This report is required by law (42 USC 1395g) and 42CFR 413.20 and 413.24.
Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0102
Expires: 11/30/2024

ORGAN PROCUREMENT ORGANIZATION HISTOCOMPATIBILITY LABORATORY GENERAL DATA AND CERTIFICATION STATEMENT	Provider CCN: _____	PERIOD: FROM:_____ TO:_____	WORKSHEET S

Provider Use Only:
1. [ ] Electronic 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. _____

Contractor Use Only:

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

5. Date Received _____
6. Contractor No. _____
7. [ ] Initial Report for this Provider CCN
8. [ ] Final Report for this Provider CCN
9. NPR Date:_____
10. Contractor's Vendor Code: _____
11. If line 4, column 1 is 4:
Enter number of times reopened.

PART I - GENERAL

1	Name:	Provider CCN:		1
1.01	Street:		P.O. Box:	1.01
1.02	City:	State:	Zip Code:	1.02
2	Name:	Provider CCN:		2
2.01	Street:		P.O. Box:	2.01
2.02	City:	State:	Zip Code:	2.02
3	Reporting Period: From	To		3

	Type of Control (see instructions)	Description (see instructions)	Type of Provider (see instructions)	Participation Date	
	1	2	3	4	
4					4

PART II-CERTIFICATION BY OFFICER OR ADMINISTRATOR OF FACILITY

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. FUTHERMORE, IF SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATION ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER, ADMINISTRATOR OR DIRECTOR OF ORGANIZATION/LABORATORY

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 CCN(s) for the cost reporting period beginning _____ and ending_____, and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the OPO/HL 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Printed Name				2
3	Title				3
4	Signature date				4

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		
		Organ Acquisition	Tissue Typing	
		1	2	
1	OPO/LAB			1

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 0938-0102. The time required to complete this information collection is estimated to average 45 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: Centers for Medicare and Medicaid Services, 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-216-94 (08/2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 3302, 3302.1 and 3302.2)

ORGAN PROCUREMENT ORGANIZATION/ HISTOCOMPATIBILITY LABORATORY IDENTIFICATION DATA	Provider CCN: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-1

PART I-OPO STATISTICS

			1	2	3	
			Local	Imported	Total (Columns 1 & 2)	
1	Total number of kidneys retrieved (viable and nonviable)					1
2	Total number of kidneys included in line 1 that were nonviable.					2
3	Net number of kidneys for which payment should have been received (line 1 minus line 2).					3
			USA	Foreign Country	Total	
4	Total number of kidneys included in line 3, column 3 that were exported out of local retrieval areas					4
			Military	VA	Total	
5	Total number of kidneys sent to military or VA hospitals that were included in line 3, column 3.	Number				5
6	Amount received for kidneys listed in line 5.	Amount Received				6
				Number of Kidneys	Amount Received	
7	Was payment received for kidneys furnished to foreign countries and included on line 4, column 2. Enter "Y" for yes or "N" for no. If yes, enter the total number of kidneys and amount received in columns 2 and 3, respectively.					7

Total number of organs/tissue other than kidneys retrieved and administratively processed. In the amount received column enter the total amount of payment received for each type of organ.

	Organ	Total	Nonviable	Amount Received	
8	Cornea				8
8.01	Liver				8.01
8.02	Pancreas				8.02
8.03	Pancreas Islet				8.03
8.04	Heart				8.04
8.05	Heart Valves				8.05
8.06	Heart/Lung				8.06
8.07	Bone				8.07
8.08	Skin				8.08
8.09	Lung				8.09
8.10	Other				8.10
9	Total				9

PART II-LAB STATISTICS

1	Total number of tests performed- all laboratory.		1
2	Total number of tests performed-tissue typing laboratory.		2
3	Total number of pre-transplant tests performed for kidney transplantation that are included in line 2.		3

Tissue typing pre-transplant tests performed for kidney transplant:

	Test Name	Number of Tests	
4			4
4.01			4.01
4.02			4.02
4.03			4.03
4.04			4.04
4.05			4.05
4.06			4.06
4.07			4.07
4.08			4.08
4.09			4.09
4.10			4.10
5	Total Tests		5

PART III-Full Time Equivalent Employees (FTEs)

