FORM CMS-2552-10

	rt is required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa made since the beginning of the cost reporting period being					FORM APPROVEI OMB NO. 0938-00 EXPIRES 09-30-20	50
HOSPIT	AL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S	
	EX COST REPORT CERTIFICATION				FROM	PARTS I, II & III	
	ETTLEMENT SUMMARY				ТО		
	- COST REPORT STATUS use only 1. [] Electronically prepared cost re	port	Date:	Time:			
TTOVIDEI	2. [] Manually prepared cost report	port	Dute:	Time			
	3. [] If this is an amended report ent	er the number of times the pr	ovider resubmitted this c	ost report			
	4. [] Medicare Utilization. Enter "F		for no.				
Contract use only		6. Date Received: 7. Contractor No.:		10. NPR Date: 11. Contractor's Vend			
use only	(2) Settled without audit	8. [] Initial Report for t	 this Provider CCN		nn 1, is 4: Enter number	of	
	(3) Settled with audit	9. [] Final Report for the		times reopeneo			
	(4) Reopened						
DADTI	(5) Amended - CERTIFICATION BY A CHIEF FINANCIAL O	FEICED OD ADMINISTRA	TOD OF DROVIDED(S)				
	PRESENTATION OR FALSIFICATION OF ANY I		. ,	ORT MAY BE PUNIS	HABLE BY CRIMINAL	CIVIL AND ADMINIST	RATIVE
ACTION THE PA	N, FINE AND/OR IMPRISONMENT UNDER FED YMENT DIRECTLY OR INDIRECTLY OF A KIO ONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFIC	ERAL LAW. FURTHERMO CKBACK OR WERE OTHEI	ORE, IF SERVICES IDE RWISE ILLEGAL, CRIN	NTIFIED IN THIS RE	PORT WERE PROVIDE	D OR PROCURED THRO	
	I HEREBY CERTIFY that I have read the above ce submitted cost report and the Balance Sheet and Sta cost reporting period beginninga complete and prepared from the books and records laws and regulations regarding the provision of hea and regulations.	rtification statement and that tement of Revenue and Expe nd ending a of the provider in accordance th care services, and that the	I have examined the acc nses prepared by and to the best of my kno e with applicable instruct services identified in thi	wledge and belief, this ions, except as noted. I	(Provider Name(s) and report and statement are further certify that I am f ded in compliance with s	Number(s)} for the true, correct, amiliar with the	
	SIGNATURE OF CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR	CHECKBOX		ELECTRONIC		
1	1		2		SIGNATURE STATEME	ntion statement. I certify	1
						ertification be the legally	
				binding equivalent of r	ny original signature.		
2	Signatory Printed Name: Signatory Title:						2
	Signature date:						4
	I - SETTLEMENT SUMMARY						
				XVIII	_		
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL						1
1.01	HOSPITAL-PARHM						1.01
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING-BED SNF						5
5.01	SWING-BED PARHM (CAH ONLY)						5.01
6	SWING-BED NF						6
7	SNF						7
8	NF, ICF/IID						8
9	HOME HEALTH AGENCY						9
10	HOSPITAL-BASED RHC						10
11	HOSPITAL-BASED FQHC OUTPATIENT REHABILITATION						11
12	PROVIDER (Specify)						12
200	TOTAL	licable program for the -1	nt of the shore	indicated			200
_1 He abo	ve amounts represent "due to" or "due from" the app	incaple program for the eleme	ent of the above complex	mulcateu.			

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 number for this information collection is OMB 0938-0050. The time required to complete this information collection is estimated to be 675 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: CMS, 7500 SecurityBoulevard, Atta: PRA Report Clearance Officer, Mall Stop C42-605, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documents containing sensitive information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

4090	(Cont.)

HOSPITAL AND HOSPITAL HEALTH CARE	

COMPLEX IDENTIFICATION DATA

PROVIDER CCN: PERIOD FROM

TO

WORKSHEET S-2

PART I

PART I	- HOSPITAL	AND	HOSPITAL	HEALTHCARE	COMPLEX	INDENTIFICATION	DATA	_	_	
	and Hospital H			-	COM LEN					
								-	-	_

	and Hospital Health Care Complex Address:									
	Street:	P.O. Box:								1
	City:	State:	ZIP Code:	County:						2
Hospital	and Hospital-Based Component Identification:									
		Component	CCN	CBSA	Provider	Date		yment System (P, T, O, o		
	Component	Name	Number	Number	Туре	Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospital-Based Hospice									14
	Hospital-Based Health Clinic-RHC									15
	Hospital-Based Health Clinic-FQHC									16
	Hospital-Based (CMHC, CORF and OPT)									10
	Renal Dialysis									17
	Other	T								19
	Cost Reporting Period (mm/dd/yyyy)	From:	To:	-						20
	Type of control (see instructions)							1 -		21
	t PPS Information						1	2	3	
22	Does this facility qualify and is it currently receiving payments for disproportionate share hospi			.106? In column 1, enter	"Y" for yes or "N" for no.					22
	Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, ent									
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting pe			or no for the portion of th	e cost reporting period occ	urring prior to October	1.			22.01
	Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurrin	ng on or after October 1.	(see instructions)							
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlem	ent? (see instructions)	Enter in column 1, "Y"	for yes or "N" for no,						22.02
	for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes o	r "N" for no, for the por	tion of the cost reportir	ng period on or after Octo	ber 1.					
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB	standards for delineating	g statistical areas adopte	ed by CMS? Enter in col	umn 1, "Y" for yes or					22.03
	"N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "	Y" for yes or "N" for no	for the portion of the co	ost reporting period occur	ring on or after October 1.	(see instructions)				
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance wi				0	· /				
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revis				Enter in column 1. "Y" fo	r ves or "N" for				22.04
	no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for ye									
	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance wi				(
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, e									23
20	Is the method of identifying the days in this cost reporting period different from the method use				I" for no					25
	is the method of identifying the days in this cost reporting period different noin the method use	a in the prior cost report	ing period. In column	In-State	In-State	Out-of State	Out-of State	Medicaid	Other	
				Medicaid	Medicaid eligible	Medicaid	Medicaid eligible	HMO	Medicaid	
				paid days	unpaid days	paid days	unpaid days	days	days	
				1	2	3	4	5	6	_
- 24	If this monthly is an IDDC handled and the instant Medical data is a lower 1 in start 1	(1	2	3	4	5	6	24
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state M									24
	Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medic	cald HMO paid and eligi	ble but unpaid days in							
	column 5, and other Medicaid days in column 6.									
25										25
	Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medica	aid HMO paid and eligit	ole but unpaid days in c	olumn 5.						
							1	2	3	
	Enter your standard geographic classification (not wage) status at the beginning of the cost repo									26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting p	period. Enter in column	1, "1" for urban or "2"	for rural.						27
	If applicable, enter the effective date of the geographic reclassification in column 2.									
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in t	the cost reporting period								35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of per	riods in excess of one an	d enter subsequent date	es.			Beginning:	Ending:	_	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in e	effect in the cost reportin	g period.							37
37.01	37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, s	subscript this line for the	number of periods in ex	cess of one and enter sub	sequent dates.		Beginning:	Ending:		38
		1	1		*		Y/N	Y/N		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospital	s in accordance with 42	CFR 412.101(b)(2)(i).	(ii), or (iii). Enter in colu	mn 1 "Y" for ves or "N" fo	or no.				39
55	Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii)									
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for									40
10	for discharges on or after October 1. (see instructions)									
TOPLO	MS-2552-10 (12-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN C	MODID 15 2 SECTIO	N 4004 1)					1		

FORM CMS-2552-10 (12-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		PROVIDER CCN:	PERIOD FROM TO	WORKSHEET S-2 PART I (CONT.)		
			V	XVIII	XIX	
Prospective Payment System (PPS)-Capital			1	2	3	45
 45 Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions) 46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst, L, Pt. III, and Wkst, L-1, 	Dt I through Dt III					45 46
47 Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no.	1 t. 1, unough 1 t. 111.					40
48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						48
Teaching Hospitals			1	2	3	
56 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "X" for yes or "N" fo beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involv approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs in the prior year or penultimate year, and you are impacted by CR 11642 (or applicable CRs) MA residents in approved GME programs.	ved in training residents	in				56
57 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GM or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If a following 1 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413. of the cost report the residents were on duty, if the response to line 65 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet F	column 2 is "Y", comple .77(e)(1)(iv) and (v), re	ete Wkst. E-4.	-			57
58 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						58
59 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.			NAUE 412.05	NAUE MA		59
			NAHE 413.85	NAHE MA 2	3	-
60 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	"N" for no in column 1	. If column 1 is "Y", ar	e you	2		60
			1	Worksheet A Line # 2	Pass-Through Qualification Criterion Code	
60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			1	2	5	60.01
	Y/N			IME	Direct GME	
	1	2	3	4	5	1
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				DAT	Dim at CME	61
			1	IME 2	Direct GME	-
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	1		1	2	3	61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA).						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	· · · · · · · · · · · · · · · · · · ·					61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus li	ne 61.03). (see instruct	ions)				61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or non-general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count 4	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTF	E unweighted count.					61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE	E unweighted count.					61.20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions)					1	62
2. Effet the number of FTE residents that your hospital trained in this cost reporting period which your hospital trained in this cost reporting period of HRSA The program. (see instructions) (2001) (20	instructions)					62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings	,		1	2	3	<u> </u>
63 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64 through 67. (see in	structions)					63
				XX 4.1 1 YORK		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 20)10.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital 2	Ratio (col. 1 ÷ (col. 1 + col. 2)) 3	_
64 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rota Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		on-provider settings.				64
Enter in column 5 the ratio of (column 1 throaded by (column 1 + column 2)). (see instructions)			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	+
	Program Name 1	Program Code	Nonprovider Site	in Hospital 4	(col. 3 + col. 4)) 5	-
65 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						65
FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)						
Rev. 18						40-505
4090 (Cont.) FORM CMS-2552-10						12-22
HOSPITAL AND HOSPITAL HEALTH CARE			PROVIDER CCN:	PERIOD	WORKSHEET S-2	

COMPLEX IDENTIFICATION DATA				FROM	PART I (CONT.)	
			Unweighted FTEs	Unweighted FTEs	Ratio (col. 1 ÷	
			Nonprovider Site	in Hospital	(col. 1 + col. 2))	4
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings-Effective for cost reporting periods beginning on or after July 1, 2010 66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the numb	per of unweighted non-pr	imary care resident	1	2	3	66
FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1+ column 2)). (see instructions)	fer of univerginee non p	initially cure resident				00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter	1	2	3	4	5	67
column 3, the number of numerighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of						0,
unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		D 40005 40050 (A	. 10, 202202		1	60
68 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 20 Inpatient Psychiatric Facility PPS	023 IPPS Final Rule, 87 I	⁴ K 49065-49072 (Augu	1 10, 2022)?	2	3	68
70 [Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			-	-	5	70
 71 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 	no. (see 42 CFR 412.424	(d)(1)(iii)(C))				71
Inpatient Rehabilitation Facility PPS			1	2	3	
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. 76 If line 75 is yes:						75 76
Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for ye Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	s or "N" for no.					70
Long Term Care Hospital PPS				1	2	
80 Is this a long term care hospital (LTCH)? Enter "Y" for yes or "N" for no.						80
81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.						81
TEFRA Providers				1	2	· · · · ·
85 I Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				-	-	85
86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.						86
87 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.						87
				Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
				1	2	
88 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and Column 2: Enter the number of approved permanent adjustments.	I line 89. (see instruction	s)	1			88
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge 3	_
89 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						89
				V	XIX	
Title V and XIX Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.				1	2	90
30 Both how the vertice vertice vertice is the vertice vertice in the vertice						91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						92
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.						93
94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 95 If line 94 is "Y", enter the reduction percentage in the applicable column.						94 95
55 If the 543 F , end the reduction percentage in the applicable contained contained of the applicable column. 56 Does tide V or tide XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.						96
97 If line 96 is "Y", enter the reduction percentage in the applicable column.						97
98 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in co		n column 2 for title XIX	, 			98
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1		2 for title XIX				98.01 98.02
30.2 Does title V or XIX follow Medicare (the XVIII) for the catculation of observation bed costs of west, D+1, F1, F1, F1, F1, F1, F1, F1, F1, F1, F						98.02
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in						98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a		IIX.				98.05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in co	olumn 2 for title XIX.					98.06
FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)					T	Dov 10
40-506						Rev. 18
DRAFT FORM CMS-2552-10						(Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			PROVIDER CCN:	PERIOD FROM	WORKSHEET S-2 PART I (CONT.)	

		ТО	
ENTIFICATION DATA		FROM	PART I (CONT.)
D HOSPITAE HEAETH CARE	FROVIDER CCN.	FERIOD	WORKSHEET 3-2

Rural Providers			1	2	-
105 Does this hospital qualify as a CAH?			1	2	105
105 Does mis nopinal quanty as a CAH, as it elected the all-inclusive method of payment for outpatient services? (see instructions)					105
100 Column 1: If limit 105 is Y, is this facility eligible for cost reimburgement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)					100
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for	no in column 2. (see in	nstructions)			
107.01 If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)		,			107.01
108 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no.					108
	Physical	Occupational	Speech	Respiratory	
	1	2	3	4	
109 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109
				1	
110 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no.					110
If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					
				2	_
			1	2	111
111 If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in		and a band the second second			111
If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional enterty of the formation of th	nai beds; and/or °C To	r tele-nealth services.			
		1	2	3	-
112 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. I	f column 1 is "V" onter	1	2	5	112
Column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cased participating in the demonstration. If any portunit of the date the hospital cased participating in the demonstration.	i columni i is i , enter				112
соними в иссоне исслования и пристрания и иссонованию и полими о сист иссине исслование совсе ранстранов и не использованов, и аррисовся					
Miscellaneous Cost Reporting Information		1	2	3	
115 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2.		-	_	-	115
If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals					
providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.					
		•	•	•	
				1	
116 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.					116
117 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.					117
118 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.					118
			i	-	-
		Premiums	Paid losses	Self insurance	_
		1	2	3	110.01
118.01 List amounts of malpractice premiums and paid losses:					118.01
			1	2	-
118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained there	vin		1	2	118.02
110 What is the liability limit for the malpractice insurance policy. Enter in column 1 the monetary limit per lawsuit. Enter in column 1 the monetary limit per lawsuit.					110.02
120 Is this a SCH or EACH that qualifies for the Outpatient Hold Harden Provision in ACA §3121 and applicable amendments? (see instructions) Inter in column 1, "X" for yes or "N" for no. Is the second seco	his a				110
rural hospital with <100 beds that qualifies for the Outpatient Hold Harmless provision in AGA §3121 and applicable amendments? (see instructions) Enter in correct or "N" for no.	ino u				120
121 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.					121
122 Does the cost report contain healthcare related taxes as defined in \$1903(w)(3) of the Act? Enter "V" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.					
123 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from a			122 123		
enter "Y" for yes or "N" for no.					
If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside	of the main hospital C	BSA? In column 2,			
enter "Y" for yes or "N" for no.	*				
124 Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicinn	es according				124
to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.					

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIO	DN 4004.1)				
Rev.					40-507
4090 (Cont.)	FORM CMS-2552-10				DRAFT
HOSPITAL AND HOSPITAL HEALTH CARE		PROVIDER CCN:	PERIOD	WORKSHEET S-2	
COMPLEX IDENTIFICATION DATA			FROM	PART I (CONT.)	
			ТО		
Certified Transplant Center Information			1	2	

125 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no. If yes, enter cert	tification date(s) (mm/dd/	vvvv) below.	_					125
126 If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination d								126
127 If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination dat								127
128 If this is a Medicare certified liver transplant program, enter the certification date in column 1 and termination date								128
129 If this is a Medicare certified lung transplant program, enter the certification date in column 1 and termination date								129
130 If this is a Medicare certified pancreas transplant program, enter the certification date in column 1 and termination								130
131 If this is a Medicare certified intestinal transplant program, enter the certification date in column 1 and termination								131
132 If this is a Medicare certified islet transplant program, enter the certification date in column 1 and termination date								132
133 Removed and reserved	,,							133
134 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and terminat	ion date, if applicable, in	column 2.						134
	· · · · · · · · · · · · · · · · · · ·							
All Providers						1	2	
140 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for ye	es or "N" for no in column	n 1.						140
If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)								
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and en	ter the home office contra	actor name and contractor r	umber.					
141 Name:		Contractor's Name:			Contractor's Number:			141
142 Street:	P. O. Box:							142
143 City:	State:	Zip Code:						143
		•						
						1	2	
144 Are provider based physicians' costs included in Worksheet A?								144
145 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for	yes or "N" for no in colum	nn 1.						145
If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for								
146 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for n	o in column 1. (See CMS	5 Pub. 15-2, chapter 40, §40	020)					146
If yes, enter the approval date (mm/dd/yyyy) in column 2.								
147 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147
148 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								148
149 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								149
				Tit	le XVIII			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges?				Part A	Part B	Title V	Title XIX	
Enter "Y" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13)				1	2	3	4	
155 Hospital								155
156 Subprovider - IPF								156
157 Subprovider - IRF								157
158 Subprovider - Other								158
159 SNF								159
160 HHA								160
161 CMHC								161
Multicampus				i				
165 Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for y								165
166 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in colum	nn 3, CBSA in column 4,	FTE/Campus in column 5.	· · · · · · · · · · · · · · · · · · ·					166
Name			County	State	Zip Code	CBSA	FTE/Campus	_
0			1	2	3	4	5	_
					i		-	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						1	2	
167 Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.								167
168 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incu								168
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §4		" tor yes or "N" for no. (se	ee instructions)					168.01
169 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor	· /							169
170 Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/y								170
171 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans rep	ported on Wkst. S-3, Pt. I,	, line 2, col. 6? Enter "Y"	tor yes and "N" for no in co	lumn 1.				171
If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							1	1

