100		TOTAL (sum of lines 1 through 58)									100

RECLASSIFICATIONS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASE				DECREASE				
			COST CENTER	LINE NO.	SALARY	NON SALARY	COST CENTER	LINE NO.	SALARY	NON SALARY	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
100	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)										100

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

(2) Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A. column 5, line as appropriate.

ADJUSTMENTS TO EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8

	DESCRIPTION (1)	BASIS (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	
		1	2	3	4	
1	Capital Related Costs - Buildings and fixtures	A		Capital Related Costs Buildings & Fixtures	1	1
2	Capital Related Costs - Movable Equipment	A		Capital Related Costs Movable Equipment	2	2
3	Payments received from specialists	B				3
4	Investment income (chapter 2)					4
5	Trade, quantity, and time discounts (chapter 8)	B				5
6	Refunds and rebates of expenses (chapter 8)	B				6
7	Laundry and linen service			Laundry and Linen Service	7	7
8	Cafeteria-employees, guests, etc.	A		Cafeteria	9	8
9	Sale of medical and surgical supplies to other than patients			Central Services and Supplies	10	9
10	Sale of workshop products or services					10
11	Coffee shops and canteen					11
12	Vending Machines	A				12
13	Rental of building or office space to others					13
14	Sale of scrap, waste, etc. (Chapter 23)					14
15	Related organization transactions (chapter 10)	Wkst. A-8-1				15
16	Provider-based physician adjustment	Wkst. A-8-2				16
17	Other (Specify) (3)					17
50	TOTAL (sum of lines 1 through 49) (Transfer to Worksheet A, col. 7, line 100.)					50

(1) Include amounts not already applied against expenses included on Worksheet A, column 4

(2) 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 subscripts of this line.

Chapter references are to CMS Pub.15-1

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

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

	Wkst. A Line No.	Cost Center	Amount	Amount Allowable In Cost	Amount Included in Wkst. A, column 7	Net Adjustments (col. 3 minus col. 4) *	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (Sum of lines 1 through 4) Transfer col. 6, line 5 to Worksheet A-8, column 2, line 15.						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 7, 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, 2 and/or 3, the amount allowable should be indicated in column 4 of this part.

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

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

This information is used by the Centers for Medicare and Medicaid Services and its 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 Medicare.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5

(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 _____

PROVIDER-BASED PHYSICIANS ADJUSTMENTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-2

	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted 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
100	TOTAL									100

	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100	TOTAL									100

COST ALLOCATION GENERAL SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B

	COST CENTERS	Net Expenses (from Wkst. A, col.8)	Capital Related: Buildings & Fixtures	Capital Related: Movable Equipment	Employee Benefits	Subtotal (cols. 0-3)	Administrative & General	Maintenance & Repairs	Operation of Plant
		0	1	2	3	3A	4	5	6
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs - Bldg & Fixt								
2	Cap Rel Costs - Mvble Equip								
3	Employee Benefits								
4	Administrative and General								
5	Maintenance and Repairs								
6	Operation of Plant								
7	Laundry and Linen Service								
8	Housekeeping								
9	Cafeteria								
10	Central Services and Supplies								
11	Medical Records and Library								
12	Pro Ed & Training (Approved)(1)								
13	Other (specify)								
	REIMBURSABLE COST CENTERS								
23	Drugs & Biologicals								
24	Occupational Therapy								
25	Behavioral Health Treatment/Services								
26	Individual Therapy								
27	Group Therapy								
28	Activity Therapy								
29	Family Therapy								
30	Psychiatric Testing								
31	Education Training								
32	Other (specify)								
	NONREIMBURSABLE COST CENTERS								
42	Sheltered Workshops								
43	Recreational Programs								
44	Resident Day Camps								
45	Diagnostic Clinics								
46	Physicians' Private Office								
47	Fundraising								
48	Coffee Shops &Canteen								
49	Research								
50	Investment Property								
51	Advertising								
52	Franchise Fees & Other Assessments								
53	Pro Ed & Training (Not Approved)(2)								
54	Meals and Transportation								
55	Activity Therapies								
56	Psychosocial Programs								
57	Vocational Training								
58	Other (specify)								
100	TOTAL (sum of line 1 through 58)								

