

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<br>HISTOCOMPATIBILITY LABORATORY GENERAL<br>DATA AND CERTIFICATION STATEMENT | Provider CCN:<br>_____ | PERIOD:<br>FROM: _____<br>TO: _____ | WORKSHEET S |
|---|------------------------|-------------------------------------|-------------|

|                    |   |             |             |
|--------------------|---|-------------|-------------|
| Provider Use Only: | 1. <input type="checkbox"/> Electronic filed cost report  | Date: _____ | Time: _____ |
|                    | 2. <input type="checkbox"/> Manually submitted cost report  |             |             |
|                    | 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report. _____ |             |             |

|                      |  |  |
|----------------------|--|--|
| Contractor Use Only: | 4. <input type="checkbox"/> Cost Report Status | 5. Date Received _____   |
|                      | (1) As Submitted                               | 6. Contractor No. _____  |
|                      | (2) Settled without audit                      | 7. <input type="checkbox"/> Initial Report for this Provider CCN |
|                      | (3) Settled with audit                         | 8. <input type="checkbox"/> Final Report for this Provider CCN   |
|                      | (4) Reopened                                   | 9. NPR Date: _____   |
|                      | (5) Amended                                    | 10. Contractor's Vendor Code: _____                              |
|                      |  | 11. If line 4, column 1 is 4:<br>Enter number of times reopened. |

|                          |                                       |                                   |  |                    |
|--------------------------|---------------------------------------|-----------------------------------|--|--------------------|
| <b>PART I - GENERAL</b>  |                                       |                                   |  |                    |
| 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<br>(see instructions) | Description<br>(see instructions) | Type of Provider<br>(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. FUTUREMORE, 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 to be the legally binding equivalent of my original signature. |
| 2 | Printed Name  |          | 2  |
| 3 | Title   |          | 3  |
| 4 | Signature date  |          | 4  |

|                                      |                   |               |
|--------------------------------------|-------------------|---------------|
| <b>PART III - SETTLEMENT SUMMARY</b> |                   |               |
|                                      | 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/<br>HISTOCOMPATIBILITY LABORATORY<br>IDENTIFICATION DATA<br>PART I-OPO STATISTICS | Provider CCN:<br>_____<br>_____ | PERIOD:<br>FROM _____<br>TO _____ | WORKSHEET S-1 |
|--|---------------------------------|-----------------------------------|---------------|

|   |  | 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<br>QUESTIONNAIRE | PROVIDER CCN:<br>_____ | PERIOD:<br>FROM: _____<br>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?<br>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?<br>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?<br>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<br>FROM: _____<br>TO: _____ |   | WORKSHEET A   |  |   |    |
|--|------|--|---------------------|-------|--|---|---|--|---|----|
| COST CENTERS (OMIT CENTS)                                    |      |  | SALARIES            | OTHER | TOTAL<br>(Cols. 1 & 2)                       | RECLASS.<br>TO EXPENSES<br>(FROM<br>WKST.A-4) | RECLASSIFIED<br>TRIAL BALANCE<br>(COL.3<br>+/- COL.4) | ADJUSTMENTS<br>TO COST<br>(FROM<br>(WKST. A-5) | NET COST<br>FOR COST<br>ALLOCATION<br>(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 ( <b>subscript line 19 and do not use line 20</b> )                               |                     |       |  |   |   |  |   | 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:<br>FROM _____<br>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<br>(sum of lines 1 through 19)<br>Transfer the totals for columns 1 and 2 to<br>Worksheet A, columns 1 and 2, line 4. |               |   |               | 20 |

FORM CMS 216-94 (06/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 3305)

|                        |                        |   |               |
|------------------------|------------------------|---|---------------|
| ORGAN ACQUISITION COST | Provider CCN:<br>_____ | REPORTING PERIOD:<br>FROM _____<br>TO _____ | WORKSHEET A-2 |
|------------------------|------------------------|---|---------------|

Check One:

Kidney  Liver  Heart  Pancreas  Lung  Other \_\_\_\_\_

|    | COST CENTER   | SALARIES | OTHER | TOTAL |    |
|----|---|----------|-------|-------|----|
|    |   | 1        | 2     | 3     |    |
|    | Organ Acquisition Costs<br>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<br>(sum of lines 10 and 22)<br>Transfer columns 1 and 2, line 23 to W/S A.<br>(see instructions) |          |       |       | 23 |

FORM CMS 216-94 (06/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 3306)

| TISSUE TYPING LABORATORY COSTS |   | Provider CCN:<br>_____ | REPORTING PERIOD:<br>FROM _____<br>TO _____ | WORKSHEET A-3 |    |
|--------------------------------|---|------------------------|---|---------------|----|
|                                | COST CENTER   | SALARIES<br>1          | OTHER<br>2                                  | TOTAL<br>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<br>(sum of lines 1-10)<br>Transfer columns 1 and 2 to<br>Worksheet A, columns 1 and 2, line 14. |                        |   |               | 11 |

FORM CMS 216-94 (06/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 3307)



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

| EXPLANATION OF RECLASSIFICATION ENTRY | CODE   | INCREASE    |          |            | DECREASE    |          |            |    |
|---------------------------------------|--|-------------|----------|------------|-------------|----------|------------|----|
|                                       | (1)  | COST CENTER | LINE NO. | AMOUNT (2) | COST CENTER | LINE NO. | 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:<br>FROM: _____<br>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 |   |               |
|                         | 1   |                      | 2   | 3   | Ln No. 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: _____ | WORKSHEET A-6 |
|  |                     | TO: _____                    |               |

| 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 Description |                        | Beginning Balance | Additions | Deletions | Ending Balance |   |
|---|------------------------|-------------------|-----------|-----------|----------------|---|
|   |                        | 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:<br>FROM _____<br>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:<br>_____ | REPORTING PERIOD<br>FROM _____<br>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 |
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|   |
|---|
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |

\_\_\_\_\_

Rev. 7

| CALCULATION OF REIMBURSEMENT<br>SETTLEMENT |   | Provider CCN:<br>_____ | REPORTING PERIOD<br>FROM _____<br>TO _____ | WORKSHEET D       |   |
|--|---|------------------------|--|-------------------|---|
|  |   | 1                      |  | 2                 |   |
|  |   | Kidney Acquisition     |  | Tissue Typing Lab |   |
| 1  | Medicare Reimbursable Cost-Kidney Acquisition-<br>W/S-C, Part I, line 5<br>Tissue Typing-Laboratory W/S-C, Part II, line 5  |                        |  |                   | 1 |
| 2  | Total Revenue Received for Lab Services Furnished to<br>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<br>and Transplant Hospitals for Kidneys Furnished or<br>Laboratory Services Provided for Kidney Transplantation<br>(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)<br>(line 5 - (line 6 + line 7))  |                        |  |                   | 8 |



| BALANCE SHEET          |  | Provider CCN:        | PERIOD:<br>FROM _____<br>TO _____               | WORKSHEET<br>E  |
|------------------------|--|----------------------|---|---|
| Assets<br>(Omit cents) |  | General<br>Fund<br>1 | Liabilities and Fund<br>Balance<br>(Omit Cents) | General<br>Fund<br>1  |
| <b>CURRENT ASSETS</b>  |  |                      | <b>CURRENT LIABILITIES</b>                      |   |
| 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<br>(sum of lines 34 - 41)                                 |
| 9                      | Other current assets   |                      |   |   |
| 10                     | Due from other funds   |                      | <b>LONG TERM LIABILITIES</b>                    |   |
| 11                     | TOTAL CURRENT ASSETS<br>(sum of lines 1 - 10)                    |                      | 43  | Mortgage payable  |
|                        |  |                      | 44  | Notes payable   |
| <b>FIXED ASSETS</b>    |  |                      | 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<br>(sum of lines 43 - 48)                               |
| 17                     | Leasehold improvements   |                      | 50  | TOTAL LIABILITIES<br>(sum of lines 42 and 49)                                       |
| 18                     | Less: Accumulated depreciation                                   | ( )                  |   |   |
| 19                     | Fixed equipment  |                      | <b>CAPITAL ACCOUNTS</b>                         |   |
| 20                     | Less: Accumulated depreciation                                   | ( )                  | 51  | General fund balance  |
| 21                     | Automobiles and trucks   |                      | 52  | Specific purpose fund balance   |
| 22                     | Less: Accumulated depreciation                                   | ( )                  | 53  | Donor created - endowment fund<br>balance - restricted                              |
| 23                     | Major movable equipment  |                      | 54  | Donor created - endowment fund<br>balance - unrestricted                            |
| 24                     | Less: Accumulated depreciation                                   | ( )                  |   |   |
| 25                     | Minor equipment nondepreciable                                   |                      | 55  | Governing board created - endowment<br>fund balance                                 |
| 26                     | Other fixed assets   |                      | 56  | Plant fund balance - invested in plant  |
| 27                     | TOTAL FIXED ASSETS<br>(Sum of lines 12 - 26)                     |                      | 57  | Plant fund balance - reserve for<br>plant improvement, replacement and<br>expansion |
| <b>OTHER ASSETS</b>    |  |                      | 58  | TOTAL FUND BALANCE<br>(sum of lines 51 thru 57)                                     |
| 28                     | Investments  |                      | 59  | TOTAL LIABILITIES AND<br>FUND BALANCE<br>(sum of lines 50 and 58)                   |
| 29                     | Deposits on leases   |                      |   |   |
| 30                     | Due from owners/officers   |                      |   |   |
| 31                     |  |                      |   |   |
| 32                     | TOTAL OTHER ASSETS<br>(sum of lines 28 - 31)                     |                      |   |   |
| 33                     | TOTAL ASSETS<br>(sum of lines 11, 27 and 32)                     |                      |   |   |

( ) = contra amount



| STATEMENT OF OPERATING EXPENSES<br>AND REVENUES |                                     | Provider CCN:<br>_____ | REPORTING PERIOD<br>FROM _____<br>TO _____ | WORKSHEET E-1 |    |
|---|-------------------------------------|------------------------|--|---------------|----|
| PART I<br>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<br>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) |     |  |     | 12 |
|                     | Transfer to Worksheet E-2 Line 4                         |     |  |     |    |



| STATEMENT OF REVENUES<br>AND EXPENSES |   | Provider CCN:<br>_____ | REPORTING PERIOD<br>FROM _____<br>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:<br>_____ | REPORTING PERIOD:<br>FROM _____<br>TO _____ | SUPPLEMENTAL WORKSHEET<br>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)<br>(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.

| SYMBOL<br>(1) | Name | Percentage of Ownership | RELATED ORGANIZATION(S) AND/ OR HOME OFFICE |                         |                  |   |
|---------------|------|-------------------------|---|-------------------------|------------------|---|
|               |      |                         | 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 \_\_\_\_\_