12-24	FORM CMS-2552-10				4090	(Cont.)	
	AL AND HOSPITAL HEALTH CARE COMPLEX PROVIDER CCN: URSEMENT QUESTIONNAIRE	PERIOD FROM TO		WORKSHEET S-2 PART II			
	I - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	10					
General	Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPL	ETED BY ALL HOSPITALS						
			Y/N	Date			
	Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost reporting period?		1	2		1	
1	If yes, enter the date of the change in column 2. (see instructions)					1	
			Y/N 1	Date 2	V/I 3	-	
2	Has the provider terminated participation in the Medicare Program?		1	2	3	2	
	If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.						
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical					3	
	staff, management personnel, or members of the board of directors through ownership, control, or family and						
	other similar relationships? (see instructions)						
			Y/N	Туре	Date		
	l Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant?		1	2	3	4	
4	Column 1: were the mancial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter					4	
	date available in column 3. (see instructions) If no, see instructions.						
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.					5	
	n yeoj suome reconemutori						
Approve	d Educational Activities			Y/N 1	Y/N 2	-	
6	Column 1: Are costs claimed for a nursing program?			1	2	6	
	Column 2: If yes, is the provider the legal operator of the program?			_			
	Are costs claimed for allied health programs? If yes, see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period?					7	
	If yes, see instructions.						
	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see					9 10	
	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A?	e instructions.				10	
	If yes, see instructions.						
Bad Deb	ts				Y/N	1	
	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					12	
	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit co If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	opy.				13 14	
						1 1	
	nplement Did total beds available change from the prior cost reporting period? If yes, see instructions.				1	15	
	Dia totai beus avanable change from the pros cost reporting period: 11 yes, see instructions.					1 15	
		P Y/N	art A Date	Pa Y/N	irt B	-	
PS&R R	eport Data	1	2	3	Date 4	1	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4,					16	
	from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)						
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?					17	
	If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)						
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been					18	
	billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	_				L	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other?					20	
	Describe the other adjustments:					21	
	was are cost report prepared only using the provider 5 records: 11 yes, see instructions.					41	

FORM CMS-2552-10 (12-2024) (INSTRUCTION	S FOR THIS WORKSHEET ARE PUBLIS	SHED IN CMS PUB 15-2, SECTION	IS 4004.2)	
Rev. 23				40-50
4090 (Cont.)	FORM C	CMS-2552-10		12-2
HOSPITAL AND HOSPITAL HEALTH CARE C	OMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2

FROM _____ TO _____

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

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

22 Have assets been relifed for Medicare purposes? If yes, see instructions.			22
23 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period?			2
If yes, see instructions.			
24 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instruction	IS.	-	24
25 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		-	2
26 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		-	2
27 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.			22
nterest Expense			
28 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instruction			28
29 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded de	preciation		29
account? If yes, see instructions.			
30 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			3
31 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			3
urchased Services			
32 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with supplie	rs of services?		3
If yes, see instructions.			
33 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?			3
If no, see instructions.			
rovider-Based Physicians			
34 Were services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instruction	25		34
35 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the			3
reporting period? If yes, see instructions.	COSt		
reporting period: if yes, see instructions.			1
	Y/N	Date	1
Iome Office Costs	1	2	1
36 Are home office costs claimed on the cost report?			30
37 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			3
38 If line 36 is yes , was the fiscal year end of the home office different from that of the provider?			3
If yes, enter in column 2 the fiscal year end of the home office.			
39 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			3
40 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			4
Cost Report Preparer Contact Information			_
41 First name: Last name:	Title:		4
42 Employer:			4
			4

12-24					FORM	I CMS-2	552-10									4090	(Cont.)
	AL AND HOSPITAL HEALTH CARE COMPLEX TICAL DATA										PROVIDER	CCN:	PERIOD FROM TO		WORKSH PART I	EET S-3	
PARTI	- STATISTICAL DATA												10				
	STATISTICAL BATTA				1	Inpatie	ent Days / Ou	tpatient Visit	s / Trips	Full	Time Equiva	lents	1	Disc	harges		T
		Worksheet				inputt											1
	Component	A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
	Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)																1
	HMO and other (see instructions)														_		2
	HMO IPF Subprovider																3
	HMO IRF Subprovider														L		4
	Hospital Adults & Peds. Swing Bed SNF							L	I								5
	Hospital Adults & Peds. Swing Bed NF																6
7	Total Adults and Peds. (exclude																7
	observation beds) (see instructions)																<u> </u>
	Intensive Care Unit	_															8
	Coronary Care Unit																9
	Burn Intensive Care Unit																10
	Surgical Intensive Care Unit																11
	Other Special Care																12
	Nursery																13
	Total (see instructions)																14
	CAH visits																15
	REH hours and visits																15.1
	Subprovider - IPF	_															16
	Subprovider - IRF														_		17
	Subprovider - Other																18
	Skilled Nursing Facility																19
	Nursing Facility																20
	Other Long Term Care																22
	Home Health Agency									-							22
	ASC (Distinct Part)																23
	Hospice (Distinct Part) Hospice (non-distinct part)																24.10
	CMHC RHC/FQHC (specify)														-		25
	Total (sum of lines 14-26)																20
	Observation Bed Days														-		27
	Ambulance Trips																28
29	Employee discount days (see instructions)								-								30
21	Employee discount days (see instructions)																31
	Labor & delivery (see instructions)																31
	Total ancillary labor & delivery room								l						-		32.01
52.01	outpatient days (see instructions)																32.01
	LTCH non-covered days																33
	LTCH non-covered days LTCH site neutral days and discharges																33.01
00.01	Temporary Expansion COVID-19 PHE Acute Care																33.01

HOSPIT	AL WAGE INDEX INFORMATION				PROVIDER CCN:		WORKSHEET	S-3
						FROM	PART II	
						то		
Part II -	Wage Data							
				Reclassification	Adjusted	Paid Hours	Average	1
		Wkst. A		of Salaries	Salaries	Related	Hourly Wage	1
		Line	Amount	(from	(col. 2 ±	to Salaries	(col. 4 ÷	1
		Number	Reported	Wkst. A-6)	col. 3)	in column 4	col. 5)	1
	SALARIES	1	2	3	4	5	6	
1	Total salaries (see instructions)							1
- 1	Non-physician anesthetist Part A							2
3								3
	Physician-Part A - Administrative							4
	Physician-Part A - Teaching							4.01
	Physician and Non Physician-Part B							4.01
								6
	Interns & residents (in an approved program)							7
	Contracted interns & residents (in an approved program)							7.01
	Home office and/or related organization personnel							7.01
0	0 1							9
	Excluded area salaries (see instructions)							10
10	OTHER WAGES AND RELATED COSTS							10
11	Contract labor: Direct Patient Care							11
	Contract labor: Top level management and other management and							11
12	administrative services							12
12	Contract labor: Physician-Part A - Administrative							13
	Home office and/or related organization salaries and wage-related costs							13
	Home office salaries							14.01
	Related organization salaries							14.01
	Home office: Physician Part A - Administrative							14.02
	Home office Physicians Part A - Administrative							15.01
	Home office contract Physicians Part A - Administrative							15.02
	Home office & Contract Physicians Part A - Teaching							15.02
	Home office Physicians Part A - Teaching							16.01
	Home office contract Physicians Part A - Teaching							16.02
10.02	WAGE-RELATED COSTS							10.02
17	Wage-related costs (core) (see instructions)							17
	Wage-related costs (core) (see instructions)							18
	Excluded areas							10
	Non-physician anesthetist Part A							20
	Non-physician anesthetist Part B							20
22	Physician Part A - Administrative							22
	Physician Part A - Teaching							22.01
	Physician Part B							22.01
	Wage-related costs (RHC/FQHC)			1				24
	Interns & residents (in an approved program)			1				25
	Home office wage-related (core)							25.50
	Related organization wage-related (core)			1				25.51
	Home office: Physician Part A - Administrative - wage-related (core)			1				25.52
	Home office: Physicians Part A - Teaching - wage-related (core)							25.53

FORM CMS-2552-10 (12-2024) (INSTRUCTIONS FOR T	HIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECT	FION 4005.2 - 4005.3)	
40-512				Rev. 23
11-16	FORM CMS-2552-10			4090 (Cont.)
HOSPITAL WAGE INDEX INFORMATION		PROVIDER CCN:	PERIOD	WORKSHEET S-3
			FROM	PART II & III
			ТО	

	Worksheet		Reclassification	Adjusted	Paid Hours	Average	Г
	A		of Salaries	Salaries	Related	Hourly Wage	
	Line	Amount	(from	(column 2 ±	to Salaries	(column 4 ÷	
	Number	Reported	Worksheet A-6)	column 3)	in column 4	column 5)	
	1	2	3	4	5	6	
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits Department	4						
27 Administrative & General	5						
28 Administrative & General under contract (see ins	tructions)						
29 Maintenance & Repairs	6						Г
30 Operation of Plant	7						
31 Laundry & Linen Service	8						
32 Housekeeping	9						
33 Housekeeping under contract (see instructions)							
34 Dietary	10						Γ
35 Dietary under contract (see instructions)							Γ
36 Cafeteria	11						Γ
37 Maintenance of Personnel	12						Γ
38 Nursing Administration	13						Γ
39 Central Services and Supply	14						Γ
40 Pharmacy	15						Γ
41 Medical Records & Medical Records Library	16						Γ
42 Social Service	17						Γ
43 Other General Service	18						
rt III - Hospital Wage Index Summary							
1 Net salaries (see instructions)							Γ
2 Excluded area salaries (see instructions)							Г
3 Subtotal salaries (line 1 minus line 2)					1		Γ
4 Subtotal other wages and related costs (see instru	ctions)				[Γ
5 Subtotal wage-related costs (see instructions)	,				1		t
6 Total (sum of lines 3 through 5)							t
7 Total overhead cost (see instructions)							t

4090 (Cont.)	FORM CMS-2552-10	11-16
HOSPITAL WAGE RELATED COSTS	PROVIDER CCN: PERIOD WORKSHEET S-3	
	FROM PART IV	
	то	
Part IV - Wage Related Cost		

Part A - Core List

		Amount Reported	
	RETIREMENT COST		_
1	401k Employer Contributions		
2	Tax Sheltered Annuity (TSA) Employer Contribution		
3	Nonqualified Defined Benefit Plan Cost (see instructions)		
4	Qualified Defined Benefit Plan Cost (see instructions)		
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration fees		Į.
6	Legal/Accounting/Management Fees-Pension Plan		-
7	Employee Managed Care Program Administration Fees		
	HEALTH AND INSURANCE COST	•	
8	Health Insurance (Purchased or Self Funded)		1
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.0
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.0
8.03	Health Insurance (Purchased)		8.0
9	Prescription Drug Plan		
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		1
12	Accident Insurance (If employee is owner or beneficiary)		1
13	Disability Insurance (If employee is owner or beneficiary)		1
14	Long-Term Care Insurance (If employee is owner or beneficiary)		1
15	Workers' Compensation Insurance		1
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Noncumulative portion)		1
	TAXES	•	
17	FICA-Employers Portion Only		1
18	Medicare Taxes - Employers Portion Only		1
19	Unemployment Insurance		1
20	State or Federal Unemployment Taxes		2
	OTHER	•	
	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above) (see instructions)		2
22	Day Care Cost and Allowances		2
23	Tuition Reimbursement		2
24	Total Wage Related cost (Sum of lines 1 through 23)		24

Part B -	Other	than C	Core Re	elated	Cost		
			- 1	1.0			

25 Other Wage Related Costs (specify)

25

Τ

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

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

TATIS	'AL-BASED HOME HEALTH AGENCY TICAL DATA	PROVIDEI HHA CCN		PERIOD: FROM TO		WORKSHI	EET S-4	
	HOME HEALTH AGENCY STATISTICAL DATA			County	:	l		
			Title V	Title XVIII	Title XIX	Other	Total	
	Description		1	2	3	4	5	
1	Home Health Aide Hours							
2	Unduplicated Census Count (see instructions)							
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
	Enter the number of berns in					ber of Emplo		
	Enter the number of hours in					Time Equiv		-
	your normal work week				Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				1		5	-
	Director(s) and Assistant Director(s)							\vdash
5								<u> </u>
	Direct Nursing Service							
7								
8								1
9								
	Occupational Therapy Service							
11								
12								
13								
14	Medical Social Service							
15								
16	Home Health Aide							
17								
	Home Health Aide Supervisor							
17	Home Health Aide Supervisor Other (specify)							
17 18	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES							
17 18	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period.	code).						
17 18 19	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first	code).						
17 18 19	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period.	code).	Full E	pisodes			Total	
17 18 19	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first	code).		pisodes With	LUPA	PEP only	Total (columns 1	
17 18 19	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first	code).	Full E Without Outliers		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
17 18 19	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first	code).	Without	With			(columns 1	
17 18 19 20	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 21	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 20 20 21 22 23 24 25 26	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visit Charges Physical Therapy Visits Occupational Therapy Visit Charges	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 21 22 23 24 25	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23 24 25 26 27 28	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visit Charges	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23 24 25 26 27 28 29	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visit Charges Medical Social Service Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23 24 25 26 26 27 28 29 30	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visit Charges	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 20 20 21 22 23 24 25 26 27 28 29 30 31	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Home Health Aide Visits	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 20 20 21 22 23 24 25 26 27 28 29 30 31 32	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Charges Home Health Aide Visits Charges	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 20 20 21 22 23 24 25 26 27 28 29 30 31 32 23 33	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Home Health Aide Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23 24 25 26 27 28 29 30 31 32 28 29 30 31 32 33 33	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visits Home Health Aide Visit Charges Total Visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 20 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Charges (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
17 18 19 20 20 21 22 23 24 25 26 27 28 29 30 31 32 28 29 30 31 32 33 33	Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visit Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	code).	Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	

1-16		FOR	M CMS-2552-10				(Cont.
HOSPITAL RENAL DIALYSIS DEPA STATISTICAL DATA	ARTMENT			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-5	
RENAL DIALYSIS STATIST	TICS				10		
	Outpa	atient		ining		ome	_
	Regular	High Flux	Hemo- dialysis	CAPD CCPD	Hemo- dialysis	CAPD CCPD	
DESCRIPTION	1	2	3	4	5	6	
1 Number of patients in							1
program at end of cost							
reporting period							-
2 Number of times per week patient receives							-
dialysis							
3 Average patient dialysis							
time including setup							
4 CAPD exchanges per day							
5 Number of days in year							
dialysis furnished 6 Number of stations							-
7 Treatment capacity per							
day per station							
8 Utilization (see instructions)							
9 Average times							
dialyzers re-used 10 Percentage of patients							1
re-using dialyzers							1
re using unityzers							
ESRD PPS					1	2	
10.01 Is the dialysis facility approve		y for this cost reporting	period?				10.0
Enter "Y" for yes or "N" for n 10.02 Did your facility elect 100% I		0112 Entry "X" frames					10.0
(See instructions for "new" pr		2011? Enter Y for yes	or in tor no.				10.0
10.03 If you responded "N" to line 1		he year of transition for	periods prior to January	1 and			10.0
enter in column 2 the year of							
TRANSPLANT INFORMATI						1	1 1
11 Number of patients on transpl 12 Number of patients transplant		ng period					11
12 Humber of puttents unisplant	eu uuring me cost reporti	ng period					1.
EPOETIN							
13 Net costs of Epoetin furnished			der				1
14 Epoetin amount from Worksh							1
15 Number of EPO units furnish 16 Number of EPO units furnish							1
10 Number of EFO units furnish	ed relating to the nome of	arysis department					1
ARANESP							
17 Net costs of ARANESP furni			ovider				1
18 ARANESP amount from Wor							1
19 Number of ARANESP units f 20 Number of ARANESP units f	· · · ·	¢ 1					1
20 Number of ARAINESP units I	utilished relating to the h	ome diarysis department					2
PHYSICIAN PAYMENT ME	THOD (Enter "X" for app	plicable method(s))					
21 MCP	INITIAL METHOD						2
		EC.	Net Cost of	Net Cost of	Number of ESA	Number of ESA	
		ESA Description	ESAs for Renal Patients	ESAs for Home Patients	Units - Renal Dialysis Dept.	Units - Home Dialysis Dept.	
Erythropoiesis-Stimulating Ag	ents (ESA) Statistics:	1	2	Home Patients	dialysis Dept.	5	-
22 Enter in column 1 the ESA de		-	-		· · · · · · · · · · · · · · · · · · ·	5	2
Enter in column 2 the net cost	ts of ESAs furnished						
to all renal dialysis patients.							
Enter in column 3 the net cost							
to all home dialysis program p Enter in column 4 the number							
furnished to patients in the ren							
department.	-						
Enter in column 5 the number							
to patients in the home dialysi	is program.						
(see instructions)			I	1	1	1	1
					CCN	Treatments	
LOW VOLUME					1	2	
23 If line 10.01 is yes, enter in co its subscripts. Enter in colum				Part I, line 18, and			2

4090 (Cont.)	FORM CMS-2552-10				11-16
HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER A	ND	PROVIDER CCN:	PERIOD:	WORKSHEET S-6	
OTHER OUTPATIENT REHABILITATION			FROM		
PROVIDER STATISTICAL DATA		COMPONENT CCN:	то		

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

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

Enter the number of hours in your normal workweek _____

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

ROSPEC	CTIVE PAYMENT FOR SNF	FORM CMS-2552-10 PROVIDER CCN:	PERIOD:	4090 (WORKSHEET S-7	(
	ICAL DATA		FROM	-	
			TO		
			V/N	Data	
			Y/N 1	Date 2	-
1	If this facility contains a hospital-based SNF, were all patients under ma	maged care or was there no Medicare utilization?	1	2	
1	Enter "Y" for yes and do not complete the rest of this worksheet.				
2	Does this hospital have an agreement under either section 1883 or section	on 1913 for swing beds? Enter "Y" for yes or			
'	"N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy)	in column 2.			
		SNF	Swing Bed SNF	TOTAL	
	Group	Days	Days	(sum of col. 2 + 3)	
F	1	2	3	4	•
3	RUX				1
4	RUL				
5	RVX				
6	RVL RHX				_
7	RHL				-
9	RMX		1		1
10	RML				
11	RLX				
12	RUC				
13	RUB RUA		_	_	
14 15	RVC				
16	RVB				-
17	RVA				-
18	RHC				
19	RHB				
20	RHA				
21 22	RMC RMB				
22	RMA				
24	RLB				
25	RLA				
26	ES3				
27	ES2				
28 29	ES1 HE2				
30	HE1				-
31	HD2				-
32	HD1				
33	HC2				
34	HC1				
35 36	HB2 HB1				┣
36	LE2		+		+
38	LE1				\vdash
39	LD2				
40	LD1				
41	LC2				
42 43	LC1 LB2				
43	LB2 LB1		+	+	├
45	CE2				+
46	CE1				
47	CD2				
48	CD1				
49	CC2				<u> </u>
50 51	CC1 CB2				┣─
52	CB1				+
53	CA2				-
54	CA1				T

Form CMS-2552-10 (10-2012) (instructions for Rev. 3 $$		40-519		
4090 (Cont.)	FORM CMS-2552-10			10-12
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROV		WORKSHEET S-7 (CONT.)	