Number of full-time equivalent employees

	Administrative		OPO		Histo-Lab		
	1	2	3	4	5	6	
1	Medical Director		Medical Director		Lab Director		1
1.01	Exec. Director		Procurement Coordinator		Technicians		1.01
1.02	Clerical		Preservation Technicians		Tissue Typing Tech.		1.02
1.03	Other		Other		Other		1.03
2	Total FTEs						2

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

General Instruction: For all column 1 responses, enter "Y" for YES or "N" for NO

Enter all dates in the format (mm/dd/yyyy)

COMPLETED BY ALL OPO/HISTO LABS

		Y/N	Date		
	Provider Organization and Operation	1	2	3	
1	Has the provider filed a less than or greater than 12 month cost report due to a change of ownership? If yes, enter the date of the change in column 2. Enter in column 3 the date the 855A was submitted.				1
2	Has the provider terminated participation in the Medicare program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

		Y/N	Type	Date	
	Financial Data and Reports	1	2	3	
4	Column 1: Were the financial statements prepared by a certified public accountant? Column 2: If column 1 is yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

Cost Report Preparer Contact Information

6	First name:	Last name:	Title:	6
7	Employer:			7
8	Phone number:	E-mail Address:		8

RESERVED FOR FUTURE USE

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

		COST CENTERS (OMIT CENTS)	SALARIES	OTHER	TOTAL (Cols. 1 & 2)	RECLASS. TO EXPENSES (FROM WKST.A-4)	RECLASSIFIED TRIAL BALANCE (COL.3 +/- COL.4)	ADJUSTMENTS TO COST (FROM (WKST. A-5)	NET COST FOR COST ALLOCATION (COL.5+/-COL.6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Capital Costs--Buildings and Fixtures								1
2	0200	Capital Costs--Movable Equipment								2
3	0300	Employee Benefits								3
4	0400	Administrative and General (from W/S-A-1, cols. 1 and 2, line 20)								4
5	0500	Operation and Maintenance of Plant								5
6	0600	Housekeeping								6
7	0700	Medical Supplies								7
8	0800	Other Overhead (specify)								8
		ORGAN ACQUISITION OVERHEAD								
9	0900	Procurement Coordinators								9
10	1000	Professional Education								10
11	1100	Public Education								11
12	1200	Other Acquisition (specify)								12
		REIMBURSABLE COST CENTERS								
13	1300	Kidney Acquisitions (from W/S A-2, cols. 1 and 2, line 23)								13
14	1400	Tissue Typing Laboratory (W/S-A-3, cols. 1 and 2, Line 11)								14
		NON-REIMBURSABLE COST CENTERS								
15	1500	Liver Acquisitions (W/S-A-2, cols. 1 and 2, line 23)								15
16	1600	Heart Acquisitions (W/S-A-2, cols. 1 and 2, line 23)								16
17	1700	Pancreas Acquisitions (W/S-A-2, cols. 1 and 2, line 23)								17
18	1800	Lung Acquisitions (W/S-A-2, cols. 1 and 2, line 23)								18
19	1900	Other Acquisitions (W/S-A-2, cols. 1 and 2, line 23)								19
20	2000	*Other Acquisitions* ***(subscript line 19 and do not use line 20)***								20
21	2100	Research								21
22	2200	Blood Bank								22
23	2300	Laboratory-Non-Tissue Typing								23
24	2400	Dialysis Units								24
25	2500	Other Non-Reimbursable (Specify)								25
26		Total Expenses (sum of lines 1-25), Transfer Column 7 to W/S-B line 1, or W/S-C, as per instructions								26

FORM CMS-216-94 (06/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3304)

ADMINISTRATIVE AND GENERAL EXPENSES	Provider CCN: _____	REPORTING PERIOD: FROM_____ TO_____	WORKSHEET A-1

	COST CENTER	SALARIES	OTHER	TOTAL	
		1	2	3	
1	Medical Director				1
2	Executive Director				2
3	Home Office/Central Administration				3
4	Data Processing				4
5	Accounting-Legal-Audit				5
6	Rent and Lease Expense				6
7	Office Supplies				7
8	Telephone				8
9	Travel-Meetings and Seminars				9
10	Insurance				10
11	Employee Professional Education				11
12	Public Relations				12
13	Interest Expense				13
14	Taxes				14
15	Office Salaries				15
16	Other Administrative and General:				16
17					17
18					18
19					19
20	Total Administrative and General (sum of lines 1 through 19) Transfer the totals for columns 1 and 2 to Worksheet A, columns 1 and 2, line 4.				20

