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

FORM APPROVED
OMB NO. 0938-0037
EXPIRES: 03/31/2025

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

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically prepared cost report Date: _____ Time: _____ 2. [ ] Manually prepared cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received:_____ 7. Contractor No.:_____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date:_____ 11. Contractor's Vendor Code: _____ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

	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	Signatory Printed Name				2
3	Signatory Title				3
4	Signature date				4

PART III - SETTLEMENT SUMMARY

		TITLE XVIII	
		1	
1	COMMUNITY MENTAL HEALTH CENTER		1

The above amount represents "due to" or "due from" the Medicare program.

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 0938-0037. The time required to complete this information collection is estimated to average 90 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports 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.

COMMUNITY MENTAL HEALTH CENTER IDENTIFICATION DATA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-1 PARTS I & II

PART I - IDENTIFICATION DATA

			PROVIDER CCN	CBSA	DATE CERTIFIED	TYPE OF CONTROL (SEE INSTRUCTIONS)	
	1		2	3	4	5	
1	Site Name:						1
2	Street:		P O Box:				2
3	City:		State:	ZIP Code:	County:		3
4	Cost Reporting Period (mm/dd/yyyy)	From:	To:				4
5	Is this CMHC part of a HO/CO as defined in §2150 of CMS Pub. 15-1 that claims HO/CO costs in a home office cost statement? Enter "Y for yes or "N" for no in column 1. If yes, enter the HO/CO information below.						5
6	Name of HO/CO:						6
7	Street:		P O Box:	HO/CO CCN:			7
8	City:		State:	ZIP Code:			8

Medical Malpractice

9	Is this CMHC legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				9
10	If line 9 is "Y", is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				10

		PREMIUMS	PAID LOSSES	SELF INSURANCE	
		1	2	3	
11	Enter total malpractice premiums in col. 1, total paid losses in col. 2, and total self insurance in col. 3				11
12	Are malpractice premiums and/or paid losses reported in other than the A&G cost center? Enter "Y" for yes or "N" for no. (see instructions)				12

Miscellaneous

		Y/N	DEMONSTRATION TYPE	
		1	2	
13	Did this facility participate in any payment demonstration during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2. If the CMHC participated in more than one demonstration, subscript this line accordingly.			13
14	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.			14

PART II - STATISTICAL DATA

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

	REIMBURSABLE COST CENTERS	WKST.	FTES ON PAYROLL						
			STAFF THERAPISTS	PHYSICIANS	SOCIAL WORKERS	OTHERS			
		A	7	8	9	10			
1	Drugs & Biologicals	23							1
2	Occupational Therapy	24							2
3	Behavioral Health Treatment/Services	25							3
4	Individual Therapy	26							4
5	Group Therapy	27							5
6	Activity Therapy	28							6
7	Family Therapy	29							7
8	Psychiatric Testing	30							8
9	Education Training	31							9
10	Other (specify)	32							10
11	TOTAL (sum of lines 1 through 10)								11
12	Unduplicated Census								12

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

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

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

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

		Y/N	DATE	
	PS&R REPORT DATA	1	2	
9	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions)			9
10	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in col. 1. If yes, enter in col. 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions			10
11	If line 9 or 10 is yes, were adjustments made to PS&R report data for additional claims that have been billed but are not include on the PS&R report used to file the cost report? Enter "Y" for yes or "N" for no. If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments:			13
14	Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

COST REPORT PREPARER CONTACT INFORMATION

15	First name:		Last name:		Title:	15
16	Employer:					16
17	Phone number:		E-mail Address:			17

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

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

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD: FROM ____ TO ____	WORKSHEET A

	EXPLANATION OF RECLASSIFICATION(S)	CODE [1]	INCREASE				DECREASE				
			COST CENTER	LINE NO.	SALARY [2]	NON SALARY [2]	COST CENTER	LINE NO.	SALARY [2]	NON SALARY [2]	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36
37											37
38											38
39											39
40											40
100	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)										100

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

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

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

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

[1] Include amounts not already applied against expenses included on Worksheet A, column 4

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

[3] Additional adjustments may be made on lines 17 thru 49 and subscripts thereof.

Chapter references are to CMS Pub.15-1

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

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

	WKST A LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT ALLOWABLE IN COST	AMOUNT INCLUDED IN WKST A, COL 6	NET ADJUSTMENTS (COL 4 MINUS COL 5) *	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1 through 4) Transfer col. 6, line 5, to Worksheet A-8, col. 2, line 15.						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 7, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1, 2 and/or 3, the amount allowable should be indicated in column 4 of this part.

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

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

This information is used by the Centers for Medicare and Medicaid Services and its contractors in determining that the costs applicable to services, facilities and supplies furnished by organizations related to you by common ownership or control, represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under Medicare.