_____ то ____

		SNF	Swing Bed SNF	TOTAL	
	Group	Days	Days	(sum of col. 2 + 3)	
	1	2	3	4	
55	SE3				55 56
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA2				63 64 65
64	IA1				64
65	BB2				65
66	BB1				66 67
67	BA2				67
68	BA1				68
69	PE2				69 70 71
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				72 73 74 75 76 77
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" or "N" for no if the spending reflects increase associated with direct patient care and related expenses for each category. (see instructions)

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

12-24				F	ORM	CMS-2	2552-1	10							4090 (Cont.)
HOSPITAL-BASED RHC/FQHC STA	ATISTICAL DATA							PROVI	DER CCI	N:	PERIO			WORK	SHEET S	
								COMPC	ONENT (CN.	FROM TO					
											10	I				
Check [] Hospital-base applicable box: [] Hospital-base																
Clinic Address and Identification:																
1 Street:		<u></u>														1
2 City: 3 HOSPITAL-BASED FOHCs		State:	r "R" for	rural or "	Zip Cod				County:							2
	S ONE I. Designate	JII LIIICI	1 10 101	Turur or	0 101 01	oun										5
Source of Federal Funds:											Cront	Award			ata	
											Grant				ate 2	
4 Community Health Center (S	Section 330(d), PHS	Act)										-				4
5 Migrant Health Center (Secti																5
6 Health Services for the Home), PHS A	.ct)													6
7 Appalachian Regional Comn 8 Look-alikes	nission															7
9 Other (specify)																9
																÷
														1	2	
10 Does this facility operate as a				QHC? En	ter "Y" f	or yes or	"N" for n	o in colur	nn 1.					1	2	10
10 Does this facility operate as o If yes, indicate the number o				QHC? En	ter "Y" f	or yes or	"N" for n	o in colur	nn 1.					1	2	10
				QHC? En	ter "Y" f	or yes or '	"N" for n	o in colur	nn 1.					1	2	10
If yes, indicate the number o Facility hours of operations ¹	f other operations in	column : Sun	2. Iday	Mor	nday	Tue	sday	Wedn	esday		rsday		day	Satu	2 Irday	10
If yes, indicate the number of Facility hours of operations1 Type Operation	f other operations in	column Sun from	2. Iday to	Mon	nday to	Tue	sday to	Wedn from	esday to	from	to	from	to	Satu	ırday to	10
If yes, indicate the number o Facility hours of operations ¹ Type Operation 0	f other operations in	column : Sun	2. Iday	Mor	nday	Tue	sday	Wedn	esday					Satu	ırday	
If yes, indicate the number o Facility hours of operations ¹ Type Operations ¹ 0 11 Clinic	f other operations in	column Sun from 1	2. Iday to 2	Mon from 3	nday to 4	Tue from 5	sday to 6	Wedn from 7	esday to 8	from 9	to	from	to	Satu	ırday to	10
If yes, indicate the number o Facility hours of operations ¹ Type Operation 0	f other operations in ion n on line 11 and othe	Sun from 1 er type op	2. day to 2 perations	Mon from 3	nday to 4 ripts of li	Tue from 5 ne 11 (bo	sday to 6 th type a	Wedm from 7 nd hours of	esday to 8 of operati	from 9	to	from	to	Satu	ırday to	
If yes, indicate the number of Facility hours of operations ¹ Type Operation 0 11 Clinic Enter clinic hours of operation	f other operations in ion n on line 11 and othe	Sun from 1 er type op	2. day to 2 perations	Mon from 3	nday to 4 ripts of li	Tue from 5 ne 11 (bo	sday to 6 th type a	Wedm from 7 nd hours of	esday to 8 of operati	from 9	to	from	to	Satu from 13	to 14	
If yes, indicate the number of Facility hours of operations1 Type Operation 0 11 Clinic Enter clinic hours of operation based	f other operations in ion n on line 11 and oth on a 24 hour clock.	Sun from 1 er type op For exar	day to 2 perations mple: 8:	Mon from 3 s on subsc 00am is 0	nday to 4 ripts of li 800, 6:30	Tue from 5 ne 11 (bo	sday to 6 th type a	Wedm from 7 nd hours of	esday to 8 of operati	from 9	to	from	to	Satu	ırday to	11
If yes, indicate the number o Facility hours of operations ¹ Type Operation 0 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approx	f other operations in ion ion on line 11 and othe on a 24 hour clock. val for an exception	Sun from 1 er type op For exar	2. day to 2 perations mple: 8:	Mon from 3 s on subsc 00am is 0 y standard	nday to 4 ripts of li 800, 6:30	Tue from 5 ne 11 (bo 0pm is 183	sday to 6 th type au 30, and m	Wedn from 7 nd hours o hidnight is	esday to 8 of operati 2400.	from 9 on).	to 10	from	to 12	Satu from 13	to 14	11
If yes, indicate the number o Facility hours of operations ¹ Type Operation 0 11 Clinic Enter clinic hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for	f other operations in ion ion on line 11 and othe on a 24 hour clock. val for an exception	Sun from 1 er type op For exar	2. day to 2 perations mple: 8:	Mon from 3 s on subsc 00am is 0 y standard	nday to 4 ripts of li 800, 6:30	Tue from 5 ne 11 (bo 0pm is 183	sday to 6 th type au 30, and m	Wedn from 7 nd hours o hidnight is	esday to 8 of operati 2400.	from 9 on).	to 10	from	to 12	Satu from 13	to 14	11
If yes, indicate the number of Facility hours of operations ¹ Type Operation 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1.	f other operations in ion ion line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro	Sun from 1 er type op For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C	Moo from 3 o on subsc 00am is 0 y standard CMS Pub.	nday to 4 ripts of li 800, 6:30 ? 100-04,	Tue from 5 ne 11 (bo)pm is 183 chapter 9,	sday to 6 th type an 30, and m section 2	Wedm from 7 nd hours o nidnight is 30.8? Ent	esday to 8 of operati 2400. er "Y" fo	from 9 on).	to 10	from 11	to 12	Satu from 13	to 14	11
If yes, indicate the number o Facility hours of operations ¹ Type Operations 0 0 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in col	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o	Sun from 1 er type op For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C	Moo from 3 o on subsc 00am is 0 y standard CMS Pub.	nday to 4 ripts of li 800, 6:30 ? 100-04,	Tue from 5 ne 11 (bo)pm is 183 chapter 9,	sday to 6 th type an 30, and m section 2	Wedm from 7 nd hours o nidnight is 30.8? Ent	esday to 8 of operati 2400. er "Y" fo	from 9 on).	to 10	from 11	to 12	Satu from 13	to 14	11
If yes, indicate the number of Facility hours of operations ¹ Type Operation 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1.	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	esday to 8 of operati 2400. er "Y" fo	from 9 on).	to 10	from 11	to 12	Satu from 13	to 14	11
If yes, indicate the number of Facility hours of operations ¹ Type Operations 0 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in col in the consolidated group on If column 1 is Y, in column 3 13.01 Reserved	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	to 8 of operati 2400. er "Y" fo rovider n ectively.	from 9 on).	to 10	from 11	to 12	Satu from 13	to 14	11
If yes, indicate the number of Facility hours of operations ¹ Type Operations 0 11 Clinic Enter clinic hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in colini the consolidated group on If column 1 is Y, in column 5	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	esday to 8 of operati 2400. er "Y" fo	from 9 on).	to 10	from 11	to 12	Satu from 13	to 14	11 12 13
If yes, indicate the number of Facility hours of operations ¹ Type Operations 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in col in the consolidated group on If column 1 is Y, in column 3 13.01 Reserved	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	to 8 of operati 2400. er "Y" fo rovider n ectively.	from 9 on).	to 10	from 11	to 12	Satu from 13	rday to 14 3	11 12 13 13.01
If yes, indicate the number of Facility hours of operations ¹ Type Operations 0 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in col in the consolidated group on If column 1 is Y, in column 3 13.01 Reserved	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	to 8 of operati 2400. er "Y" fo rovider n ectively.	from 9 on).	to 10 'N" for each mer	from 11		Satu from 13	rrday to 14 3 3 Total	11 12 13 13.01
If yes, indicate the number of Facility hours of operations ¹ Type Operations 0 11 Clinic Enter clinic hours of operation List hours of operation based 12 Have you received an approv 13 Is this worksheet prepared for no in column 1. If column 1 is Y, enter in col in the consolidated group on If column 1 is Y, in column 3 13.01 Reserved	f other operations in ion n on line 11 and oth on a 24 hour clock. val for an exception or a consolidated gro lumn 2 the number o line 14.	Sun from 1 For exar to the pro- up as def	2. to 2 perations mple: 8: oductivity fined in C ers incluce	Moi from s on subsc 00am is 0 y standard CMS Pub. ded in the	nday to 4 ripts of li 800, 6:30 ? 100-04, group. I	Tue from 5 ne 11 (bo)pm is 183 chapter 9, .ist the pro	sday to 6 th type ai 30, and m section 3 ovider na	Wedn from 7 idnight is 30.8? Ent me and pu	to 8 of operati 2400. er "Y" fo rovider n ectively.	from 9 on).	to 10	from 11	to 12	Satu from 13	rday to 14 3	11 12 13 13.01

		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1.						
	If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V,						
	XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						

4090 (Cont.)	FORM CMS-2552-10			12-24
HOSPITAL-BASED HOSPICE IDENTIFICATION DATA	PROVID	IDER CCN:	PERIOD:	WORKSHEET S-9
		1	FROM	PARTS I THROUGH IV
	HOSPIC	ICE CCN:	то	

PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015

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

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

				Title XVIII	Title XIX		Total	
				Skilled Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 and 5)	
		1	2	3	4	5	6	
6	Number of patients receiving							6
	hospice care							
7	Total number of unduplicated contin-							7
	uous care hours billable to Medicare							
8	Average length of stay (line 5/line 6)							8
9	Unduplicated census count							9

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

			Unduplic	ated Days				
					Total			
					(sum of			
		Title XVIII Title XIX Other cols.						
		1	2	3	4			
10	Hospice Continuous Home Care					10		
11	Hospice Routine Home Care					11		
12	Hospice Inpatient Respite Care					12		
13	Hospice General Inpatient Care					13		
14	Total Hospice Days					14		

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

					Total	
					(sum of	
		Title XVIII	Title XIX	Other	cols. 1 through 3)	
		1	2	3	4	1
15	Hospice Inpatient Respite Care					15
16	Hospice General Inpatient Care					16

NOTE: Parts I and II, columns 1 and 2, also include the days reported in columns 3 and 4.

12-22	FORM CMS-255	2-10		4090	(Cont.)
HOSPITAL UNCOMPENSATED AND INDIGENT		PROVIDER CCN:	PERIOD:	WORKSHEET S-10	· /
CARE DATA			FROM	PART I	
			то		
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
Uncompensated and Indigent Care Cost-to-Charge Ratio					
1 Cost to charge ratio (see instructions)					1
Medicaid (see instructions for each line)					
2 Net revenue from Medicaid					2
3 Did you receive DSH or supplemental payments from the second se	om Medicaid?				3
4 If line 3 is yes, does line 2 include all DSH and/or s					4
5 If line 4 is no, enter DSH and/or supplemental payr					5
6 Medicaid charges	iens nom neueue				6
7 Medicaid cost (line 1 times line 6)					7
8 Difference between net revenue and costs for Medi	icaid program (see instructions)				8
· · · ·					
Children's Health Insurance Program (CHIP) (see instruction	ns for each line)				
9 Net revenue from stand-alone CHIP					9
10 Stand-alone CHIP charges					10
11 Stand-alone CHIP cost (line 1 times line 10)					11
12 Difference between net revenue and costs for stand	-alone CHIP (see instructions)				12
Other state or local government indigent care program (see in	nstructions for each line)				
13 Net revenue from state or local indigent care progra					13
14 Charges for patients covered under state or local in		10)			14
15 State or local indigent care program cost (line 1 tim					15
16 Difference between net revenue and costs for state		s)			16
Grants, donations and total unreimbursed cost for Medicaid,		ee instructions for each line))		
17 Private grants, donations, or endowment income re					17
18 Government grants, appropriations or transfers for					18
19 Total unreimbursed cost for Medicaid, CHIP, and s	tate and local indigent care programs (sum of l	ines 8, 12, and 16)			19
Uncompensated care cost (see instructions for each line)					
		Uninsured	Insured	Total	
		patients	patients	(col. 1 + col. 2)	
		1	2	3	
20 Charity care charges and uninsured discounts (see	instructions)				20
21 Cost of patients approved for charity care and unin	sured discounts (see instructions)				21
Payments received from patients for amounts previ	ously written off as charity care				22
23 Cost of charity care (see instructions)					23
		1			24
24 Does the amount on line 20, col. 2, include charges	for patient days beyond a length-or-stay limit	mposed on patients covered	l		24
by Medicaid or other indigent care program?		11 I. Z. I. S. J. S.			
25 If line 24 is yes, enter the charges for patient days l		ay limit (see instructions)			25
25.01 Charges for insured patients' liability (see instructi	ons)				25.01
26 Bad debt amount (see instructions)	<u></u>				26
27 Medicare reimbursable bad debts (see instructions)				27
27.01 Medicare allowable bad debts (see instructions)					27.01
28 Non-Medicare bad debt amount (see instructions)					28
29 Cost of non-Medicare and non-reimbursable Medic	· · · · · · · · · · · · · · · · · · ·				29
30 Cost of uncompensated care (line 23, col. 3, plus li					30
31 Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

CARE D	DATA		FROM	PART II	
PART II	- HOSPITAL DATA		10		
_	ensated and Indigent Care Cost-to-Charge Ratio				
	Cost to charge ratio (see instructions)				1
				1	
Medicai	(see instructions for each line)				
2	Net revenue from Medicaid				2
3	Did you receive DSH or supplemental payments from Medicaid?				3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?				4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid				5
6	Medicaid charges				6
7	Medicaid cost (line 1 times line 6)				7
8	Difference between net revenue and costs for Medicaid program (see instructions)				8
Children	's Health Insurance Program (CHIP) (see instructions for each line)				
9	Net revenue from stand-alone CHIP				9
	Stand-alone CHIP charges				10
	Stand-alone CHIP cost (line 1 times line 10)				11
12	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12
Other sta	te or local government indigent care program (see instructions for each line)				
13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)				13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)				14
15	State or local indigent care program cost (line 1 times line 14)				15
16	Difference between net revenue and costs for state or local indigent care program (see instructions)				16
Grants	donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see in	structions for each line)			<u> </u>
	Private grants, donations, or endowment income restricted to funding charity care	structions for cuch line)			17
	Government grants, appropriations or transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines	8, 12, and 16)			19
		-, ,,			
Uncomp	ensated care cost (see instructions for each line)				
		Uninsured	Insured	Total	
		Patients	Patients	(col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts (see instructions)				20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)				21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (see instructions)				23
	Describe and and the 20 col 2 include changes for actions described and the state of the state				24
24	Does the amount on line 20, col. 2, include charges for patient days beyond a length-of-stay limit impo	sed on patients covered			24
	by Medicaid or other indigent care program?				
	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay line of the second	mit (see instructions)			25
	Charges for insured patients' liability (see instructions)				25.01
	Bad debt amount (see instructions)				26
27	Medicare reimbursable bad debts (see instructions)				27
	Medicare allowable bad debts (see instructions)				27.01
28					28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29 30
30	Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)				30
31	1 otal unrennouised and uncompensated care cost (line 19 plus line 30)				31

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4090	(Cont.)			FORM CMS-2552	2-10					12-22
HOSPI	TAL-BASED FQHC IDENTIFICATION	N DATA					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET S-11 PART I	
PART	I - HOSPITAL-BASED FQHC IDENTIF	ICATION DATA								
						Type of control	Date	V/I	Date of	
						(see instructions)	Decertified	Decertification	CHOW	
		1				2	3	4	5	
1	Site Name:									1
2	2 Street:	-	P.O. Box:							2
	3 City:	State:	ZIP Code:	County:	Designation - Enter "R"	for rural or "U" for urt	an:			3
4	Is this hospital-based FQHC part of an enter the entity's information below.	entity that owns, leases or	controls multiple FQHCs	5? Enter "Y" for yes or "N" for no. If yes,						4
	5 Name of Entity:									5
F		P.O. Box:		HRSA Award Number:						6
	7 City:	State:		ZIP Code:				ļ		7
	City:	otater		Lin couct		Y/N	Date Requested	Date Approved	Number of FQHCs	,
Consoli	idated Cost Report					1	2	3	4	
	Is this hospital-based FQHC filing a co			er 9, §30.8? Enter "Y" for yes or "N" for no in co column 1 is no, leave line 9 blank. (see instruction			_			8
						CCN	CBSA	Date Requested	Date Approved	
		1				2	3	4	5	1
g	Hist of Consolidated Providers:									9
9.01	Site Name:									9.01
	al-Based FQHC Operations						1	2	3	
10			operate as more than one	sub-type of an organization, enter only the applie	cable alpha					10
	characters in column 2. (see instruction					TOULO I				
11				reporting period? If this is a consolidated cost re period? Enter "Y" for yes or "N" for no. (comple		FQHC reported				11
12				arded (see instructions). Enter the date of the gra						12
	column 2, and enter the grant award nu									
Medica	Il Malpractice	inder in column of it you	received more than one g							I
13	3 Did this hospital-based FQHC submit a	n initial deeming or annua	l redeeming application f	or medical malpractice coverage under the FTC.	A with HRSA? Enter "Y" f	or				13
	yes or "N" for no in column 1. If colur	nn 1 is yes, enter the effec	ctive date of coverage in o	column 2.						
	and Residents									
14				of Title VII of the PHS Act from HRSA? Enter						14
				your hospital-based FQHC trained and received	0 0 0					
		and in column 3, enter the	total number of visits pe	erformed by residents funded by the THC grant in	n this cost reporting					
	period. (see instructions)									

02-24				FORM C	MS-2552-10				409	0 (Cont.)
HOSPIT	AL-BASED FQHC IDENTIFICATION D	ATA					PROVIDER CCN: COMPONENT CCN: SUBCOMPONENT CCN:	PERIOD: FROM TO	WORKSHEET S-11 PART II	
PART II	- HOSPITAL-BASED FQHC CONSOLIDA	ATED COST REPORT PA	RTICIPANT IDENTI	FICATION DATA	Date Certified 2	Type of control (see instructions) 3	Date Decertified 4	V/I Decertification 5	Date of CHOW 6	
1	Site Name:									1
2	Street:	P.O. Box:				1			-	2
3	City:	State:	ZIP Code:	County:		Designation - Enter "R" for	r rural or "U" for urban:			3
4	Based FQHC Operations What type of organization is this hospital-ba alpha characters in column 2. (see instructi Did this hospital-based FQHC receive a gra If the response to line 5 is yes, indicate in co column 2 and enter the grant award number	ons) nt under §330 of the PHS olumn 1, the type of HRSA	Act during this cost re grant that was award	porting period? Enter "Y" for ye ed (see instructions). Enter the d	es or "N" for no. (complete late of the grant award in	line 6)	1	2	3	4 5 6
	Malpractice Did this hospital-based FQHC submit an ini Enter "Y" for yes or "N" for no in column 1				under the FTCA with HRSA	?				7
	nd Residents Did this hospital-based FQHC receive a TH Enter "Y" for yes or "N" for no in column 1 your THC grant in this cost reporting period	. If yes, enter in column 2	the number of FTE re	sidents that your FQHC trained a	and received funding throug	h				8
	in this cost reporting period. (see instruction	ns)								1