ORGAN ACQUISITION COST	Provider CCN: _____	REPORTING PERIOD: FROM_____ TO_____	WORKSHEET A-2

Check One:

[ ] Kidney [ ] Liver [ ] Heart [ ] Pancreas [ ] Lung [ ] Other _____

	COST CENTER	SALARIES	OTHER	TOTAL	
		1	2	3	
	Organ Acquisition Costs Amounts Paid To Excision Hospitals				
1	Operating Room				1
2	Anesthesiology				2
3	Respiratory Therapy				3
4	Intensive Care Unit				4
5	Medical Supplies				5
6	Pharmacy				6
7	Electroencephalography				7
8	Hospital Laboratory				8
9	Other Excision Hospital Cost (specify)				9
10	Subtotal-Excision Hospital Cost (sum of lines 1-9)				10
	Other Acquisitions Costs				
11	Computer Registry				11
12	Donor Evaluation				12
13	Surgeon Fee				13
14	Organ Preservation				14
15	Donor Tissue Typing				15
16	Recipient Crossmatch				16
17	Imported Organ Cost				17
18	Transportation of Organs				18
19	Tissue Typing Lab-Under Agreement				19
20	Anesthesiologist Professional Fees				20
21	Other Acquisition Costs (specify)				21
22	Subtotal-Other Acquisition Cost (sum of lines 11-21)				22
23	Total-Organ Acquisition Cost (sum of lines 10 and 22) Transfer columns 1 and 2, line 23 to W/S A. (see instructions)				23

TISSUE TYPING LABORATORY COSTS	Provider CCN: _____	REPORTING PERIOD: FROM_____ TO_____	WORKSHEET A-3

	COST CENTER	SALARIES	OTHER	TOTAL	
		1	2	3	
1	Laboratory Director				1
2	Tissue Typing Technologist				2
3	Sera Procurement				3
4	Equipment Maintenance				4
5	Other Tissue Typing Cost (specify)				5
6					6
7					7
8					8
9					9
10					10
11	Total -Tissue Typing Cost (sum of lines 1-10) Transfer columns 1 and 2 to Worksheet A, columns 1 and 2, line 14.				11

RECLASSIFICATIONS | Provider CCN: _____ | REPORTING PERIOD: FROM:_____ TO:_____ | WORKSHEET A-4

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

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

(2) Transfer to Worksheet A, Column 4, line as appropriate.

ADJUSTMENTS TO EXPENSES	Provider CCN: _____	REPORTING PERIOD: FROM:_____ TO:_____	WORKSHEET A-5

	Description (1)	Basis for Adjust-ment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added: Cost Center	Ln No.	
		1	2	3	4	
1	Purchase Discounts					1
2	Rebates and Refunds					2
3	Home Office Costs					3
4	Adjustments resulting from transactions with related organizations (Chapter 10)	From Supp. W/S A-5-1				4
5	Income received from the procurement of organs other than kidneys. (3)					5
6	Vending Machines					6
7	Rental or Lease Income					7
8	Organs Sold for Research					8
9	Public Relations-Not related to Organ Procurement					9
10	Income received from Professional Education					10
11	Sale of Supplies					11
12	Interest Income applied to interest exp.					12
13	Capital Costs -Buildings & Fixtures					13
14	Capital Costs -Movable Equipment					14
15						15
16						16
17	Total -Transfer to W/S. A, Column 6, Line as Appropriate					17

(1) Description-all line references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (SEE INSTRUCTIONS)
A. Costs-if cost, including applicable overhead, can be determined
B. Amount Received-if cost cannot be determined

(3) Only the income from organs such as Cornea, Skin, Heart Valves, Bone, and Pancreas Islet may be offset.
All solid organs such as Kidneys, Hearts, Livers, Lung, and Pancreas must go through cost finding on W/S B

CAPITAL EXPENDITURES AND DEPRECIATION RECONCILIATION	Provider CCN: _____	REPORTING PERIOD FROM:_____ TO:_____	WORKSHEET A-6

Part I - Analysis of Changes in Capital Asset Balances During Cost Reporting Period		Beginning Balance	Acquisitions			Disposals	Ending Balance	
			Purchase	Donations	Total			
		1	2	3	4	5	6	
1	Land							1
2	Land Improvements							2
3	Building and Fixtures							3
4	Fixed Equipment							4
5	Movable Equipment							5
6	Auto, Truck, Van							6
7	Other (Specify)							7
8	Total							8