				RELATED ORGANIZATIONS AND/OR HO/CO			
	SYMBOL [1]	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

[1] Use the following symbols to indicate interrelationship to related organizations:

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

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

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNTS	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
100		TOTAL								100

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DISALLOWANCE	ADJUSTMENT	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
100		TOTAL								100

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

	COST CENTERS	NET EXPENSES FROM WKST A COL 8	CAPITAL RELATED BLDGS & FIXTURES	CAPITAL RELATED MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (SUM OF COLS 0 THROUGH 3)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPRATION OF PLANT		
		0	1	2	3	3A	4	5	6		
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs - Bldgs & Fixt									1	1
2	Cap Rel Costs - Mvble Equip									2	2
3	Employee Benefits									3	3
4	Administrative & General									4	4
5	Maintenance & Repairs									5	5
6	Operation of Plant									6	6
7	Laundry & Linen Service									7	7
8	Housekeeping									8	8
9	Cafeteria									9	9
10	Central Services & Supply									10	10
11	Medical Records & Library									11	11
12	Pro Ed & Training (Approved)[1]									12	12
13	Other (specify)									13	13
	REIMBURSABLE COST CENTERS										
23	Drugs & Biologicals									23	23
24	Occupational Therapy									24	24
25	Behavioral Health Treatment/Services									25	25
26	Individual Therapy									26	26
27	Group Therapy									27	27
28	Activity Therapy									28	28
29	Family Therapy									29	29
30	Psychiatric Testing									30	30
31	Education Training									31	31
32	Other (specify)									32	32
	NONREIMBURSABLE COST CENTERS										
42	Sheltered Workshops									42	42
43	Recreational Programs									43	43
44	Resident Day Camps									44	44
45	Diagnostic Clinics									45	45
46	Physicians' Private Offices									46	46
47	Fundraising									47	47
48	Coffee Shops &Canteen									48	48
49	Research									49	49
50	Investment Property									50	50
51	Advertising									51	51
52	Franchise Fees & Other Assessments									52	52
53	Pro Ed & Training (Not Approved)[2]									53	53
54	Meals & Transportation									54	54
55	Activity Therapies									55	55
56	Psychosocial Programs									56	56
57	Vocational Training									57	57
58	Other (specify)									58	58
99	Negative Cost Centers									99	99
100	TOTAL (sum of lines 1 through 99)									100	100

[1] Approved Educational Activity [2] Not an Approved Educational Activity

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

COST CENTERS	LAUNDRY & LINEN	HOUSE-KEEPING	CAFETERIA	CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	PROF EDUCATION & TRAINING	OTHER (SPECIFY)	TOTAL	
	7	8	9	10	11	12	13	14	
GENERAL SERVICE COST CENTERS									
Cap Rel Costs - Bldgs & Fixt									1
Cap Rel Costs - Mvble Equip									2
Employee Benefits									3
Administrative & General									4
Maintenance & Repairs									5
Operation of Plant									6
Laundry & Linen Service									7
Housekeeping									8
Cafeteria									9
Central Services & Supply									10
Medical Records & Library									11
Pro Ed & Training (Approved)[1]									12
Other (specify)									13
REIMBURSABLE COST CENTERS									
Drugs & Biologicals									23
Occupational Therapy									24
Behavioral Health Treatment/Services									25
Individual Therapy									26
Group Therapy									27
Activity Therapy									28
Family Therapy									29
Psychiatric Testing									30
Education Training									31
Other (specify)									32
NONREIMBURSABLE COST CENTERS									
Sheltered Workshops									42
Recreational Programs									43
Resident Day Camps									44
Diagnostic Clinics									45
Physicians' Private Offices									46
Fundraising									47
Coffee Shops &Canteen									48
Research									49
Investment Property									50
Advertising									51
Franchise Fees & Other Assessments									52
Pro Ed & Training (Not Approved)[2]									53
Meals & Transportation									54
Activity Therapies									55
Psychosocial Programs									56
Vocational Training									57
Other (specify)									58
Negative Cost Centers									99
TOTAL (sum of lines 1 through 99)									100

[1] Approved Educational Activity [2] Not an Approved Educational Activity

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

	COST CENTERS	CAPITAL RELATED BLDGS & FIXTURES (SQUARE FEET)	CAPITAL RELATED MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL (ACCUM COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPRATION OF PLANT (SQUARE FEET)	
		1	2	3	4A	4	5	6	
	GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs - Bldgs & Fixt								1
2	Cap Rel Costs - Mvble Equip								2
3	Employee Benefits								3
4	Administrative & General								4
5	Maintenance & Repairs								5
6	Operation of Plant								6
7	Laundry & Linen Service								7
8	Housekeeping								8
9	Cafeteria								9
10	Central Services & Supply								10
11	Medical Records & Library								11
12	Pro Ed & Training (Approved)(1)								12
13	Other (specify)								13
	REIMBURSABLE COST CENTERS								
23	Drugs & Biologicals								23
24	Occupational Therapy								24
25	Behavioral Health Treatment/Services								25
26	Individual Therapy								26
27	Group Therapy								27
28	Activity Therapy								28
29	Family Therapy								29
30	Psychiatric Testing								30
31	Education Training								31
32	Other (specify)								32
	NONREIMBURSABLE COST CENTERS								
42	Sheltered Workshops								42
43	Recreational Programs								43
44	Resident Day Camps								44
45	Diagnostic Clinics								45
46	Physicians' Private Offices								46
47	Fundraising								47
48	Coffee Shops &Canteen								48
49	Research								49
50	Investment Property								50
51	Advertising								51
52	Franchise Fees & Other Assessments								52
53	Pro Ed & Training (Not Approved)(2)								53
54	Meals & Transportation								54
55	Activity Therapies								55
56	Psychosocial Programs								56
57	Vocational Training								57
58	Other (specify)								58
100	Negative Cost Center								100
101	Cost to be Allocated								101
102	Unit Cost Multiplier								102