4090 (Cont.)		FORM C	AS-2552-10				02-24
HOSPITAL-BASED FQHC IDENTIFICATION DAT	ГА			PROVIDER CCN:	PERIOD:	WORKSHEET S-1	1
					FROM	PART III	
				COMPONENT CC	то	-	
PART III - HOSPITAL-BASED FQHC STATISTICA	L DATA						
						Total	
	COMPONENT		Title	Title		All	
	CCN	Title V	XVIII	XIX	Other	Patients	
	0	1	2	3	4	5	-
1 Medical Visits							1
2 Total Medical Visits							2
3 Mental Health Visits							3
4 Total Mental Health Visits							4
5 IOP Visits							5
6 Total IOP Visits							6
7 Total FQHC Visits (sum of lines 2, 4, and 6)							7

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4090 (Cont.)		F	ORM CMS-2552	2-10					01-22
RECLAS	SSIFICATI	ON AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A	
	COS	T CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		GENERAL SERVICE COST CENTERS	-	-	5		5		,	
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3		Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14		Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing Program								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23		Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit		1	1					33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF		1	1					40
41	04100	Subprovider - IRF								41
42		Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN	NCMS PUB. 15-2, SECTION 4013)			
40-524				Rev. 17
12-22	FORM CMS-2552-10			4090 (Cont.)
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		PROVIDER CCN:	PERIOD:	WORKSHEET A

								FROM		
	COS	T CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		ANCILLARY SERVICE COST CENTERS	-	-	5		5	0		
50	05000	Operating Room								50
51		Recovery Room								51
52		Labor Room and Delivery Room								52
53		Anesthesiology								53
54		Radiology-Diagnostic								54
55		Radiology-Therapeutic								55
56		Radioisotope								56
57		Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59		Cardiac Catheterization								59
60		Laboratory								60
61		PBP Clinical Laboratory Services-Program Only								61
62		Whole Blood & Packed Red Blood Cells								62
63		Blood Storing, Processing, & Trans.								63
64		Intravenous Therapy								64
65		Respiratory Therapy								65
66		Physical Therapy								66
67		Occupational Therapy								67
68	06800	Speech Pathology								68
69		Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
77	07700	Allogeneic HSCT Acquisition								77
78	07800	CAR T-Cell Immunotherapy OUTPATIENT SERVICE COST CENTERS								78
	00000									00
88 89		Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC)								88 89
90		Clinic								<u>89</u> 90
91	09100	Emergency								91
92 93		Observation Beds Other Outpatient Service (specify)								92 93
93.99	09399	Partial Hospitalization Program								93.99

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED I	N CMS PUB. 15-2, SECT	TON 4013)					
Rev. 18							40-525
4090 (Cont.)	FG	ORM CMS-2552-	10				12-22
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER CCN:	PERIOD:	WORKSHEET A	
					FROM		
					ТО		
				RECLASSIFIED		NET EXPENSES	

	COS	T CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	TRIAL BALANCE (col. $3 \pm$ col. 4)	ADJUSTMENTS	FOR ALLOCATION (col. $5 \pm$ col. 6)	
		(onit cents)	1	2	3	4	5	6	7	
		OTHER REIMBURSABLE COST CENTERS	-		-	-	-			
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
102	10200	Opioid Treatment Program								102
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1 through 117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118 through 199)				- 0 -				200

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4013) 40-526

Rev. 18

10-12				FORM	CMS-2552-10)							
RECLA	SSIFICATIONS							PROVIDER	CCN:	PERIOD: FROM TO	4090 (Cont.)		
			INCREASES			1	DECREASES						
		CODE		WKST. A					WKST. A			WKST. A-7	
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	SALARY	OTHER	COST C	ENTER	LINE #	SALARY	OTHER	REF.	
		1	2	3	4	5	60010		7	8	9	10	
1												-	1
2													2
3												1 1	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 17		_		_									16
17													17 18
10												+ +	10
20							-					+ +	20
20												+ +	20
22													22
23												+ +	23
24												+ +	24
25													24 25
26													26
27													27
28													28
29													29 30
30													30
31													31
32													31 32 33
33													33
34													34 35
35													35
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)												500

⁽¹⁾ A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

4090 (Cont.)		FG	ORM CMS-2552-	-10					10-12
RECONCILIATION OF CAPITAL COSTS CENTERS						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-7, PARTS I, II & III	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES									
TAKI I- AIAE 1515 OF CHARGES IN CALIFIE ASSET DAEANCES			1	Acquisitions		Disposals		Fully	
Description		Beginning Balances	Purchases 2	Donation	Total 4	and Retirements 5	Ending Balance 6	Depreciated Assets	
1 Land		1	2	3	4	5	0	/	1
2 Land Improvements									2
3 Buildings and Fixtures									3
4 Building Improvements									4
5 Fixed Equipment									5
6 Movable Equipment									6
7 HIT-designated Assets									7
8 Subtotal (sum of lines 1 through 7)									8
9 Reconciling Items									9
10 Total (line 7 minus line 9)									10
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, O	COLUMN 2, LINES 1 AN	ND 2							
					SUMMARY OF CAPIT	AL	1		
							Other Capital-	Total (1)	
					Insurance	Taxes	Related Costs	(sum of	
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
* 		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1 and 2)									3
 (1) The amount in columns 9 through 14 must equal the amount on Wo column 2, lines 1 and 2. * All lines numbers are to be consistent with Worksheet A line number 			column the appropriate a	amounts including any di	rectly assigned cost that	may have been included	in Worksheet A,		_
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS									
		COMPUTAT	ION OF RATIOS			ALLOCATION OF	F OTHER CAPITAL		
			Gross Assets					Total	1
		Capitalized	for Ratio	Ratio			Other Capital-	(sum of	
Description	Gross Assets	Leases	(col. 1 - col. 2)	(see instructions)	Insurance	Taxes	Related Costs	cols. 5 through 7)	
*	1	2	3	4	5	6	7	8	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1 and 2)				1.000000					3
					SUMMARY OF CAPIT	AL			
							Other Capital-	Total (2)	
					Insurance	Taxes	Related Costs	(sum of	
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1 and 2)									3
(2) The amounts on lines 1 and 2 must equal the corresponding amount	s on Worksheet A, colum	n 7, lines 1 and 2. Colu	nns 9 through 14 should	include related					

Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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PERIOD:

1120001							
				TO			
	DESCRIPTION (1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICA WORKSHEET A TO/FRC THE AMOUNT IS TO BE COST CENTER	M WHICH	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)		-	Buildings and Fixtures	1	5	1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)			T P			3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8							8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1					12
13	Laundry and linen service	Womblecci i o i					13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical						16
	supplies to other than patients						
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
-	Nursing and allied health education (tuition,						10
10	fees, books, etc.)						10
20	Vending machines						20
20	Income from imposition of interest,						20
21	finance or penalty charges (chapter 21)						1 -1
22	Interest expense on Medicare overpayments and						22
22	borrowings to repay Medicare overpayments						
23	Adjustment for respiratory therapy						23
25	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		25
24	Adjustment for physical therapy costs	Worksheet H 0 5					24
24	in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		1 -7
25	Utilization review - physicians' compensation (chapter 21)	Worksheet H 0 5		Utilization Review - SNF	114		25
	Depreciation - buildings and fixtures			Buildings and Fixtures	114		26
20	Depreciation - movable equipment			Movable Equipment	2		20
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant			Tonphysician rulesticust	15		29
30	Adjustment for occupational therapy costs						30
50	in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
30.99	Hospice (non-distinct) (see instructions)	worksheet 11-0-5		Adults and Pediatrics	30		30.99
	Adjustment for speech pathology costs				50		31
51	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		51
32	CAH HIT adjustment for depreciation	WORKSHEEL A-0-5		opecentratiology	00		32
	J I		<u> </u>	1			
	Other adjustments (specify) ⁽³⁾						33
50	TOTAL (sum of lines 1 through 49)						50
	(Transfer to Worksheet A, column 6, line 200)						L

 $^{\scriptscriptstyle (1)}$ Description - all chapter 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⁾ Additional adjustments may be made on lines 33 through 49 and subscripts thereof.

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

4090 (Cont.)	FORM C	MS-2552-10		03-18	
STATEMENT OF COSTS OF SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET A-8-1	
FROM RELATED ORGANIZATIONS AND			FROM		
HOME OFFICE COSTS			то		

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS

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

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

				Delated Organizati	ion(s) and/or Home Offic	10	
				Related Olganizati		e	
			Percentage		Percentage		
	Symbol		of		of	Type of	
	(1)	Name	Ownership	Name	Ownership	Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative

of such person has financial interest in provider.

G. Other (financial or non-financial) specify _____

10-12			FO	ORM CMS-2552	-10				4090	(Cont.)
PROVID	ER-BASED PHYSICIAN	S ADJUSTMENTS					PROVIDER CCN:	PERIOD:	WORKSHEET A-8-2	
								FROM	_	
								ТО	_	
		Cost Center/					Physician/		5 Percent of	
	Wkst. A	Physician	Total	Professional	Provider	RCE	Provider	Unadjusted	Unadjusted	
	Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9					İ				1	9
10					1					10
11										11
200	TOTAL									200

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-3,
FURNISHED BY OUTSIDE SUPPLIERS		FROM	PARTS I & II
		то	

Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology PART I - GENERAL INFORMATION 1 Total number of weeks worked (excluding aides) (see instructions) 2 Line 1 nutliplied by 15 hours per week 3 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 4 Number of unduplicated days in which therapy assistant was on provider site (see instructions) 5 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 6 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 7 Standard travel experse rate 8 Optional travel experse rate per mile

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	1
9	Total hours worked						9
10	AHSEA (see instructions)						10
11	Standard travel allowance (columns 1 and 2, one-half of column 2,						11
	line 10; column 3, one-half of column 3, line 10)						
12	Number of travel hours (see instructions)						12
13	Number of miles driven (see instructions)						13

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)	14
15	Therapists (column 2, line 9 times column 2, line 10)	15
16	Assistants (column 3, line 9 times column 3, line10)	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	17
18	Aides (column 4, line 9 times column 4, line 10)	18
19	Trainees (column 5, line 9 times column 9, line 10)	19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	20

If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 2, and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.

are another non-mile zor-outer wise complete media zor	
21 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	21
22 Weighted allowance excluding aides and trainees (line 2 times line 21)	22
23 Total salary equivalency (see instructions)	23

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS	S PUB. 15-2, SECTIONS 4019)			
40-532				Rev. 3
03-16	FORM CMS-2552-10			4090 (Cont.)
REASONABLE COST DETERMINATION FOR THERAPY SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET A-8-3,

10-12

FURNISHED BY OUTSIDE SUPPLIERS	FROM PARTS III & IV
Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE	
Standard Travel Allowance	
24 Therapists (line 3 times column 2, line 11)	24
25 Assistants (line 4 times column 3, line 11)	25
26 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	26
27 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	27
28 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	28
Optional Travel Allowance and Optional Travel Expense	
29 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	29
30 Assistants (column 3, line 10 times column 3, line 12)	30
31 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	31
32 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	32
33 Standard travel allowance and standard travel expense (line 28)	33
34 Optional travel allowance and standard travel expense (sum of lines 27 and 31)	34
35 Optional travel allowance and optional travel expense (sum of lines 31 and 32)	35
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE	
Standard Travel Expense	
36 Therapists (line 5 times column 2, line 11)	36
37 Assistants (line 6 times column 3, line 11)	37
38 Subtotal (sum of lines 36 and 37)	38
39 Standard travel expense (line 7 times the sum of lines 5 and 6)	39
Optional Travel Allowance and Optional Travel Expense	
40 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	40
41 Assistants (column 3, line 12.01 times column 3, line 10)	41
42 Subtotal (sum of lines 40 and 41)	42
43 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate.	
44 Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)	44
45 Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)	45
46 Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)	46

FORM CMS-2552-10 (03-2016) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-2, SECT	IONS 4019)			
Rev. 9				40-533
4090 (Cont.)	FORM CMS-2552-10			03-16
REASONABLE COST DETERMINATION FOR THERAPY SERVICES		PROVIDER CCN:	PERIOD:	WORKSHEET A-8-3,
FURNISHED BY OUTSIDE SUPPLIERS			FROM	PARTS V-VI
			то	

Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology

PART V - OVERTIME COMPUTATION	Therapists	Assistants	Aides	Trainees	Total	
	1	2	3	4	5	
47 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or great than 2,080, do not complete	-	_	5			47
lines 48-55 and enter zero in each column of line 56)					1	
48 Overtime rate (see instructions)					1	48
49 Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT						
50 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47.					1	50
51 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)					(51
	•			•		
DETERMINATION OF OVERTIME ALLOWANCE						
52 Adjusted hourly salary equivalency amount (see instructions)						52
53 Overtime cost limitation (line 51 times line 52)						53
54 Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55 Portion of overtime already included in hourly computation at the AHSEA (multiply					1	55
line 47 times line 52)						
56 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5, the sum of columns 1, 3, and 4, for respiratory					1	56
therapy, and columns 1 through 3 for all others.)					L	
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57 Salary equivalency amount (from line 23)						57
57 Salary equivalency and and (non me 25) 58 Travel allowance and expense - provider site (from lines 33, 34, or 35))						58
59 Travel allowance and expense - Offsite services (from lines 55, 54, 61 55))					·	59
60 Overtime allowance (from column 5, line 56)					i	60
ou overtime intowarce (non-columno), the obj						61
61 Equipment cost (see instructions) 62 Supplies (see instructions)					i	61
02 Suppres (see instructions) 63 Total allowance (sum of lines 57-62)					l	63
64 Total cost of outside supplier services (from provider records)					i	64

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4019) 40-534

12-22			FO	ORM CMS-2552-	-10				4090	(Cont.)
COST A	LLOCATION - GENERAL SERVICE COSTS						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	<u> </u>
		NET EXPENSES FOR COST		ITAL D COSTS						
COS	T CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	4	4A	5	6	7	
1	Capital Related Costs-Buildings and Fixtures							-		1
	Capital Related Costs-Dundings and Fixtures									2
	Employee Benefits Department									4
	Administrative and General									5
	Maintenance and Repairs									6
	Operation of Plant									7
	Laundry and Linen Service									8
	Housekeeping									9
	Dietary									10
	Cafeteria									11
	Maintenance of Personnel									11
	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									2.5
30	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									40
	Subprovider (specify)									42
	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility									45
	Other Long Term Care									45

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS	PUB. 15-2, SECTION 4020)		
Rev. 18			40-535
4090 (Cont.)	FORM CMS-2552-10		12-22
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN: PERIOD:	WORKSHEET B,

					1	1		FROM TO	_ PART I	
		NET EXPENSES FOR COST		ITAL D COSTS						
COST	CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	4	4A	5	6	7	
										50
	Operating Room Recovery Room									
	Labor Room and Delivery Room									51
	Anesthesiology									52
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									82
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)									76
	Allogeneic HSCT Acquisition									77
	CAR T-Cell Immunotherapy									78
	OUTPATIENT SERVICE COST CENTERS									1 /
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
	Emergency									91
	Observation Beds									92
	Other Outpatient Service (specify)									92
	Partial Hospitalization Program									93.99

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEE	T ARE PUBLISHED IN	CMS PUB. 15-2, SECTION 4020)					
40-536						F	Rev. 18
12-22		FORM CMS-2552-	10			4090	(Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:	PERIOD:	WORKSHEET B,	
					FROM	PART I	
					то		
	NET EXPENSES	CAPITAL					

		FOR COST	RELATE	D COSTS	l		I	I	1	1
COS	F CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	4	4A	5	6	7	
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
102	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
	Other Nonreimbursable (specify)									194
200	Cross Foot Adjustments									200
201	Negative Cost Centers									201
202	TOTAL (sum lines 118 through 201)									202

 $\overline{\text{FORM CMS-}2552-10}$ (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) Rev. 18

4090 (Cont.)			FOF	M CMS-255	52-10						12-22
COST ALLOCATION - GENERAL SERVICE COSTS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
GENERAL SERVICE COST CENTERS	8	9	10	11	12	13	14	15	16	17	-
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Buildings and Fixtures											2
4 Employee Benefits Department											4
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
			4								9
9 Housekeeping				4							10
10 Dietary					4						
11 Cafeteria											11
12 Maintenance of Personnel							4				12
13 Nursing Administration								4			13 14
14 Central Services and Supply									4		
15 Pharmacy										-	15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing Program											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Education Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider (specify)											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CM	IS PUB. 15-2, SECTION 4020)		
40-538			Rev. 18
12-22	FORM CMS-2552-10		4090 (Cont.)
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN: PERIOD:	WORKSHEET B,

		-1	1	1	1	1	i	1		FROM TO	_ PART I	
COS	Γ CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
	ANCILLARY SERVICE COST CENTERS	0		10			10		10	10		
50	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization											59
	Laboratory											60
	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
	Respiratory Therapy											65
	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											82
73	Drugs Charged to Patients											73
74	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
77	Allogeneic HSCT Acquisition											77
78	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient Service (specify)											93
93.99	Partial Hospitalization Program											93.99

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKS	HEET ARE PUBLI	SHED IN CMS PU	JB. 15-2, SECTIO	N 4020)						
Rev. 18										40-539
4090 (Cont.)			FOF	RM CMS-255	52-10					12-22
COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER CCN:	PERIOD:	WORKSHEET B,	
								FROM	PART I	
								то		

COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
102	Opioid Treatment Program											102
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
	Hospice											116
117	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1 through 117)											118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)											194
200	Cross Foot Adjustments											200
201	Negative Cost Centers											201
202	TOTAL (sum lines 118 through 201)											202

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) 40-540

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

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE	PUBLISHED IN CMS PUB. 15-2, SECTION 4020)				
Rev. 18					40-541
4090 (Cont.)	FORM CMS-2552-10				12-22
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET B,	

									FROM TO	PART I	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS		-								
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology								-		53
	Radiology-Diagnostic								-		54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan									-	57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catheterization									+	59
	Laboratory									-	60
	PBP Clinical Laboratory Services-Program Only										61
	Whole Blood & Packed Red Blood Cells										62
	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										67
											69
	Electrocardiology										
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										82
	Drugs Charged to Patients										73
	Renal Dialysis								_	_	74
	ASC (Non-Distinct Part)									_	75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
78	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)										93
93.99	Partial Hospitalization Program										93.99