Part II - Analysis of Changes In Accumulated Depreciation		Beginning Balance	Additions	Deletions	Ending Balance	
Description		1	2	3	4	
1	Land					1
2	Land Improvements					2
3	Buildings and Fixtures					3
4	Building Improvements					4
5	Fixed Equipment					5
6	Movable Equipment					6
7	Auto, Truck, Van					7
8	Other (Specify)					8
9	Total					9

Part III - Depreciation Reported In Cost Statement				
1	Straight Line			1
2	Declining Balance			2
3	Sum of Years Digits			3
4	Depreciation reported on W/S -A column 7. (Total- Sum of 1, 2 and 3)			4
		1	2	
5	Is depreciation funded? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the balance in fund at the end of the period.			5
6	Was there a gain or loss on the sale of assets during the cost reporting period? (See CMS Pub-15-1, Section 132)			6

FORM CMS-216-94 (06/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2 SECTION 3310)

COST ALLOCATION-GENERAL SERVICE COSTS | Provider CCN: _____ | REPORTING PERIOD FROM_____ TO_____ | WORKSHEET B

	COST CENTER	NET COST FOR ALLOCATION (FROM WKST. A, COL.7)	CAPITAL-BUILDING, OPERATION OF PLANT AND HOUSE KEEPING	CAPITAL COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	MEDICAL SUPPLIES	OTHER		ORGAN ACQUISITION COSTS	SUBTOTAL (COLS.1-8)	ADMIN. & GENERAL	TOTAL EXPENSES	
		1	2	3	4	5	6	7	8	9	10	11	
1	COSTS TO BE ALLOCATED		( )	( )	( )	( )	( )				( )		1
2	Organ Acquisitions								( )	-0-			2
	REIMBURSABLE COST CENTERS												
3	Kidney Acquisitions (1)												3
4	Tissue Typing Laboratory(2)												4
	NONREIMBURSABLE COST CENTERS												
5	Liver Acquisitions												5
6	Heart Acquisitions												6
7	Pancreas Acquisitions												7
8	Lung Acquisitions												8
9	Other Acquisitions												9
10	Research												10
11	Blood Bank												11
12	Laboratory-Non-Tissue Typing												12
13	Dialysis Units												13
14													14
15													15
16	Totals Expenses		-0-	-0-	-0-	-0-	-0-		-0-		-0-		16

(1) Transfer amount on line 3, column 11 to Worksheet C, line 4, Part I

(2) Transfer amount on line 4, column 11 to Worksheet C, line 4, Part II

COST ALLOCATION-STATISTICAL BASIS | Provider CCN: _____ | REPORTING PERIOD: FROM_____ TO_____ | WORKSHEET B-1

	COST CENTERS	CAPITAL BUILDING OPERATION OF PLANT AND HOUSE-KEEPING (SQ. FEET)	CAPITAL COSTS MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (ADJUSTED SALARIES)	MEDICAL SUPPLIES (COSTED REQUISITIONS)	OTHER		ORGAN ACQUISITION COSTS (NUMBER OF ORGANS)		RECONCILIATION	ADMINISTRATION & GENERAL (ACCUMULATED COSTS)	
		2	3	4	5	6	7	8	9	10A	10	
1	COSTS TO BE ALLOCATED											1
2	Organ Acquisition Costs											2
	REIMBURSABLE COST CENTERS											
3	Kidney Acquisitions											3
4	Tissue Typing Laboratory											4
	NONREIMBURSABLE COST CENTERS											
5	Liver Acquisitions											5
6	Heart Acquisitions											6
7	Pancreas Acquisitions											7
8	Lung Acquisitions											8
9	Other Organ Acquisitions											9
10	Research											10
11	Blood Bank											11
12	Laboratory-Non-Tissue Typing											12
13	Dialysis Units											13
14												14
15												15
16	Total (lines 2-15)											16
17	COSTS TO BE ALLOCATED PER W/S B											17
18	UNIT COST MULTIPLIER (line 17/line 16)											18

FORM CMS-216-94 (10/2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3311)