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

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

	COST CENTERS	LAUNDRY & LINEN (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PROF EDUCATION & TRAINING (ASSIGNED TIME)	OTHER (SPECIFY)	TOTAL	
		7	8	9	10	11	12	13	14	
	GENERAL SERVICE COST CE									
1	Cap Rel Costs - Bldgs & Fixt									1
2	Cap Rel Costs - Mvble Equip									2
3	Employee Benefits									3
4	Administrative & General									4
5	Maintenance & Repairs									5
6	Operation of Plant									6
7	Laundry & Linen Service									7
8	Housekeeping									8
9	Cafeteria									9
10	Central Services & Supply									10
11	Medical Records & Library									11
12	Pro Ed & Training (Approved)(1)									12
13	Other (specify)									13
	REIMBURSABLE COST CENTERS									
23	Drugs & Biologicals									23
24	Occupational Therapy									24
25	Behavioral Health Treatment/Services									25
26	Individual Therapy									26
27	Group Therapy									27
28	Activity Therapy									28
29	Family Therapy									29
30	Psychiatric Testing									30
31	Education Training									31
32	Other (specify)									32
	NONREIMBURSABLE COST CENTERS									
42	Sheltered Workshops									42
43	Recreational Programs									43
44	Resident Day Camps									44
45	Diagnostic Clinics									45
46	Physicians' Private Offices									46
47	Fundraising									47
48	Coffee Shops &Canteen									48
49	Research									49
50	Investment Property									50
51	Advertising									51
52	Franchise Fees & Other Assessments									52
53	Pro Ed & Training (Not Approved)(2)									53
54	Meals & Transportation									54
55	Activity Therapies									55
56	Psychosocial Programs									56
57	Vocational Training									57
58	Other (specify)									58
100	Negative Cost Center									100
101	Cost to be Allocated									101
102	Unit Cost Multiplier									102

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

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET C

	REIMBURSABLE COST CENTERS	FROM WKST B, COL. 14, REIMBURSABLE COSTS	TOTAL CHARGES	RATIO OF COST TO CHARGES (COL 1 ÷ COL. 2)	MEDICARE PHP CHARGES	MEDICARE IOP CHARGES	MEDICARE PHP COST (COL 3 X COL 4)	MEDICARE IOP COST (COL 3 X COL 4.01)	
		1	2	3	4	4.01	5	5.01	
23	Drugs & Biologicals								23
24	Occupational Therapy								24
25	Behavioral Health Treatment/Services								25
26	Individual Therapy								26
27	Group Therapy								27
28	Activity Therapy								28
29	Family Therapy								29
30	Psychiatric Testing								30
31	Education Training								31
32	Other (specify)								32
50	TOTAL (lines 23 through 32)								50

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

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

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

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

				PART B MM/DD/YYYY 1	PART B AMOUNT 2	
1	Total interim payments paid to CMHC					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the contractor, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write '"NONE" or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (sum of lines 3.01 through 3.49, minus sum of lines 3.50 through 3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2 and 3.99) (Transfer to Wkst. D, line 19)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 through 5.49, minus sum of lines 5.50 through 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions) (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7

	0		1		2		
8	Name of Contractor		Contractor Number		NPR Date (MM/DD/YYYY)		8

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

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

	DESCRIPTION		
1	Total patient revenue		1
2	Less: Allowance and discounts on patients' accounts		2
3	Net patient revenues (line 1 minus line 2)		3
4	Less: Total operating expenses (per Worksheet A, column 4, line 100)		4
5	Net income from service to patients (line 3 minus line 4)		5
	OTHER INCOME		
6	Grants, gifts, and income designated by donor for specific expenses		6
7	Payments received from specialists		7
8	Investment income on unrestricted funds		8
9	Trade, quantity, time and other discounts on purchases		9
10	Rebates and refunds of expenses		10
11	Income from laundry and linen service		11
12	Income from cafeteria - employees, guests, etc.		12
13	Sale of medical supplies to other than patients		13
14	Sale of workshop products or services		14
15	Coffee shops and canteen		15
16	Vending machines		16
17	Rental of building or office space to others		17
18	Sale of scrap, waste, etc.		18
19	Sale of medical records and abstracts		19
20	Other (Specify)		20
20.50	COVID-19 PHE funding		20.50
21	Total other income (sum of lines 6 through 20)		21
22	Total (line 5 plus line 21)		22
	OTHER EXPENSES		
23	Fund raising		23
24	Gift, coffee shops, and canteen		24
25	Investment property		25
26	Other (specify)		26
27	Total other expenses (sum of lines 23 through 26)		27
28	Net income (or loss) for the period (line 22 minus line 27)		28