SHEET ARE PUB	LISHED IN CMS P	UB. 15-2, SECTIO	ON 4020)						
								F	Rev. 18
	FOF	RM CMS-255	52-10					4090 ((Cont.)
						PROVIDER CCN:	PERIOD:	WORKSHEET B,	
							FROM	PART I	
							ТО		
							INTERN &		
	KSHEET ARE PUB			SHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) FORM CMS-2552-10		FORM CMS-2552-10	FORM CMS-2552-10	FORM CMS-2552-10 PROVIDER CCN: PERIOD: FROM TO	FORM CMS-2552-10 4090 PROVIDER CCN: PERIOD: WORKSHEET B, FROM TO PART I

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
OTHER REIMBURSABLE COST CENTERS	10	15	20	21	22	23	24	2.5	20	<u> </u>
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										100
102 Opioid Treatment Program										101
SPECIAL PURPOSE COST CENTERS										102
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1 through 117)										118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118 through 201)										202

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) Rev. 18

4090 (Cont.)		F	ORM CMS-2552	-10					12-22
ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
	DIRECTLY ASSIGNED NEW CAPITAL		PITAL ED COSTS	SUBTOTAL	EMDLOVEE	ADMINIC	MAIN		
COST CENTER DESCRIPTIONS	RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	(sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	0	1	2	2A	4	5	6	7	_
GENERAL SERVICE COST CENTERS 1 Capital Related Costs-Buildings and Fixtures			-	-					1
2 Capital Related Costs-Buildings and Fixtures				-					1
						_			2
4 Employee Benefits Department 5 Administrative and General							_		4
6 Maintenance and Repairs								-	5
6 Maintenance and Repairs 7 Operation of Plant									7
8 Laundry and Linen Service									8
									-
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration									13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library									16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing Program									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)									30
31 Intensive Care Unit									31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									36
40 Subprovider IPF									40
41 Subprovider IRF									41
42 Subprovider (specify)									42
43 Nursery									43
44 Skilled Nursing Facility									44
45 Nursing Facility									45
46 Other Long Term Care									46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHE	ED IN CMS PUB. 15-2, SECTION 4021)			
40-544				Rev. 18
12-22	FORM CMS-2552-10			4090 (Cont.)
ALLOCATION OF CAPITAL-RELATED COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET B,

							FROM TO	PART II	
	DIRECTLY ASSIGNED		PITAL ED COSTS						
COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
ANCILLARY SERVICE COST CENTERS	0	1	2	2A	4	5	0	/	
50 Operating Room									5
51 Recovery Room									5
51 Recovery Room 52 Labor Room and Delivery Room									5
53 Anesthesiology									5
									5
54 Radiology-Diagnostic									
55 Radiology-Therapeutic									5
56 Radioisotope									5
57 Computed Tomography (CT) Scan									5
58 Magnetic Resonance Imaging (MRI)									5
59 Cardiac Catheterization									5
60 Laboratory									6
61 PBP Clinical Laboratory Services-Program Only									6
62 Whole Blood & Packed Red Blood Cells									6
63 Blood Storing, Processing, & Trans.									6
64 Intravenous Therapy									6
65 Respiratory Therapy									6
66 Physical Therapy									6
67 Occupational Therapy									6
68 Speech Pathology									6
69 Electrocardiology									6
70 Electroencephalography									7
71 Medical Supplies Charged to Patients									7
72 Implantable Devices Charged to Patients									7
73 Drugs Charged to Patients									7
74 Renal Dialysis									7
75 ASC (Non-Distinct Part)									7
76 Other Ancillary (specify)									7
77 Allogeneic HSCT Acquisition									7
78 CAR T-Cell Immunotherapy									7
OUTPATIENT SERVICE COST CENTERS									
88 Rural Health Clinic (RHC)									8
89 Federally Qualified Health Center (FQHC)								-	8
90 Clinic					1			+	9
91 Emergency								+	
92 Observation Beds									9
92 Observation Beds 93 Other Outpatient Service (specify)									
									9
93.99 Partial Hospitalization Program									93.9

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS V	VORKSHEET	ARE PUBLISHED	IN CMS PUB. 15	5-2, SECTION 4021)							
Rev. 18											40-545
4090 (Cont.)				FORM CM	S-2552-	-10					12-22
ALLOCATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
		DIRECTLY		CAPITAL							

		ASSIGNED	RELATE	D COSTS	I	1		1	I	1
COS	T CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	_
	OTHER REIMBURSABLE COST CENTERS		-	_				-		
94	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
102	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									113
	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices									192
	Nonpaid Workers									193
	Other Nonreimbursable (specify)									194
	Cross Foot Adjustments									200
	Negative Cost Centers									201
202	TOTAL (sum lines 118 through 201)									202

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4021) 40-546

12-22				FORM CM	IS- 2552-10					4090	(Cont.)
ALLOCATION OF CAPITAL-RELATED COSTS								PROVIDER CCN:	PERIOD: FROM	WORKSHEET B, PART II	
									то	_	
	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
COST CENTER DESCRIPTIONS	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
COST CENTER DESCRIPTIONS	SERVICE	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	
	8	9	10	11	12	13	14	15	16	17	-
GENERAL SERVICE COST CENTERS	-	-									
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment	1										2
4 Employee Benefits Department	1										4
5 Administrative and General	1										5
6 Maintenance and Repairs]						1				6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria											11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply											14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing Program											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Education Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											30
30 Adults and Pediatrics (General Routine Care) 31 Intensive Care Unit											30
31 Intensive Care Unit 32 Coronary Care Unit											31
32 Coronary Care Unit 33 Burn Intensive Care Unit											32
33 Burn Intensive Care Unit 34 Surgical Intensive Care Unit											33
34 Surgical Intensive Care Unit 35 Other Special Care Unit (specify)											34
40 Subprovider IPF											40
40 Subprovider IPF 41 Subprovider IRF											40
41 Subprovider (specify)					+		+			+	41 42
42 Subprovider (specify) 43 Nursery											42
43 Nursery 44 Skilled Nursing Facility											43
44 Skilled Nursing Facility 45 Nursing Facility					+		+			+	44
46 Other Long Term Care											45
	I										40

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISH	ED IN CMS PUB. 15-2, SECTION 4021)				
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4090 (Cont.)	FORM CMS-2552-10				12-22
ALLOCATION OF CAPITAL-RELATED COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET B,	

				1					FROM TO	_ PART II	
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
ANCILLARY SERVICE COST CENTERS	0	9	10	11	12	15	14	15	10	17	
50 Operating Room											5
51 Recovery Room											5
52 Labor Room and Delivery Room											5
53 Anesthesiology											5
54 Radiology-Diagnostic											5
55 Radiology-Therapeutic											5
56 Radioisotope											5
57 Computed Tomography (CT) Scan											
57 Computed Tomography (C1) Scan 58 Magnetic Resonance Imaging (MRI)											5
59 Cardiac Catheterization											5
											6
60 Laboratory											
61 PBP Clinical Laboratory Services-Program Only											(
62 Whole Blood & Packed Red Blood Cells											(
63 Blood Storing, Processing, & Trans.											e
64 Intravenous Therapy											6
65 Respiratory Therapy											(
66 Physical Therapy											(
67 Occupational Therapy											(
68 Speech Pathology											(
69 Electrocardiology											(
70 Electroencephalography											5
71 Medical Supplies Charged to Patients											
72 Implantable Devices Charged to Patients											1
73 Drugs Charged to Patients											
74 Renal Dialysis											1 2
75 ASC (Non-Distinct Part)											
76 Other Ancillary (specify)											
77 Allogeneic HSCT Acquisition											5
78 CAR T-Cell Immunotherapy											
OUTPATIENT SERVICE COST CENTERS											
88 Rural Health Clinic (RHC)											1
89 Federally Qualified Health Center (FQHC)											8
90 Clinic											9
91 Emergency											9
92 Observation Beds											9
93 Other Outpatient Service (specify)											9
93.99 Partial Hospitalization Program											93.9

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WO	ORKSHEET ARE	PUBLISHED IN CI	MS PUB. 15-2, SE	CTION 4021)						
40-548]	Rev. 18
12-22				FORM CM	IS-2552-10				4090	(Cont.)
ALLOCATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD:	WORKSHEET B,	
								FROM	PART II	
								то		
										T

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
OTHER REIMBURSABLE COST CENTERS						-					
94 Home Program Dialysis											94
95 Ambulance Services											95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
101 Home Health Agency											101
102 Opioid Treatment Program											102
SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition											106
107 Liver Acquisition											107
108 Lung Acquisition											108
109 Pancreas Acquisition											109
110 Intestinal Acquisition											110
111 Islet Acquisition											111
112 Other Organ Acquisition (specify)											112
115 Ambulatory Surgical Center (Distinct Part)											115
116 Hospice											113
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1 through 117)											118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen											190
191 Research											191
192 Physicians' Private Offices											192
193 Nonpaid Workers											193
194 Other Nonreimbursable (specify)											194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118 through 201)											202

4090 (Cont.)			FORM CM	IS-2552-10						12-22
ALLOCATION OF CAPITAL-RELATED COSTS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	_
GENERAL SERVICE COST CENTERS	10	15	20	21	22	23	24	25	20	
1 Capital Related Costs-Buildings and Fixtures		-								1
2 Capital Related Costs-Movable Equipment			1							2
4 Employee Benefits Department			1							4
5 Administrative and General			1							5
6 Maintenance and Repairs			1							6
7 Operation of Plant			1							7
8 Laundry and Linen Service			1							8
9 Housekeeping]							9
10 Dietary]							10
11 Cafeteria]							11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library			1							16
17 Social Service										12
18 Other General Service (specify)			1							1
19 Nonphysician Anesthetists										19
20 Nursing Program										2
21 Intern & Res. Service-Salary & Fringes (Approved)										2
22 Intern & Res. Other Program Costs (Approved)										2
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										36
40 Subprovider IPF										40
41 Subprovider IRF				-				+	+	41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility								+	+	44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISH	IED IN CMS PUB. 15-2, SECTION 4021)		
40-550			Rev. 18
12-22	FORM CMS-2552-10		4090 (Cont.)
ALLOCATION OF CAPITAL-RELATED COSTS		PROVIDER CCN: PERIOD:	WORKSHEET B,

									FROM	PART II	
COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										58
	Cardiac Catheterization										59
	Laboratory										60
	PBP Clinical Laboratory Services-Program Only										61
	Whole Blood & Packed Red Blood Cells										61
	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
77	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
	Clinic										90
91	Emergency										91
	Observation Beds										92
	Other Outpatient Service (specify)										93
	Partial Hospitalization Program										93.99

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSH	EET ARE PUBLISE	IED IN CMS PUB. 1	5-2, SECTION 4021)					
Rev. 18									40-551
4090 (Cont.)			FORM CM	/IS-2552-10					12-22
ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CCN:	PERIOD:	WORKSHEET B,	
							FROM	PART II	
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							INTERN &		\Box

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	-
OTHER REIMBURSABLE COST CENTERS	10	15	20			20		20	20	
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
102 Opioid Treatment Program										
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										113
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1 through 117)										118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118 through 201)										202

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4021) 40-552

12-22			FORM CN	4090 (Cont					
COST A	LLOCATION - STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B-1	
CO	ST CENTER DESCRIPTIONS	CAPITAL RE BLDGS. & FIXTURES (SQUARE FEET) 1	ELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 5A	ADMINIS- TRATIVE & GENERAL (ACCUM. COST) 5	MAIN- TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7	
	GENERAL SERVICE COST CENTERS				-	-			
1	Capital Related Costs-Buildings and Fixtures								1
	Capital Related Costs-Movable Equipment				1				2
	Employee Benefits Department				1				4
5	Administrative and General						-		5
6	Maintenance and Repairs								6
	Operation of Plant								7
	Laundry and Linen Service								8
	Housekeeping								9
	Dietary								10
	Cafeteria								11
	Maintenance of Personnel								12
	Nursing Administration								13
	Central Services and Supply								14
	Pharmacy								15
	Medical Records & Medical Records Library								16
	Social Service								17
18	Other General Service (specify)								18
	Nonphysician Anesthetists								19
	Nursing Program								20
21	Intern & Res. Service-Salary & Fringes (Approved)								21
	Intern & Res. Other Program Costs (Approved)								22
	Paramedical Education Program (specify)								23
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults and Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
	Other Special Care Unit (specify)		1	1					35
	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (specify)		1	1					42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION	4020)				
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4090 (Cont.)	FORM CMS-2552-10				12-22
COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:	PERIOD:	WORKSHEET B-1	

							FROM TO		
		CADITAL DI	ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BENEFITS DEPARTMENT		TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
COST	I CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	1
	ANCILLARY SERVICE COST CENTERS				-				
50	Operating Room								50
	Recovery Room								51
52	Labor Room and Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
	Cardiac Catheterization								59
	Laboratory								60
	PBP Clinical Laboratory Services-Program Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Trans.								63
	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged to Patients								70
	Implantable Devices Charged to Patients								71
	Drugs Charged to Patients								72
	Renal Dialysis								73
	ASC (Non-Distinct Part)								74
	Other Ancillary (specify)								75
	Allogeneic HSCT Acquisition								76
	CAR T-Cell Immunotherapy								77
	OUTPATIENT SERVICE COST CENTERS								/8
	Rural Health Clinic (RHC)								
									88
	Federally Qualified Health Center (FQHC)								89
	Clinic								90
	Emergency								91
	Observation Beds								92
	Other Outpatient Service (specify)								93
93.99	Partial Hospitalization Program								93.99

	CAPITAL RELATED COST	EMPLOYEE	ADMINIS-	MAIN-		
				то		
				FROM		
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
12-22	FORM CM	IS-2552-10			4090 ((Cont.)
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FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PU	BLISHED IN CMS PUB. 15-2, SECTION 4020)					

COST CENTER DESCRIPTIONS	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE) 2	BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 5A	TRATIVE & GENERAL (ACCUM. COST) 5	TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7	
OTHER REIMBURSABLE COST CENTERS	1	2	4	JA	5	0	/	
94 Home Program Dialysis								94
95 Ambulance Services								95
96 Durable Medical Equipment-Rented								96
97 Durable Medical Equipment-Sold								97
98 Other Reimbursable (specify)								98
99 Outpatient Rehabilitation Provider (specify)								99
100 Intern-Resident Service (not appvd. tchng. prgm.)								100
101 Home Health Agency								100
102 Opioid Treatment Program								101
SPECIAL PURPOSE COST CENTERS								102
105 Kidney Acquisition								105
106 Heart Acquisition								105
107 Liver Acquisition								107
108 Lung Acquisition								108
109 Pancreas Acquisition								100
110 Intestinal Acquisition								110
111 Islet Acquisition								111
112 Other Organ Acquisition (specify)								112
115 Ambulatory Surgical Center (Distinct Part)								115
116 Hospice								116
117 Other Special Purpose (specify)								117
118 SUBTOTALS (sum of lines 1 through 117)								118
NONREIMBURSABLE COST CENTERS								110
190 Gift, Flower, Coffee Shop, & Canteen								190
191 Research								191
192 Physicians' Private Offices								192
193 Nonpaid Workers								193
194 Other Nonreimbursable (specify)								194
200 Cross foot adjustments								200
201 Negative cost centers								201
202 Cost to be allocated (per Worksheet B, Part I)								202
203 Unit cost multiplier (Worksheet B, Part I)								203
204 Cost to be allocated (per Worksheet B, Part II)								204
205 Unit cost multiplier (Worksheet B, Part II)								205
206 NAHE adjustment amount to be allocated (per Wkst. B-2)								206
207 NAHE unit cost multiplier (Wkst. D, Parts III and IV)								207

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COST A	LLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B-1	
COST	CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
	GENERAL SERVICE COST CENTERS	0	5	10			10		10	10		
1	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
4	Employee Benefits Department	-										4
5	Administrative and General	-										5
6	Maintenance and Repairs	-										6
7	Operation of Plant	1										7
8	Laundry and Linen Service											8
	Housekeeping			1								9
	Dietary				1							10
	Cafeteria					1						11
12	Maintenance of Personnel						1					12
13	Nursing Administration							1				13
14	Central Services and Supply								1			14
15	Pharmacy									-		15
16	Medical Records & Medical Records Library										1	16
	Social Service											17
18	Other General Service (specify)											18
	Nonphysician Anesthetists											19
20	Nursing Program											20
21	Intern & Res. Service-Salary & Fringes (Approved)											21
22	Intern & Res. Other Program Costs (Approved)											22
	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit				1							31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											35
	Subprovider IPF											40
41	Subprovider IRF											41
42												42
43	Nursery											43
	Skilled Nursing Facility											44
45	Nursing Facility											45
	Other Long Term Care											46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARI	E PUBLISHED IN CMS PUB. 15-2, SECTION 4020)			
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12-22	FORM CMS-2552-10			4090 (Cont.)
COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:	PERIOD:	WORKSHEET B-1

									FROM		
	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
COST CENTER DESCRIPTIONS	(POUNDS OF LAUNDRY) 8	(HOURS OF SERVICE) 9	(MEALS SERVED) 10	(MEALS SERVED) 11	(NUMBER HOUSED) 12	(DIRECT NURS. HRS) 13	(COSTED REQUIS.) 14	(COSTED REQUIS.) 15	(TIME SPENT) 16	(TIME SPENT) 17	
ANCILLARY SERVICE COST CENTERS	8	9	10	11	12	13	14	15	16	17	-
50 Operating Room											50
51 Recovery Room											51
52 Labor Room and Delivery Room											52
53 Anesthesiology	_										53
54 Radiology-Diagnostic											54
54 Radiology-Diagnostic 55 Radiology-Therapeutic											55
											56
56 Radioisotope	_										56
57 Computed Tomography (CT) Scan	_										
58 Magnetic Resonance Imaging (MRI)											58
59 Cardiac Catheterization											59
60 Laboratory											60
61 PBP Clinical Laboratory Services-Program Only											61
62 Whole Blood & Packed Red Blood Cells											62
63 Blood Storing, Processing, & Trans.											63
64 Intravenous Therapy											64
65 Respiratory Therapy											65
66 Physical Therapy											66
67 Occupational Therapy											67
68 Speech Pathology											68
69 Electrocardiology											69
70 Electroencephalography											70
71 Medical Supplies Charged to Patients											71
72 Implantable Devices Charged to Patients											72
73 Drugs Charged to Patients											73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)											75
76 Other Ancillary (specify)											76
77 Allogeneic HSCT Acquisition											77
78 CAR T-Cell Immunotherapy									1	İ	78
OUTPATIENT SERVICE COST CENTERS											
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)											89
90 Clinic											90
91 Emergency											91
92 Observation Beds											92
93 Other Outpatient Service (specify)											93
93.99 Partial Hospitalization Program											93.99

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4090 (Cont.)			FOF	RM CMS-255	2-10						12-22
COST ALLOCATION - STATISTICAL BASIS								PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
									FROM		
									то		
	LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		