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

COST ALLOCATION GENERAL SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B

		COST CENTERS	Laundry and Linen Services	House-keeping	Cafeteria	Central Services & Supplies	Medical Records Library	Prof. Education and Training	Other (Specify)	Total	
			7	8	9	10	11	12	13	14	
		GENERAL SERVICE COST CENTERS									
1	1	Cap Rel Costs - Bldg & Fixt									1
2	2	Cap Rel Costs - Mvble Equip									2
3	3	Employee Benefits									3
4	4	Administrative and General									4
5	5	Maintenance and Repairs									5
6	6	Operation of Plant									6
7	7	Laundry and Linen Service									7
8	8	Housekeeping									8
9	9	Cafeteria									9
10	10	Central Services and Supplies									10
11	11	Medical Records and Library									11
12	12	Pro Ed & Training (Approved)(1)									12
13	13	Other (specify)									13
		REIMBURSABLE COST CENTERS									
23	23	Drugs & Biologicals									23
24	24	Occupational Therapy									24
25	25	Behavioral Health Treatment/Services									25
26	26	Individual Therapy									26
27	27	Group Therapy									27
28	28	Activity Therapy									28
29	29	Family Therapy									29
30	30	Psychiatric Testing									30
31	31	Education Training									31
32	32	Other (specify)									32
		NONREIMBURSABLE COST CENTERS									
42	42	Sheltered Workshops									42
43	43	Recreational Programs									43
44	44	Resident Day Camps									44
45	45	Diagnostic Clinics									45
46	46	Physicians' Private Office									46
47	47	Fundraising									47
48	48	Coffee Shops &Canteen									48
49	49	Research									49
50	50	Investment Property									50
51	51	Advertising									51
52	52	Franchise Fees & Other Assessments									52
53	53	Pro Ed & Training (Not Approved)(2)									53
54	54	Meals and Transportation									54
55	55	Activity Therapies									55
56	56	Psychosocial Programs									56
57	57	Vocational Training									57
58	58	Other (specify)									58
100	100	TOTAL (sum of line 1 through 58)									100

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B-1

	COST CENTERS		Capital Related: Buildings & Fixtures (Square Feet)	Capital Related: Movable Equipment (Dollar Value)	Employee Benefits (Gross Salaries)	Reconcil-iation	Administrative & General (Accum. Cost)	Maintenance & Repairs (Square Feet)	Operation of Plant (Square Feet)
		0	1	2	3	4A	4	5	6
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs - Bldg & Fixt								
2	Cap Rel Costs - Mvble Equip								
3	Employee Benefits								
4	Administrative and General								
5	Maintenance and Repairs								
6	Operation of Plant								
7	Laundry and Linen Service								
8	Housekeeping								
9	Cafeteria								
10	Central Services and Supplies								
11	Medical Records and Library								
12	Pro Ed & Training (Approved)(1)								
13	Other (specify)								
	REIMBURSABLE COST CENTERS								
23	Drugs & Biologicals								
24	Occupational Therapy								
25	Behavioral Health Treatment/Services								
26	Individual Therapy								
27	Group Therapy								
28	Activity Therapy								
29	Family Therapy								
30	Psychiatric Testing								
31	Education Training								
32	Other (specify)								
	NONREIMBURSABLE COST CENTERS								
42	Sheltered Workshops								
43	Recreational Programs								
44	Resident Day Camps								
45	Diagnostic Clinics								
46	Physicians' Private Office								
47	Fundraising								
48	Coffee Shops &Canteen								
49	Research								
50	Investment Property								
51	Advertising								
52	Franchise Fees & Other Assessments								
53	Pro Ed & Training (Not Approved)(2)								
54	Meals and Transportation								
55	Activity Therapies								
56	Psychosocial Programs								
57	Vocational Training								
58	Other (specify)								
100	TOTAL (sum of line 1 through 58)								

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B-1

		COST CENTERS	Laundry and Linen Services (Pounds of Laundry)	House-keeping (Hrs. of Service)	Cafeteria (Meals Served)	Central Services & Supplies	Medical Records Library (Time Spent)	Prof.Educ. & Training (Assigned Time)	Other (Specify)	Total	
			7	8	9	10	11	12	13	14	
		GENERAL SERVICE COST CENTERS									
1	1	Cap Rel Costs - Bldg & Fixt									1
2	2	Cap Rel Costs - Mvble Equip									2
3	3	Employee Benefits									3
4	4	Administrative and General									4
5	5	Maintenance and Repairs									5
6	6	Operation of Plant									6
7	7	Laundry and Linen Service									7
8	8	Housekeeping									8
9	9	Cafeteria									9
10	10	Central Services and Supplies									10
11	11	Medical Records and Library									11
12	12	Pro Ed & Training (Approved)(1)									12
13	13	Other (specify)									13
		REIMBURSABLE COST CENTERS									
23	23	Drugs & Biologicals									23
24	24	Occupational Therapy									24
25	25	Behavioral Health Treatment/Services									25
26	26	Individual Therapy									26
27	27	Group Therapy									27
28	28	Activity Therapy									28
29	29	Family Therapy									29
30	30	Psychiatric Testing									30
31	31	Education Training									31
32	32	Other (specify)									32
		NONREIMBURSABLE COST CENTERS									
42	42	Sheltered Workshops									42
43	43	Recreational Programs									43
44	44	Resident Day Camps									44
45	45	Diagnostic Clinics									45
46	46	Physicians' Private Office									46
47	47	Fundraising									47
48	48	Coffee Shops &Canteen									48
49	49	Research									49
50	50	Investment Property									50
51	51	Advertising									51
52	52	Franchise Fees & Other Assessments									52
53	53	Pro Ed & Training (Not Approved)(2)									53
54	54	Meals and Transportation									54
55	55	Activity Therapies									55
56	56	Psychosocial Programs									56
57	57	Vocational Training									57
58	58	Other (specify)									58
100	100	TOTAL (sum of line 1 through 58)									100