COMPUTATION OF MEDICARE COST	Provider CCN: _____	REPORTING PERIOD FROM_____ TO_____	WORKSHEET C

	Part I - KIDNEY ACQUISITION	
1	Total Number of Viable Kidneys Procured (W/S S-1, Part 1, line 3, col. 3)	
2	Total Number of Medicare Kidneys (see instructions)	
3	Ratio of Medicare Kidneys to Total Kidneys (line 2 / line 1)	
4	Total Cost Applicable to Kidney Acquisition (see instructions)	
5	Total Medicare Kidney Acquisition Costs (line 3 x line 4) (1)	

(1) Transfer amount on line 5 to Worksheet D, Column 1, Line 1

	Part II - TISSUE TYPING LABORATORY	
1	Gross Charges - Tissue Typing Laboratory-All Tests	
2	Gross Charges - Tissue Typing Laboratory-Kidney Transplant Related Tests Only (2)	
3	Ratio of Kidney Transplant Charges to Total Charges (line 2 / line 1)	
4	Total Cost Applicable to Tissue Typing Lab. (see instructions)	
5	Reimbursable Kidney Transplant Related Costs (line 3 x line 4) (3)	

(2) If the cost report is a partial year under the program, show only the kidney related revenue earned since the participation date.

(3) Transfer amount on line 5 to Worksheet D, Column 2, Line 1.

Cont.)

1
2
3
4
5

1
2
3
4
5

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: _____	REPORTING PERIOD FROM_____ TO_____	WORKSHEET D

		1	2	
		Kidney Acquisition	Tissue Typing Lab	
1	Medicare Reimbursable Cost-Kidney Acquisition- W/S-C, Part I, line 5 Tissue Typing-Laboratory W/S-C, Part II, line 5			1
2	Total Revenue Received for Lab Services Furnished to Foreign Countries, Military and VA Hospitals			2
3	Total Reimbursable Cost to OPO/LAB (line 1 - line 2)			3
4	Total Payments Received and Receivable from OPOs and Transplant Hospitals for Kidneys Furnished or Laboratory Services Provided for Kidney Transplantation (From Your Records)			4
5	Subtotal (line 3 - line 4)			5
6	Sequestration Adjustment (see instructions)			6
7	Interim Payments			7
8	Net Balance Due to/from the OPO/LAB (Medicare Program) (line 5 - (line 6 + line 7)			8

BALANCE SHEET	Provider CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E

	Assets (Omit cents)	General Fund		Liabilities and Fund Balance (Omit Cents)	General Fund
		1			1
	CURRENT ASSETS			CURRENT LIABILITIES	
1	Cash		34	Accounts payable	
2	Temporary investments		35	Salaries, wages & fees payable	
3	Notes receivable		36	Payroll taxes payable	
4	Accounts receivable		37	Notes & loans payable (Short term)	
5	Other receivables		38	Advanced blood deposits	
6	Less: allowances for uncollectible notes and accounts receivable	( )	39		
			40	Due to other funds	
7	Inventory		41		
8	Prepaid expenses		42	TOTAL CURRENT LIABILITIES (sum of lines 34 - 41)	
9	Other current assets				
10	Due from other funds			LONG TERM LIABILITIES	
11	TOTAL CURRENT ASSETS (sum of lines 1 - 10)		43	Mortgage payable	
			44	Notes payable	
	FIXED ASSETS		45	Unsecured loans	
12	Land		46		
13	Land improvements				
14	Less: Accumulated depreciation	( )	47		
15	Buildings		48		
16	Less: Accumulated depreciation	( )	49	TOTAL LONG TERM LIABILITIES (sum of lines 43 - 48)	
17	Leasehold improvements				
18	Less: Accumulated depreciation	( )	50	TOTAL LIABILITIES (sum of lines 42 and 49)	
19	Fixed equipment				
20	Less: Accumulated depreciation	( )		CAPITAL ACCOUNTS	
21	Automobiles and trucks		51	General fund balance	
22	Less: Accumulated depreciation	( )	52	Specific purpose fund balance	
23	Major movable equipment		53	Donor created - endowment fund balance - restricted	
24	Less: Accumulated depreciation	( )			
25	Minor equipment nondepreciable		54	Donor created - endowment fund balance - unrestricted	
26	Other fixed assets				
27	TOTAL FIXED ASSETS (Sum of lines 12 - 26)		55	Governing board created - endowment fund balance	
	OTHER ASSETS		56	Plant fund balance - invested in plant	
28	Investments		57	Plant fund balance - reserve for plant improvement, replacement and expansion	
29	Deposits on leases				
30	Due from owners/officers				
31			58	TOTAL FUND BALANCE (sum of lines 51 thru 57)	
32	TOTAL OTHER ASSETS (sum of lines 28 - 31)		59	TOTAL LIABILITIES AND FUND BALANCE (sum of lines 50 and 58)	
33	TOTAL ASSETS (sum of lines 11, 27 and 32)				