COST CENTER DESCRIPTIONS	& LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	TENANCE OF PERSONNEL (NUMBER HOUSED)	ADMINIS- TRATION (DIRECT NURS. HRS)	SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
OTHER REIMBURSABLE COST CENTERS	8	9	10	11	12	13	14	15	16	17	<u> </u>
94 Home Program Dialysis											94
95 Ambulance Services											95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
100 Intern Kesident Service (not appvd. tening. prgm.)											100
102 Opioid Treatment Program											101
SPECIAL PURPOSE COST CENTERS											102
105 Kidney Acquisition											105
106 Heart Acquisition											105
107 Liver Acquisition											100
108 Lung Acquisition											107
109 Pancreas Acquisition											100
110 Intestinal Acquisition											110
111 Islet Acquisition											110
112 Other Organ Acquisition (specify)											111
115 Ambulatory Surgical Center (Distinct Part)											112
116 Hospice											115
117 Other Special Purpose (specify)											110
118 SUBTOTALS (sum of lines 1 through 117)											117
NONREIMBURSABLE COST CENTERS											110
190 Gift, Flower, Coffee Shop, & Canteen											190
190 Girt, Flower, Corree Shop, & Canteen											190
191 Research 192 Physicians' Private Offices											191
192 Physicians Private Offices											192
193 Nonpaid Workers 194 Other Nonreimbursable (specify)											193
200 Cross foot adjustments											200
200 Cross foot adjustments 201 Negative cost centers											200
202 Cost to be allocated (per Worksheet B, Part I)											202
203 Unit cost multiplier (Worksheet B, Part I)											203
204 Cost to be allocated (per Worksheet B, Part II)							ļ				204
205 Unit cost multiplier (Worksheet B, Part II)											205
206 NAHE adjustment amount to be allocated (per Wkst. B-2											206
207 NAHE unit cost multiplier (Wkst. D, Parts III and IV)											207

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) 40-558

12-22			FORM C	MS-2552-10						(Cont.)
COST ALLOCATION - STATISTICAL BASIS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B-1	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING PROGRAM (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS	10	15	20		22	25	24	25	20	
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment	-									2
4 Employee Benefits Department	-									4
5 Administrative and General	-									5
6 Maintenance and Repairs	-									6
7 Operation of Plant	-									7
8 Laundry and Linen Service	1									8
9 Housekeeping	-									9
10 Dietary	1									10
11 Cafeteria	1									11
12 Maintenance of Personnel	1									12
13 Nursing Administration	1									13
14 Central Services and Supply	1									14
15 Pharmacy	1									15
16 Medical Records & Medical Records Library	7									16
17 Social Service	7									17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists			1							19
20 Nursing Program										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLIS	HED IN CMS PUB. 15-2, SECTION 4020)			
Rev. 18				40-559
4090 (Cont.)	FORM CMS-2552-10			12-22
COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:	PERIOD:	WORKSHEET B-1

								FROM TO		
		NON-		INTEDNS &	RESIDENTS	PARA-		INTERN &		
	OTHER	PHYSICIAN	NURSING	SALARY AND	PROGRAM	MEDICAL		RESIDENT		
	GENERAL	ANES-	PROGRAM	FRINGES	COSTS	EDUCATION		COST & POST		
COST CENTER DESCRIPTIONS	SERVICE	THETISTS	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED		STEPDOWN		
COST CENTER DESCRIPTIONS		(ASGND TIME)	(ASSIGNED TIME)		(ASSIGNED TIME)		CUDTOTAL	1	TOTAL	
	(SPECIFY) 18	(ASGND TIME) 19	20	TIME) 21	22	TIME) 23	SUBTOTAL 24	ADJUSTMENTS 25	TOTAL 26	_
ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	-
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
53 Alleshesiology 54 Radiology-Diagnostic										53
55 Radiology-Therapeutic										55
56 Radioisotope							-			56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
77 Allogeneic HSCT Acquisition										77
78 CAR T-Cell Immunotherapy										78
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										91
93 Other Outpatient Service (specify)										92
93.99 Partial Hospitalization Program										93.99
95.99 Parual Hospitalization Program										93.99

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORK	SHEET ARE PUBL	ISHED IN CMS PUI	3. 15-2, SECTION 40	020)					
40-560]	Rev. 18
12-22			FORM CM	AS-2552-10				4090	(Cont.)
COST ALLOCATION - STATISTICAL BASIS						PROVIDER CCN:	PERIOD:	WORKSHEET B-1	
							FROM		
							то		
		NON-		INTERNS & RESIDENTS	PARA-		INTERN &		

COST	CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING PROGRAM (ASSIGNED TIME) 20	SALARY AND FRINGES (ASSIGNED TIME) 21	PROGRAM COSTS (ASSIGNED TIME) 22	MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	10	15	20	21	22	23	24	23	20	_
	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										100
	Opioid Treatment Program										101
	SPECIAL PURPOSE COST CENTERS										102
105	Kidney Acquisition										105
	Heart Acquisition										105
	Liver Acquisition										100
	Lung Acquisition										107
	Pancreas Acquisition										100
	Intestinal Acquisition										110
	Islet Acquisition										110
	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)										202
203	Unit cost multiplier (Worksheet B, Part I)										203
	Cost to be allocated (per Worksheet B, Part II)										204
	Unit cost multiplier (Worksheet B, Part II)										205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)										206
207	NAHE unit cost multiplier (Wkst. D, Parts III and IV)										207

 $\overline{\rm FORM}$ CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020) Rev. 18

	(Cont.) FORM CMS-2552-10 STEPDOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD: FROM TO		WORKSHEET B-2	12-22
				KSHEET		-
	DESCRIPTION			LINE NO.	AMOUNT	
	1		2	3	4	-
1	Adjustment for EPO costs in Renal Dialysis cost center		1	74		1
2	2 Adjustment for EPO costs in Home Program Dialysis cost center		1	94		2
	Adjustment for ARANESP costs in Renal Dialysis cost center		1	74		3
4	Adjustment for ARANESP costs in Home Program Dialysis cost center		1	94		4
5	Adjustment for ESA costs in Renal Dialysis cost center (see instructions)		1	74		5
(Adjustment for ESA costs in Home Program Dialysis cost center (see instructions)		1	94		(
7	7					5
6						8
ę						9
10						10
11						11
12				_		12
13						13
14						14
15				_		15
16				_		16
17						17
18				-		18
19						19
20			_	-		
21				_		21
22			-	_		22
23						23
22			_	_		24
26				-		26
27				_		27
28				-		28
29			-	_		29
30						30
31						31
32						32
33						33
34						34
35	5					35
36	5					36
37	7					37
38						38
39						39
4(40
41						41
42				_		42
43				_		43
44			-			44
45						45
46				_		46
47			+	-		47
48						
45			+	-		49
51			+			E1
52			-			51 52 53
52			+	-		52
54						5/
55			-			50
56			-			54 55 56
57			+	1		57
58			+	1		58
			_			59

12-22												4090 (Cont.)	
COMPU	TATION OF RATIO OF COSTS TO CHARGES							PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET O PART I	
		Total Cost	Therapy		Costs RCE			Charges	Total	1	TEFRA	PPS	
COST (CENTER DESCRIPTIONS	(from Wkst. B, Part I,, col. 26)	Limit Adj. 2	Total Costs		Total Costs 5	Inpatient 6	Outpatient 7	(column 6 + column 7) 8	Cost or Other Ratio 9	Inpatient Ratio 10	Inpatient Ratio 11	-
	INPATIENT ROUTINE SERVICE COST CENTERS	1		5	4	5	0	,	0	5	10	11	
	Adults and Pediatrics (General Routine Care)												30
	Intensive Care Unit												31
	Coronary Care Unit												32
	Burn Intensive Care Unit												33
	Surgical Intensive Care Unit												34
	Other Special Care (specify)												35
	Subprovider IPF												40
	Subprovider IRF												41
	Subprovider (Specify)												42
	Nursery												43
	Skilled Nursing Facility												44
	Nursing Facility												45
	Other Long Term Care												46
	ANCILLARY SERVICE COST CENTERS												
	Operating Room												50
	Recovery Room												51
	Labor Room and Delivery Room												52
	Anesthesiology												53
	Radiology-Diagnostic												54
	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory												60
	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
	Blood Storing, Processing, & Trans.												63
	Intravenous Therapy												64
65	Respiratory Therapy												65
	Physical Therapy												66
67	Occupational Therapy												67
68	Speech Pathology												68

FORM CMS-2552-10 (10-2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)									
Rev. 18				40-563					
4090 (Cont.)	FORM CMS-2552-10			12-22					
COMPUTATION OF RATIO OF COSTS TO CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET C					

									FROM TO		PART I	
	- I I			Costs		1	Charges		10			<u> </u>
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I,, col. 26)	Therapy Limit Adj. 2	Total Costs 3	RCE Dis- allowance 4	Total Costs 5	Inpatient 6	Outpatient 7	Total (column 6 + column 7) 8	Cost or Other Ratio 9	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio 11	
69 Electrocardiology			-					, , , , , , , , , , , , , , , , , , ,	-			69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients												71
72 Implantable Devices Charged to Patients												72
73 Drugs Charged to Patients	-											73
74 Renal Dialysis	-											73
75 ASC (Non-Distinct Part)												74
76 Other Ancillary (specify)				-								75
77 Allogeneic HSCT Acquisition				_							+	70
78 CAR T-Cell Immunotherapy												77
OUTPATIENT SERVICE COST CENTERS												/0
88 Rural Health Clinic (RHC)	-										+	88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency												90
92 Observation Beds (see instructions)												91
93 Other Outpatient Service (specify)	_											92
93.99 Partial Hospitalization Program				_								93.99
OTHER REIMBURSABLE COST CENTERS											_	93.99
94 Home Program Dialysis												04
95 Ambulance Services				_								94
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold											_	97
98 Other Reimbursable (specify)											-	98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency												101
102 Opioid Treatment Program												102
SPECIAL PURPOSE COST CENTERS												105
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition	_											107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition	_											110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112
115 Ambulatory Surgical Center (Distinct Part)												115
116 Hospice												116
117 Other Special Purpose (specify)												117
200 Subtotal (see instructions)											_	200
201 Less Observation Beds												201
202 Total (see instructions)												202

40-564

12-22	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF OUTPATIENT SERVICE COST TO		PROVIDER CCN:	PERIOD:	WORKSHEET C,
CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY			FROM	PART II
			то	

Check applicable box: [] Title V

[] Title XIX

	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26) 1	Capital Cost (Wkst B, Part II, col. 26) 2	Operating Cost Net of Capital Cost (col. 1 - col. 2) 3	Capital Reduction 4	Operating Cost Reduction Amount 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8) 7	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7) 8	
-	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
	PBP Clinical Laboratory Services-Prgm. Only									61
	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
	Speech Pathology									68
69	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
77	Allogeneic HSCT Acquisition									77
78	CAR T-Cell Immunotherapy									78

Rev. 18					40-56
4090 (Cont.)	FORM CMS-2552-10				12-2
CALCULATION OF OUTPATIENT SERVICE COST TO		PROVIDER CCN:	PERIOD:	WORKSHEET C.	

CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAII	ONLY (
--	--------

Check applicable box:

[] Title V [] Title XIX

			Capital Cost	Operating Cost			Cost Net of	Total		T
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	(Wkst B, Part II, col. 26)	Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Capital and Operating Cost Reduction	Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
		1	2	3	4	5	6	7	8	1
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds (see instructions)									92
	Other Outpatient Service (specify)									93
	Partial Hospitalization Program									93.99
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Opioid Treatment Program									102
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)									117
200	Subtotal (sum of lines 50 through 199)									200
201	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

07-23					FORM CM	1S- 2552-10				4090 (Cont.)		
		ENT OF INPATIENT ROUT	INE			PROVIDER CC	IN:	PERIOD:		WORKSHEET I),	
SERVIC	E CAPI	TAL COSTS						FROM		PART I		
								то				
Check		[] Title V	[] Hospital		[] PPS							
applicabl	e	[] Title XVIII, Part A	[] PARHM De	monstration	[] TEFRA							
boxes:		[] Title XIX										
						Reduced				Inpatient		
						Capital				Program		
				Capital		Related		Per		Capital		
				Related Cost	Swing	Cost	Total	Diem	Inpatient	Cost		
				(from Wkst. B,	Bed	(col. 1 minus	Patient	(col. 3 ÷	Program	(col. 5		
				Part II, col. 26)	Adjustment	col. 2)	Days	col. 4)	Days	x col. 6)		
(A)		ost Center Description		1	2	3	4	5	6	7		
		TENT ROUTINE SERVICE	COST CENTERS									
		& Pediatrics										
30	(Gene	ral Routine Care)									30	
31	Intens	ive Care Unit									31	
32	Coron	ary Care Unit									32	
33	Burn I	ntensive Care Unit									33	
34	Surgic	al Intensive Care Unit									34	
35	Other	Special Care Unit (specify)									35	
40	Subpro	vider IPF									40	
		_										
41	Subpro	vider IRF									41	
42	Subpro	ovider (Other)									42	
43	Nurser	ry									43	
44	Skilled	l Nursing Facility								+	44	
45	ът .	. T. 111									4-	
45	INUTSIT	ng Facility								+	45	
200	Tetel	();									200	
200	1 otal ((lines 30 through 199)									200	

(A) Worksheet A line numbers

4090 ((Cont.)	FC	ORM CMS-2552	-10			07-23
APPORT	FIONMENT OF INPATIENT ANCILLARY			PROVIDER CCN:	PERIOD:	WORKSHEET D	
SERVIC	E CAPITAL COSTS				FROM	PART II	
				COMPONENT CCN:	то	-	
Check	[] Title V [] Hospital	l [] Subprovider ((Other)	[] PPS			
applicabl		[] PARHM Den	. ,	[] TEFRA			
boxes:	[] Title XIX [] IRF						
		Capital					T
		Related Cost	Total Charges	Ratio of Cost	Inpatient		
		(from Wkst. B	(from Wkst. C,	to Charges	Program	Capital Costs	
		Part II, col. 26)	Pt .I, col. 8)	(col .1 ÷ col. 2)	Charges	(col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	1 0						50
51							51
52							52
53							53
54							54
55							55
56							56
57				_			57
58							58
59							60
60							60
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing						63
<u>64</u> 65	Intravenous Therapy Respiratory Therapy						64
66							66
67	Occupational Therapy						67
68							68
69	1 00						69
70							70
70	Medical Supplies Charged to Patients						70
72							72
73							73
74							74
75	5						75
76							76
77	Allogeneic HSCT Acquisition						77
78							78
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92							92
93	1 (1)/						93
93.99							93.99
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95							95
96							96
97	Durable Medical Equipment-Sold						97
98							98
200	Total (sum of lines 50 through 199)	1	1			1	200

(A) Worksheet A line numbers

07-23					FORM CM	IS-2552-10						4090 ((Cont.)
	TIONMENT OF INPATIENT ROUTINE E OTHER PASS-THROUGH COSTS							PROVIDER CCN	1:	PERIOD FROM		WORKSHEET D PART III	, ,
										то			
Check applicab	[] Title V le [] Title XVIII, Part A	[] Hospital [] PARHM Der	nonstration		[] PPS [] TEFRA								
boxes:	[] Title XIX				[] Other								
		Nursing		Allied		All	Swing-Bed	T . 1.C		D		Inpatient	
		Program Post-		Health Post-		Other Medical	Adjustment Amount	Total Costs (sum of cols.	Total	Per Diem	Inpatient	Program Pass-Through	
		Stepdown	Nursing	Stepdown	Allied Health	Education	(see	1, 2, and 3,	Patient	(col. 5 ÷	Program	Cost	
		Adjustments	Program	Adjustments	Cost	Cost	instructions)	minus col. 4)	Days	col. 6)	Days	(col. 7 x col. 8)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTER: Adults & Pediatrics												
30	(General Routine Care)												30
31	Intensive Care Unit												31
32	Coronary Care Unit							-				_	32
33	Burn Intensive Care Unit							_					33
34	Surgical Intensive Care Unit												34
35	Other Special Care Unit (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
	Subprovider (Other)												42
	Subprovider (Guier)												
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
200	Total (sum of lines 30 through 199)												200

(A) Worksheet A line numbers

4090 (Cont.)			F	ORM CMS-2552-	-10					07-23
	TIONMENT OF INPATIENT/OUTP. E OTHER PASS-THROUGH COST							PROVIDER CCN:	PERIOD: FROM	WORKSHEET D,	
SERVIC	E OTHER PASS-THROUGH COST	5						COMPONENT CCN:	ТО	PART IV	
Check applicab boxes:	[] Title V [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed SI	NF	[] PARHM Demon [] PARHM CAH S		[] PPS [] TEFRA [] Other				
			Non Physician Anesthetist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CE	NTERS									
	Operating Room										50
51	Recovery Room										51
	Labor room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
	Radioisotope										56
57	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization	,									59
	Laboratory										60
	PBP Clinical Laboratory ServPrgm	n Only									61
	Whole Blood & Packed Red Blood										62
	Blood Storing, Processing, & Transf										63
	Intravenous Therapy	using									64
											65
	Physical Therapy										66
	Occupational Therapy										67
67	Speech Pathology										67
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged To Patier Implantable Devices Charged to Pat										71
		lents									
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	Allogeneic HSCT Acquisition										77
	CAR T-Cell Immunotherapy										78
	OUTPATIENT SERVICE COST CE	ENTERS									
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (I	FQHC)									89
	Clinic										90
	Emergency										91
92	Observation Beds										92
	Other Outpatient Service (specify)										93
93.99	Partia Hospitalization Program										93.99

FORM CMS-2552-10 (07-2023) (INSTRUCTIONS FOR THIS WORKSHI				
	LET ARE PUBLISHED IN GWS PUB. 15-2, SECTION 4024.4)			
40-570				Rev. 21
07-23	FORM CMS-2552-10			4090 (Cont.)
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY		PROVIDER CCN:	PERIOD:	WORKSHEET D,

SERVIC	E OTHER PASS THROUGH COSTS							COMPONENT CCN:	FROM TO	PART IV (Cont.)	
Check applicabl boxes:	[] Title V e [] Title XVIII, Part A [] Title XIX	[] Hospital [] IPF [] IRF [] Subprovider (Other)	[] SNF [] NF [] ICF/IID [] Swing-Bed S	NF	[] PARHM Demon [] PARHM CAH S		[] PPS [] TEFRA [] Other	I		1	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total cost (sum of cols. 1, 2 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
(A)	Cost Center Description		1	2A	2	3A	3	4	5	6	
	OTHER REIMBURSABLE COST CH	ENTERS									
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
200	Total (sum of lines 50 through 199)										200