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

FORM CMS-2088-17 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4510)

APPORTIONMENT OF PATIENT SERVICE COSTS		PROVIDER CCN: _____		PERIOD: FROM _____ TO _____		WORKSHEET C	
REIMBURSABLE COST CENTERS		From Wkst. B, col. 14, Reimbursable Costs	Total Charges	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Medicare Charges	Medicare Cost (col. 3 × col. 4)	
		1	2	3	4	5	
23	Drugs & Biologicals						23
24	Occupational Therapy						24
25	Behavioral Health Treatment/Services						25
26	Individual Therapy						26
27	Group Therapy						27
28	Activity Therapy						28
29	Family Therapy						29
30	Psychiatric Testing						30
31	Education Training						31
32	Other (specify)						32
50	TOTAL (Lines 23 through 32)						50

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D

	DESCRIPTION		
1	Gross APC/PPS payments		1
2	Outlier payments		2
3	Outlier reconciliation amount (transfer from line 54)		3
4	Gross reimbursement (sum of lines 1 through 3)		4
5	Primary payer payments		5
6	Deductibles billed to program patients (do not include coinsurance)		6
7	Coinsurance billed to program patients (see instructions)		7
8	Subtotal (line 4 minus lines 5, 6, and 7)		8
9	Reimbursable bad debts (see instructions)		9
10	Adjusted reimbursable bad debts		10
11	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		11
12	Subtotal (line 8 plus line 10)		12
13	Other adjustments (specify) (see instructions)		13
14	Other demonstration payment adjustment amount before sequestration		14
15	Amount due prior to the sequestration adjustment (see instructions)		15
16	Sequestration adjustment (see instructions)		16
17	Other demonstration payment adjustment amount after sequestration		17
18	Amount due after sequestration adjustment (see instructions)		18
19	Interim payments		19
20	Tentative settlement (For contractor use only)		20
21	Balance due provider/program (line 18 minus lines 19 and 20) (indicate overpayment in brackets)		21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		22

	TO BE COMPLETED BY CONTRACTOR		
50	Original outlier amount (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money		52
53	Time Value of Money (see instructions)		53
54	Total (sum of lines 51 and 53)		54

ANALYSIS OF PAYMENTS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET D-1

	DESCRIPTION			PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to CMHC					1
2	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.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01-3.49, minus sum of lines 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99) (Transfer to Wkst. D, line 19)					4

TO BE COMPLETED BY CONTRACTOR

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01-5.49, minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (SEE INSTRUCTIONS). (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7

(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.

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET F

1	Total patient revenue			1
2	Less: Allowance and discounts on patients' accounts			2
3	Net patient revenues (line 1 minus line 2)			3
4	Less: Total operating expenses (per Worksheet A, column 4, line 100)			4
5	Net income from service to patients (line 3 minus line 4)			5
	OTHER INCOME			
6	Grants, gifts, and income designated by donor for specific expenses			6
7	Payments received from specialists			7
8	Investment income on unrestricted funds			8
9	Trade, quantity, time and other discounts on purchases			9
10	Rebates and refunds of expenses			10
11	Income from laundry and linen service			11
12	Income from cafeteria - employees, guests, etc.			12
13	Sale of medical supplies to other than patients			13
14	Sale of workshop products or services			14
15	Coffee shops and canteen			15
16	Vending machines			16
17	Rental of building or office space to others			17
18	Sale of scrap, waste, etc.			18
19	Sale of medical records and abstracts			19
20	Other (Specify)			20
21	Total other income (sum of lines 6 through 20)			21
22	Total (line 5 plus line 21)			22
	OTHER EXPENSES			
23	Fund raising			23
24	Gift, coffee shops, and canteen			24
25	Investment property			25
26	Other (specify)			26
27	Total other expenses (sum of lines 23 through 26)			27
28	Net income (or loss) for the period (line 22 minus line 27)			28