( ) = contra amount

STATEMENT OF OPERATING EXPENSES AND REVENUES	Provider CCN: _____	REPORTING PERIOD FROM_____ TO_____	WORKSHEET E-1

PART I REVENUES		OPO	BLOOD BANK/LAB	TOTAL	
1	Whole Blood and Components				1
2	Processing Fees				2
3	Other Blood Products and Services				3
4	Tissue Typing Services				4
5	Other Laboratory Services				5
6	Other Patient Service Fees:				6
7					7
8					8
9					9
10	Kidney Procurement Revenue				10
11	Other Organ Procurement Revenue				11
12	Total Revenue for Services Provided				12

PART II EXPENSES				
1	Operating Expenses (W/S A, column 3, line 26)			1
2	Add (Specify)			2
3				3
4				4
5				5
6	Total Additions			6
7	Deduct (Specify)			7
8		( )		8
9		( )		9
10		( )		10
11	Total Deductions		( )	11
12	Total Operating Expenses (sum of lines 1 and 6 minus 11) Transfer to Worksheet E-2 Line 4			12

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: _____	REPORTING PERIOD FROM_____ TO_____	WORKSHEET E-2

1	Total Revenues for Services Provided (W/S E-1, Part I, line 12)			1
2	Less: Allowances for Discounts on Services		( )	2
3	Net Revenue for Services Provided			3
4	Less: Total Operating Expenses (W/S E-1, Part II line 12)		( )	4
5	Net Income From Services			5
6	Other Income:			6
7	Contributions			7
8	Income From Investments			8
9	Purchase Discounts			9
10	Rebates and Refunds of Expenses			10
11	Parking Lot Receipts			11
12	Vending Machine Receipts			12
13	Rental or Lease Income			13
14	Income From Sales of Supplies			14
15	Federal Research Grants (Specify)			15
16	Federal Research Grants (Specify)			16
17	Federal Research Grants (Specify)			17
18	Other Research Grants (Specify)			18
19	Other Research Grants (Specify)			19
20	Other (Specify)			20
21	Other (Specify)			21
22	Other (Specify)			22
23	Other (Specify)			23
24	Total Other Income (sum of lines 6-23)			24
25	Total (line 5 plus line 24)			25
26	Other Expenses(Specify)			26
27	Other Expenses(Specify)			27
28	Total Other Expenses (sum of lines 26 & 27)		( )	28
29	Net Income (or Loss) for the Period (line 25 minus line 28)			29

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: _____	REPORTING PERIOD: FROM_____ TO_____	SUPPLEMENTAL WORKSHEET A-5-1

A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part 1, Chapter 10?
[ ] Yes [ ] No (If "Yes", complete Parts B and C)

B. Costs incurred and adjustments required as a result of transactions with related organizations or claimed home office costs

	LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT OF ALLOWABLE COST	NET ADJUSTMENT (COL.4 MINUS COL. 5)	
	LINE NO.	COST CENTER	EXPENSES ITEMS	AMOUNT			
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer col.6, line 1-4 to Wkst. A,col.6 as appropriate) (Transfer col.6, line 5 to Wkst. A-5, col.2, line 4, Adjustment to Expenses)						5

C. Interrelationship of facility 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 the provider to furnish the information requested on Part C of this worksheet.

This information will be 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 the facility by common ownership or control, represent reasonable costs as determined under section 1861(v) (1) (a) of the Social Security Act. If the provider does not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				RELATED ORGANIZATION(S) 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

(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 the facility;
B. Corporation, partnership, or other organization has financial interest in the facility;
C. Facility has financial interest in corporation, partnership, or other organization(s);
D. Director, officer, administrator, or key person of the facility or relative of such person has financial interest in related organization;
E. Individual is director, officer, administrator, or key person of the facility and related organization;
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the facility;
G. Other (financial or non-financial) specify _____