(A) Worksheet A line numbers

FORM CMS-2552-10 (07-2023) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SE	ECTION 4024.4)			
Rev. 21				40-570.1
4090 (Cont.)	FORM CMS-2552-10			07-23
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY		PROVIDER CCN:	PERIOD:	WORKSHEET D,
SERVICE OTHER PASS THROUGH COSTS			FROM	PART IV (Cont.)
		COMPONENT CCN:	то	

Check [] Title V [] Hospital [] SNF applicable [] Title XVIII, Part A [] IPF [] NF boxes: [] Title XIX [] IRF [] ICF/IID [] Subprovider (Other) [] Swing-B	ed SNF	[] PARHM Demon [] PARHM CAH S		[] PPS [] TEFRA [] Other				
	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A) Cost Center Description	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS								
50 Operating Room								50
51 Recovery Room								51
52 Delivery Room and Labor Room								52
53 Anesthesiology								53
54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT) Scan 58 Magnetic Resonance Imaging (MRI)								57
59 Cardiac Catheterization								58
60 Laboratory								59 60
61 PBP Clinical Laboratory ServPrgm. Only								60
62 Whole Blood & Packed Red Blood Cells								61
63 Blood Storing, Processing, & Transfusing								63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged To Patients								71
72 Implantable Devices Charged to Patients								72
73 Drugs Charged to Patients								73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76
77 Allogeneic HSCT Acquisition								77
78 CAR T-Cell Acquisition								78
OUTPATIENT SERVICE COST CENTERS								
88 Rural Health Clinic (RHC)								88
89 Federally Qualified Health Center (FQHC)								89
90 Clinic								90
91 Emergency		1						91
92 Observation Beds								92
93 Other Outpatient Service (specify)								93
93.99 Partia Hospitalization Program								93.99

FORM CMS-25	552-10 (07-2023) (INSTRUCTI	IONS FOR THIS WORKS	HEET ARE PUBLISHED IN CMS PUE	B. 15-2, SECTION 4024.4)				
40-570.2								Rev. 21
07-23				FORM CMS-2552-10				4090 (Cont.)
APPORTION	IENT OF INPATIENT/OUTPA	ATIENT ANCILLARY				PROVIDER CCN:	PERIOD:	WORKSHEET D,
SERVICE OTI	HER PASS THROUGH COSTS	5					FROM	PART IV (Cont.)
						COMPONENT CCN:	ТО	
Check	[] Title V	[] Hospital	[] SNF	[] PARHM Demonstration	[] PPS			
applicable	[] Title XVIII, Part A	[] IPF	[] NF	[] PARHM CAH Swing Bed-SNF	[] TEFRA			
boxes:	[] Title XIX	[] IRF	[] ICF/IID		[] Other			

[] Subprovider (Other) [] Swing-Bed St	NF							
					Inpatient		Outpatient	
			Outpatient		Program		Program	
	Total	Ratio	Ratio		Pass-		Pass-	
	Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
	(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
	Part I, col. 8)	(col. 5 ÷ col. 7)	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A) Cost Center Description	7	8	9	10	11	12	13	
OTHER REIMBURSABLE COST CENTERS								
94 Home Program Dialysis								94
95 Ambulance Services								95
96 Durable Medical Equipment-Rented								96
97 Durable Medical Equipment-Sold								97
98 Other Reimbursable (specify)								98
200 Total (sum of lines 50 through 199)								200

(A) Worksheet A line numbers

FORM CMS-2552-10 (07-2023) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4) Rev. 21

APPORTIONM HEALTH SERV Check applicable boxes:	IENT OF MEDICAL AND OTI VICES COSTS	HER				PROVIDER CCN:	IPER	IOD:	WORKSHEET D	
Check applicable	VICES COSTS								PART V	,
applicable						COMPONENT CC		OM	PARIV	
applicable						COMPONENT CO.				
	[] Title V - O/P	[] Hospital		[] Subprovide	(Other)	[] Swing-Bed SN	F []	PARHM Demonstration	on	
boxes:	[] Title XVIII, Part B	[] IPF		[] SNF		[] Swing-Bed NF	[]	PARHM CAH Swing-	Bed SNF	
	[] Title XIX - O/P	[] IRF		[] NF		[] ICF/IID				
PART V - APP	ORTIONMENT OF MEDICAL	AND OTHER	HEALIH SERVI		Program Charges			Program Cost		—
			Cost		Cost	Cost		Cost	Cost	1
			to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
			Charge	PPS	Services	Services Not	PPS	Services	Services Not	
			Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
			Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
			Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	<u> </u>
(A)	Cost Center Description	TEDC	1	2	3	4	5	6	7	<u> </u>
	LLARY SERVICE COST CEN tting Room	1ERS								50
50 Opera						+			1	50
	& Delivery Room					+ +				52
53 Anest									1	53
	logy-Diagnostic									54
	logy-Therapeutic									55
56 Radio										56
	uted Tomography (CT) Scan					\downarrow			1	57
	etic Resonance Imaging (MRI)									58
	ac Catheterization									59
60 Labor 61 PBP 0	atory Clinical Laboratory ServPrgm.	Only								61
	e Blood & Packed Red Blood C									62
	Storing, Processing, & Transfu									63
	enous Therapy	0								64
65 Respir	ratory Therapy									65
	cal Therapy									66
	pational Therapy									67
	h Pathology									68
	ocardiology oencephalography									69
	cal Supplies Charged To Patient	s								71
	ntable Devices Charged to Patie									72
	Charged to Patients									73
74 Renal	Dialysis									74
	(Non-Distinct Part)									75
	Ancillary (specify)									76
	eneic HSCT Acquisition T-Cell Immunotherapy									77
	ATIENT SERVICE COST CEN	ITERS								78
	Health Clinic (RHC)	.1200								88
	ally Qualified Health Center (FO	QHC)								89
90 Clinic										90
91 Emerg										91
	vation Bed					ļ				92
93 Other	Outpatient Service (specify)									93
	l Hospitalization Program R REIMBURSABLE COST CE	INTERS								93.99
	Program Dialysis	LITIENJ								94
95 Ambu										95
	ble Medical Equipment-Rented									96
	le Medical Equipment-Sold								1	97
98 Other	Reimbursable Cost Center									98
	tal (see instructions)									200
	PBP Clinic Lab. Services-Progra	im							1	201
	Charges harges (line 200 - line 201)					₽				202

1	2.	.2	Δ

12-24		101	WI GIWIJ-2002-10			-050 (C0
COMPUTATI	ON OF INPATIENT			PROVIDER CCN:	PERIOD:	WORKSHEET D-1,
OPERATING	COST				FROM	PART I
				COMPONENT CCN:	то	
Check	[] Title V - I/P	[] Hospital [] NF			[] PPS	
applicable	[] Title XVIII, Part A	[] IPF [] ICF/II	D		[] TEFRA	
boxes:	[] Title XIX - I/P		IM Demonstration		[] Other	
DOXES.		[] Subprovider (other)	IW Demonstration		[] Ouler	
		[] SNF				
	L PROVIDER COMPONENTS					
	TIENT DAYS					
		days and swing-bed days, excluding newborn)				
		days, excluding swing-bed and newborn days)				
		d and observation bed days). If you have only p	rivate room days, do not comp	olete this line.		
		ing-bed and observation bed days)				
		ys (including private room days) through Decem				
	0 01 1	ys (including private room days) after December	31 of the cost reporting perio	od (if		
	dar year, enter 0 on this line)					
		s (including private room days) through Decemb				
	0 01 1 0	s (including private room days) after December	31 of the cost reporting period	l (if		
	ndar year, enter 0 on this line)					
		oom days applicable to the Program (excluding				
10 Swin	g-bed SNF type inpatient days ap	plicable to title XVIII only (including private roo	om days) through December 3	1 of the		
cost	reporting period (see instructions					
11 Swin	g-bed SNF type inpatient days ap	plicable to title XVIII only (including private roo	om days) after December 31 o	of the		
cost	reporting period (if calendar year	enter 0 on this line)				
12 Swin	g-bed NF type inpatient days app	icable to titles V or XIX only (including private	room days) through Decembe	er 31 of		
the c	cost reporting period.					
13 Swin	g-bed NF type inpatient days app	icable to titles V or XIX only (including private	room days) after December 3	1 of the		
cost 1	reporting period (if calendar year,	enter 0 on this line)				
14 Medi	ically necessary private room days	applicable to the Program (excluding swing-bee	1 days)			
15 Total	I nursery days (title V or XIX only)				
16 Nurs	ery days (title V or XIX only)					
SWIN	NG BED ADJUSTMENT					
17 Medi	icare rate for swing-bed SNF serv	ces applicable to services through December 31	of the cost reporting period			
		ces applicable to services after December 31 of				
19 Medi	icaid rate for swing-bed NF servic	es applicable to services through December 31 c	of the cost reporting period			
		es applicable to services after December 31 of th				
	general inpatient routine service	**	1 01			
		services through December 31 of the cost repo	rting period (line 5 x line 17)			
		services after December 31 of the cost reportin				
	5 II II	ervices through December 31 of the cost report	<u>, , , , , , , , , , , , , , , , , , , </u>			
		services after December 31 of the cost reporting				
	swing-bed cost (see instructions)					
		et of swing-bed cost (line 21 minus line 26)				
	ATE ROOM DIFFERENTIAL A					1
		es (excluding swing-bed and observation bed ch	arges)			
	ite room charges (excluding swing		. 0/			
	-private room charges (excluding					
	eral inpatient routine service cost/					
	age private room per diem charge					
	age semi-private room per diem c					
		differential (line 32 minus line 33) (see instruct	ions)			
	age per diem private room cost di					
	te room cost differential adjustme					
		et of swing-bed cost and private room cost diffe	rential (line 27 minus line 26)			
J/ Gelle	an inpatient routile service COSt I	ice of swing-bed cost and private room cost diffe	rendar (nne 27 minus nne 50)			

COMPUTAT	nt.) TION OF INPATIENT	FORM CM	0 2002 10	PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	12-2
OPERATING	G COST				FROM	PART II	
				COMPONENT CCN:	то	_	
Check	[] Title V - I/P [] Hospital	[] PARH	M Demonstration	[] PPS			
pplicable	[] Title XVIII, Part A [] IPF	() mu	Demonstration	[] TEFI	RA		
oxes:	[] Title XIX - I/P [] IRF			[] Othe			
	[] Subprovider (other)					
	OSPITAL AND SUBPROVIDERS ONLY						
	OGRAM INPATIENT OPERATING COST BEFORE SS-THROUGH COST ADJUSTMENTS					1	
	justed general inpatient routine service cost per diem (see instructio	nc)				1	
	gram general inpatient routine service cost per diem (see instruction) gram general inpatient routine service cost (line 9 x line 38)	115)					
	dically necessary private room cost applicable to the Program (line	14 x line 35)					
	al Program general inpatient routine service cost (line 39 + line 40)						
				Average			
		Total	Total	Per Diem	Program	Program Cost	
		Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2)	Days	(col. 3 x col. 4)	4
40.137	(A) VIV	1	2	3	4	5	
	rsery (title V & XIX only)						-
	nsive Care Type Inpatient pital Units						
	ensive Care Unit						
	ronary Care Unit					1	
	m Intensive Care Unit						
	gical Intensive Care Unit						
47 Oth	er Special Care Unit (specify)						
						1	
48 Prog	gram inpatient ancillary service cost (Worksheet D-3, column 3, lir	200)					
							_
48.01 Prog	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa	rt III, line 10, column 1)					48.
48.01 Prog		rt III, line 10, column 1)					48.
48.01 Pros 49 Tota	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pe al Program inpatient costs (sum of lines 41 through 48.01) (see ins	rt III, line 10, column 1)					48.
48.01 Prog 49 Tota PAS	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS	rt III, line 10, column 1) tructions)	etc Land III)				48.
48.01 Prog 49 Tota PAS 50 Pass	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro	nt III, line 10, column 1) tructions) om Worksheet D, sum of Pa					48.
48.01 Prog 49 Tota PAS 50 Pass 51 Pass	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fr s through costs applicable to Program inpatient ancillary services (f	nt III, line 10, column 1) tructions) om Worksheet D, sum of Pa					48.
48.01 Prog 49 Tota PAS 50 Pass 51 Pass 52 Tota	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro s through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51)	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prog 49 Tota PAS 50 Pass 51 Pass 52 Tota	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fr s through costs applicable to Program inpatient ancillary services (f	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prog 49 Tota PAS 50 Pass 51 Pass 52 Tota 53 Tota	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro s through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51)	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prog 49 Tota PAS 50 50 Pass 51 Pass 52 Tota 53 Tota	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro s through costs applicable to Program inpatient ancillary services (f a l Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prop 49 Tota PAS 50 Pass 51 Pass 52 Tota 53 Tota TAR 54 Prop 55 Targ	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS is through costs applicable to Program inpatient routine services (fr is through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharges get amount per discharge	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Proj 49 Tota 700 Pass 50 Pass 51 Pass 52 Tota 53 Tota 53 Tota 55 Targ 55.01 Pern	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro s through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharges get amount per discharge manent adjustment amount per discharge	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prog 49 Tota 9AS 50 Pass 51 Pass 52 Tota 53 Tota 53 Tota 55 Targ 55.01 Perr 55.02 Adj	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fro s through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharges get amount per discharge manent adjustment amount per discharge justment amount per discharge (contractor use only)	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prog 49 Tota 9 PAS 50 Pass 51 Pass 52 Tota 53 Tota 53 Tota 55 Prog 55.01 Perr 55.02 Adj 55.03 CAI	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS s through costs applicable to Program inpatient routine services (fr s through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharge get amount per discharge manent adjustment amount per discharge justment amount per discharge (contractor use only) R T-cell amount paid as an interim payment	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I nysician anesthetist, and me	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prop 49 Tota 704 Tota 50 Pass 51 Pass 52 Tota 53 Tota 54 Prop 55.01 Perr 55.01 Perr 55.03 CAI 55.03 CAI 55.03 CAI	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS is through costs applicable to Program inpatient routine services (fr is through costs applicable to Program inpatient ancillary services (fa al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharges get amount per discharge manent adjustment amount per discharge justment amount pei discharge (contractor use only) R T-cell amount paid as an interim payment get amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line i	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I nysician anesthetist, and me	Parts II and IV)	ine 49 minus line 52)			48.
48.01 Prop 49 Tota 701 Tota 50 Pass 51 Pass 52 Tota 53 Tota 54 Prop 55.01 Perr 55.02 Adj 55.03 CAI 55.03 Tota 55 Targ 55.03 CAI 56 Targ 57 Diff	gram inpatient cellular therapy acquisition cost (Worksheet D-6, Pa al Program inpatient costs (sum of lines 41 through 48.01) (see ins SS-THROUGH COST ADJUSTMENTS is through costs applicable to Program inpatient routine services (fr is through costs applicable to Program inpatient ancillary services (f al Program excludable cost (sum of lines 50 and 51) al Program inpatient operating cost excluding capital related, nonpl RGET AMOUNT AND LIMIT COMPUTATION gram discharges get amount per discharge manent adjustment amount per discharge justment amount per discharge (contractor use only) R T-cell amount paid as an interim payment get amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line l ference between adjusted inpatient operating cost and target amount	rt III, line 10, column 1) tructions) om Worksheet D, sum of Pa rom Worksheet D, sum of I nysician anesthetist, and me	Parts II and IV)	ine 49 minus line 52)			48.
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01-22		FORM CMS-25	52-10		4090	(Cont.)
	JTATION OF INPATIENT TING COST		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-1, PARTS III & IV	
Check applical boxes:	[] Title XIX - I/P [] IRF [] Subprovi		F	[] PPS [] TEFRA [] Other		
PART I	II - SNF, NF, AND ICF/IID ONLY					
70	SNF / NF / ICF/IID routine service cost (line 37)					70
71	Adjusted general inpatient routine service cost per diem (line 70	÷ line 2)				71
72	Program routine service cost (line 9 x line 71)					72
73	Medically necessary private room cost applicable to Program (li	ne 14 x line 35)				73
74	Total Program general inpatient routine service costs (line 72 + 1	line 73)				74
75	Capital-related cost allocated to inpatient routine service costs (f	from Worksheet B, Part II, c	olumn 26, line 45)			75
76	Per diem capital-related costs (line 75 ÷ line 2)					76
	Program capital-related costs (line 9 x line 76)					77
						78
79		ler records)				79
		,	70)			
80		initation (inite 76 initids inite	79)			80
81						81
82	Inpatient routine service cost limitation (line 9 x line 81)					82
83	Reasonable inpatient routine service costs (see instructions)					83
84	Program inpatient ancillary services (see instructions)					84
85	Utilization review - physician compensation (see instructions)					85
86	Total Program inpatient operating costs (sum of lines 83 through	n 85)				86
PART I	V - COMPUTATION OF OBSERVATION BED PASS-THROUG	GH COST			-	
87	Total observation bed days (see instructions)					87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2	2)				88
89	Observation bed cost (line 87 x line 88) (see instructions)					89
	COMPUTATION OF OBSERVATION BED PASS THROUGH	I COST			•	
		Routine Cost (from line 21) 2	column 1 ÷ column 2 3	Total Observation Bed Cost (from line 89) 4	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions) 5	
	Capital-related cost					90
	Nursing Program cost					90
	Allied Health cost					91

93 All other Medical Education

93

4090 (Cont.)					
APPORTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,		
SERVICES RENDERED BY		FROM	PARTS I-III		
INTERNS AND RESIDENTS		- TO			

	- NOT IN APPROVED TEACHING PROGRAM	Percent of	Expense	Total Inpatient Days	
	Cost Centers	Assigned Time	Allocation	All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			
	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care)				
3					
4					
5					
6					
7					
8					
	IPF - Inpatient routine service				
	IRF - Inpatient routine service				
11					
	Skilled Nursing Facility				
	Nursing Facility				
15					
16					
17					
18					
19					
20	1				
	Hospital Outpatient Services:			Total Charges (from Wkst. C, Pt. I, col. 8, lines 88 through 93)	
21				unougn 93)	
21					
23					
24					
25					
26					
27					
28	Total (sum of lines 20 and 27)	100.00			
ARTI					
	I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT				
	I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT				
	I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT	ROUTINE COSTS ONLY)			
	I - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT	ROUTINE COSTS ONLY) Expenses Allocated	Swing Bed	Net Cost	
	· · · · · · · · · · · · · · · · · · ·	ROUTINE COSTS ONLY) Expenses Allocated to cost centers	Amount	(col. 1 plus col. 2)	
	Hospital Inpatient Routine Services:	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I			
29	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38 39	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38 39 40	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38 39 40 41	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38 39 40 41 42	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount	(col. 1 plus col. 2)	
29 30 31 32 33 34 35 36 37 38 39 40 41 42	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2	(col. 1 plus col. 2) 3	
29 30 31 32 33 34 35 36 37 38 39 40 41	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2	(col. 1 plus col. 2) 3 4 3 4 4 4 Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I)	d Teaching Program	
29 30 31 33 33 34 35 36 37 38 39 40 41 42 ART I	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 2 Not In Approve (from Part I) 1	(col. 1 plus col. 2) 3 4 3 4 4 4 Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 42 ART I 42 43	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital Inpatient	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9	d Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 42 ART I 43 44	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital Inpatient Outpatient	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 2 Not In Approve (from Part I) 1	d Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 42 ART I 44 43 44	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other) - Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44)	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27	d Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 41 42 4ART I 42 4ART I	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27 col. 9, line 10	d Teaching Program	
29 30 31 32 33 34 35 36 37 38 39 40 41 41 42 4ART I 42 43 44 45 5 46	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care) Swing Bed - SNF Swing Bed - NF Intensive care unit Coronary care unit Burn Intensive Care Unit Other Special Care (specify) Subtotal (sum of lines 29, and 32 through 36) IPF - Inpatient routine service IRF - Inpatient routine service Subprovider (Other)- Inpatient routine service Skilled Nursing Facility Total (sum of lines 37 through 41) II - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I Hospital Inpatient Outpatient Total Hospital (sum of lines 43 and 44) IPF - Inpatient routine service IRF - Inpatient routine service	ROUTINE COSTS ONLY) Expenses Allocated to cost centers on Wkst. B, Pt. I cols. 21 and 22	Amount 2 Not In Approve (from Part I) 1 col. 9, line 9 col. 9, line 27	d Teaching Program	

40-576

07-23 FORM CMS-2552-10			4090 (Cont.)		
APPORTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,		
SERVICES RENDERED BY		FROM	PARTS I-III (Cont.)		
INTERNS AND RESIDENTS		ТО			

PART I		TEACHING PROGRAM						
	Average Cost		h Care Program Inpatien		Title V	Title XVIII	Title XIX	
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)	4
1	4	5	6	7	8	9	10	<u> </u>
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
								11
12								12
13								13 14
14								14
16								15
10								10
18								18
19								19
20								20
		Title	es V and XIX Outpatient	and	Title	es V and XIX Outpatient	and	
	Ratio of Cost	1	Title XVIII Part B Charge	25		Title XVIII Part B Cost		
	to Charges	Title	Title XVIII	Title	Title	Title XVIII	Title	1
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX	
21								21
22								22
23								23
24								24
25								25
26								26
27								27 28
	- IN AN APPROVED T	FACHING PROGRAM	I (TITLE XVIII, PART B	INPATIENT ROUTIN	F COSTS ONLY)			20
				Expenses				<u> </u>
	Total	Average Cost	Title XVIII	Applicable				
	Inpatient Days -	Per Day	Part B	to Title XVIII				
	All Patients	(col. 3 ÷ col. 4)	Inpatient Days	(col. 5 x col. 6)				
	4	5	6	7				1
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36 37
37								3/
39								39
40								40
41								41
42								42
		TLE XVIII (TO BE CON	MPLETED ONLY IF BC	TH PARTS I AND II A	RE USED)			•
		eaching Program	Total Title	XVIII Costs				
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				1
	3	4	5	6				
43	line 37							43
44								44
45			line 22					45
46	line 38		line 22					46
47	line 39		line 22					47
48	line 40		line 22					48
49	line 41	1	line 22	1				49

	t.) NCILLARY SERVICE				PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST APPOR	TIONMENT					FROM		
					COMPONENT CCN:	то		
Check	[] Title V	[] Hospital	[] SNF	[] ICF/IID		[] PPS		
applicable boxes:	[] Title XVIII, Part A [] Title XIX	[] IPF [] IRF	[] NF [] Swing-Bed SNF	[]PARHM Den	nonstration H Swing-Bed SNF	[] TEFRA [] Other		
DUXES.		[] Subprovider (Other)	[] Swing-Bed NF		II Swilig-Ded Sivi			
					1			_
COST	CENTER DESCRIPTION	I			Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Cost (col. 1 x col. 2)	ίS
(A)	CENTER DESCRIPTION				1	2	3	-
	TIENT ROUTINE SERVIC							
	ts and Pediatrics (General Ro sive Care Unit	outine Care)						30
	nary Care Unit							32
	Intensive Care Unit							33
	cal Intensive Care Unit							34
	r Special Care (specify) rovider IPF							35
	rovider IRF							40
42 Subp	rovider (Specify)							42
43 Nurse		TENTEDC						43
	LLARY SERVICE COST C ating Room	JEINTEKS						50
	very Room				1		1	51
52 Labo	r Room and Delivery Room							52
53 Anes								53
	ology-Diagnostic ology-Therapeutic							54
	bisotope							56
	puted Tomography (CT) Sca							57
	netic Resonance Imaging (M	RI)						58
59 Cardi 60 Labo	ac Catheterization							59
	Clinical Laboratory Services	-Prgm. Only						61
	e Blood & Packed Red Bloo							62
	d Storing, Processing, & Tra	ns.						63
	venous Therapy iratory Therapy							64
	ical Therapy							66
67 Occu	pational Therapy							67
	ch Pathology							68
	rocardiology roencephalography							69 70
	cal Supplies Charged to Pati	ents						71
72 Impla	ntable Devices Charged to I							72
	s Charged to Patients							73
	l Dialysis (Non-Distinct Part)							74
	Ancillary (specify)				1		1	76
77 Allog	geneic HSCT Acquisition							77
	T-Cell Immunotherapy	CENTERC						78
	PATIENT SERVICE COST	CENTERS			1			88
	ally Qualified Health Center	r (FQHC)					1	89
90 Clinio	с С							90
91 Emer		-)						91
	rvation Beds (see instruction r Outpatient Service (specify							92 93
	Hospitalization Program)					1	93.99
OTHE	ER REIMBURSABLE COST	Γ CENTERS						
	e Program Dialysis							94
	ulance Services ble Medical Equipment-Rent	ted						95
	ble Medical Equipment-Sold							97
98 Other	Reimbursable (specify)							98
	(sum of lines 50 through 94							200
201 Less	PBP Clinic Laboratory Servi	ices-Program only charges (line	961)			1		201

(A) Worksheet A line numbers

04-20					FORM CMS-25	52-10)		4090	(Cont.)
		OF ORGAN ACQUISIT ANT HOSPITAL WITH					PROVIDER CCN:	PERIOD: FROM	WORKSHEET D-4, PART I	<u> </u>
	LANT PR						OPO CCN:	то		
Check		[] HEART	[]LIVER	[] PANCRI] ISLET				
applicable	e box:	[] KIDNEY	[]LUNG	[] INTEST	INE					
PARTI-	COMPUT	TATION OF ORGAN A	COUISITION COST	S (INPATIENT F	OUTINE AND ANCI	LARY	SERVICES)			
	000000				Inpatient		oElt(TGE0)	Organ		
Compu	itation of I	npatient			Routine Organ		Per Diem Costs	Acquisition	Cost	
	e Service (Charges		(from Wkst. D-1, Part II)		(col. 2 x col. 3)	
Applica	able to Or	gan Acquisition			1	D	2	3	4	1
1	Adults an	d Pediatrics				38				1
2	Intensive	Care				43				2
	Coronary					44				3
		nsive Care Unit				45				4
		ntensive Care Unit				46				5
		cial Care (specify)				47				6
7	TOTAL (sum of lines 1 through (6)							7
								-		
							Ratio of Cost	Organ	Organ	
C							to Charges	Acquisition	Acquisition	
	tation of A						(from	Ancillary	Ancillary	
	Costs Ap						Wkst. C)	Charges 2	Costs	-
	n Acquisit Operating					C 50	1	2	3	8
	Recovery					51				9
		om & Delivery Room				51				10
	Anesthesi					53				10
		-Diagnostic				54				11
		-Therapeutic				55				12
	Radioisote					56				13
		Tomography (CT) Sca	n			57				15
		Resonance Imaging (M				58				15
		atheterization	iiii)			59				17
	Laborator					60				18
		cal Laboratory Services	s-Program Only			61				10
		ood & Packed Red Bloo				62				20
		rage, Processing, & Tra				63				21
	IV Therap		0			64				22
		ry Therapy				65				23
	Physical 7					66				24
		onal Therapy				67				25
26	Speech Pa	athology				68				26
	Electroca					69				27
		cephalography				70				28
		Supplies Charged to Pati				71				29
		e Devices Charged to	Patients			72				30
		arged to Patients				73				31
	Renal Dia					74				32
		-distinct part)				75				33
		cillary (specify)				76				34
		lth Clinic (RHC)				88				35
		Qualified Health Cente	r (FQHC)			89				36
	Clinic					90				37
	Emergenc					91				38
	Observati					92				39
		patient Service (specify				93				40
41	TOTAL (4 sum of lines 8 through	40)							41

C = Worksheet C line numbers D = Worksheet D-1 line numbers

4090 (Cont.) FORM CMS-255					2-10			
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES					PROVIDER CCN:	PERIØD:	WORKSHEET D-4,	
FOR A TRANS	PLANT HOSPITAL	WITH A MEDICARE	-CERTIFIED		·	FROM	PART II	
					OPO CCN:	то		
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET				
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE					

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

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

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

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

03-23	FORM CM	4S-2552-10			4090	(Cont.)
COMPU	TATION OF ORGAN ACQUISITION COSTS AND CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	<u> </u>
FOR A T	FRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED			FROM	PARTS III & IV	
TRANS	PLANT PROGRAM		OPO CCN:	то		
Charle						
Check	[] HEART [] LIVER [] PANCREAS le box: [] KIDNEY [] LUNG [] INTESTINE	[] ISLET				
applicab	le box: [] KIDNEY [] LUNG [] INTESTINE I - SUMMARY OF COSTS AND CHARGES					
PARTI	1-SUMMART OF COSTS AND CHARGES	1	Cost		Charges	
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and ancillary from Part I	-	_	3		56
57	Interns and Residents (inpatient)					57
	Interns and Residents (outpatient)					58
59						59
60						60
61	Total (see instructions)					61
			Usable Organs			
		1	2	3	4	
62	Total usable organs (see instructions)					62
63						63
64	Ratio of Medicare usable organs to total usable organs (see instructions)					64
			Cost		Charges	
		Part A	Part B	Part A	Part B	
		1	2	3	4	
65						65
66				_		66
66.01	Partial primary payor amounts applicable to organ acquisition			_		66.01
66.02	Partial primary payor amounts applicable to transplants (informational only)			_		66.02
67	Subtotal (see instructions)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69
	V STATISTICS					
PARTI	V - STATISTICS		Living Related	Cadaveric	Revenue	
			1	2	3	
70	Organs excised in provider ⁽¹⁾		1	2		70
70	Organs purchased from other transplant hospitals ⁽²⁾					70
72	Organs purchased from non-transplant hospitals					72
73	Organs purchased from OPOs (see instructions)					73
74						74
75	Organs transplanted					75
75.01	Organs transplanted into Medicare beneficiaries					75.01
75.02	Kidneys transplanted into MA beneficiaries					75.02
75.03	Organs transplanted, Medicare secondary payer					75.03
75.04	Organs transplanted, Other (see instructions)					75.04
76	Organs sold to other hospitals					76
77	Organs sold to OPOs					77
78	Organs sold to transplant hospitals					78
79	Organs sold to MRTC without an agreement or VA hospitals					79
79.01	Kidneys sold to MRTC with an agreement					79.01
80	Organs sold outside the U.S.					80
81	Organs sent outside the U.S. (no revenue received)					81
82	Organs used for research					82
83	Unusable/Discarded organs (see instructions)					83
84	Total (see instructions)					84

⁽¹⁾ Organs procured outside your center by a procurement team from your center are not included in the count.
 ⁽²⁾ Organs procured outside your center by a procurement team from your center are included in the count.

4090 (0	Cont.)	FORM CMS-25	52-10					03-23
	TIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART I	
Check ar	pplicable box: [] Hospital Staff [] Medical Staff				-			
	•							
PART I -	- REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ET	NDING BEFORE JUNE 30,	2014					
					Physician/		5 Percent	
Line	Specialty	Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
No.	Description/Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
1	2	3	4	5	6	7	8	7
1	General Practitioner Family Practice							1
2	Internal Medicine							2
3	Surgery							3
4	Pediatrics							4
5	Obstetrics-Gynecology							5
6	Radiology							6
7	Psychiatry							7
8	Anesthesiology							8
	Pathology							9
10	All Other							10
11	Total							11
		Cost of		Cost of			Adjust Cost	
		Membership	Professional	Physician	Professional		of Physician's	
Line	Specialty	& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	
9	10	11	12	13	14	15	16	
1	General Practitioner Family Practice							1
2	Internal Medicine							2
3	Surgery							3
	Pediatrics							4
	Obstetrics-Gynecology							5
	Radiology							6
	Psychiatry							7
	Anesthesiology							8
	Pathology							9
	All Other							10
-	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)				+			11

09-14	FORM CMS-2552-10					
APPORTIONM	IENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD:	WORKSHEET D-5,		
			FROM	PART II		
			то			
Check	[] Hospital	•				
applicable	[] IPF					
box:	[] IRF					

1 2 3 1 1 2 3 1 1 2 3 2 Total Inpatient Days and Outpatient Visit Days 1 2 3 Average Per Diem (line 1 ÷ line 2) 1 1 1 HEALTH CARE PROGRAM REIMBURSABLE DAYS 4 Title V - Inpatient 1			Medical School	Total	
1 Adjusted Cost of Physician's Direct Medical and Surgical Services		Hospital Staff	Faculty	(col 1 + col 2)	
2 Total Inpatient Days and Outpatient Visit Days		1	2	3	
3 Average Per Diem (line 1 + line 2) HEALTH CARE PROGRAM REIMBURSABLE DAYS 4 Tide V - Inpatient 6 Tide V - Inpatient 7 Tide V - Inpatient 6 Tide V - Inpatient 7 Tide V - Inpatient 8 Tide XVIII - Part A 7 Tide XVIII - Part B 8 Tide XVII - Part A 9 Tide XVI. Outpatient 10 Inpatient and Outpatient Kidney Acquisition 11 Inpatient and Outpatient Extra Acquisition 12 Inpatient and Outpatient Luer Acquisition 13 Inpatient and Outpatient Iters Acquisition 14 Inpatient and Outpatient Iters Acquisition 15 Inpatient and Outpatient Iters Acquisition 16 Inpatient and Outpatient Iters Acquisition 17 Other Organ Acquisition Imatient and Outpatient Iters Acquisition 18 Tide V - Inpatient (line 3 x line 6) Imatient and Outpatient Iters Acquisition 19 Tide V - Inpatient (line 3 x line 7) Imatient and Outpatient Iters Acquisition (line 3 x line 10) 21 Tite XXI - Inpatient (line 3 x line 7) Imatient and Outpatient Iters Acquisition					
HEALTH CARE PROGRAM REIMBURSABLE DAYS 4 Title V - Inpatient 5 Title V - Oupatient 6 Title XVIII-Part A 7 Title XVIII-Part B 8 Title XXII-Part B 9 Title XXII-Oupatient 10 Inpatient and Oupatient Kidney Acquisition 11 Inpatient and Oupatient Heart Acquisition 12 Inpatient and Oupatient Heart Acquisition 13 Inpatient and Oupatient Parcess Acquisition 14 Inpatient and Oupatient Parcess Acquisition 15 Inpatient And Oupatient Parcess Acquisition 16 Inpatient and Oupatient Islet Acquisition 17 Other Organ Acquisition 18 Inpatient and Dupatient Islet Acquisition 19 Title V- Unpatient (Ine 3 x line 4) 19 Title V- Oupatient (Ine 3 x line 4) 19 Title V- Oupatient (Ine 3 x line 4) 19 Title V- Nupatient (Ine 3 x line 4) 19 Title V. Nupatient (Ine 3 x line 4) 19 Title V. Nupatient (Ine 3 x line 4) 10 Intel V = Nupatient (Ine 3 x line 4) 10 Title XXII- Part B (Ine 3 x line 10) <td></td> <td></td> <td></td> <td></td> <td></td>					
4 Title V - Inpatient Image: Constraint of the second	3 Average Per Diem (line 1 ÷ line 2)				
5 Title XVIII Part A 6 Title XVIII Part A 7 Title XVIII Part A 7 Title XVIII Part B 8 Title XIX Inpatient 9 Title XIX - Inpatient 10 Inpatient and Outpatient Kidney Acquisition 11 Inpatient and Outpatient Kidney Acquisition 12 Inpatient and Outpatient Heart Acquisition 13 Inpatient and Outpatient Interstine Acquisition 14 Inpatient and Outpatient Interstine Acquisition 15 Inpatient and Outpatient Interstine Acquisition 16 Inpatient and Outpatient Interstine Acquisition 17 Other Organ Acquisition 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 10 Title XVII - Part A (line 3 x line 6) 11 Thy Ther A Topatient (line 3 x line 7) 11 Thy Ther A Cline 3 x line 7) 12 Title XVII - Part A (line 3 x line 7) 13 Inpatient and Outpatient Interstine Acquisition (line 3 x line 10) 14 Trable XII - Part A (line 3 x line 10) 15 <td>HEALTH CARE PROGRAM REIMBURSABLE DAYS</td> <td></td> <td></td> <td></td> <td></td>	HEALTH CARE PROGRAM REIMBURSABLE DAYS				
6 Title XVIII - Part A 7 Title XVII - Part B 9 Title XXV - Inpatient 9 Title XXX - Outpatient 10 Inpatient and Outpatient Kidney Acquisition 11 Inpatient and Outpatient Liver Acquisition 12 Inpatient and Outpatient Liver Acquisition 13 Inpatient and Outpatient Liver Acquisition 14 Inpatient and Outpatient Incerse Acquisition 15 Inpatient and Outpatient Interse Acquisition 16 Inpatient and Outpatient Interse Acquisition 17 Other Organ Acquisition 18 Title V - Inpatient (line 3 x line 4) 19 Title XVIII - Part A (line 3 x line 5) 20 Title XVIII - Part A (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 10) 25 Inpatient and Outpatient (line 3 x line 10) 26 Inpatient and Outpatient Part Acquisition (line 3 x line 10) 27 Inpatient and Coutpatient P	4 Title V - Inpatient				
7 Title XVIII - Part B 8 Title XX - Inpatient 9 Title XX - Outpatient 10 Inpatient and Outpatient Kidney Acquisition 11 Inpatient and Outpatient Kidney Acquisition 12 Inpatient and Outpatient Heart Acquisition 13 Inpatient and Outpatient Heart Acquisition 14 Inpatient and Outpatient Heart Acquisition 15 Inpatient and Outpatient Intestine Acquisition 16 Inpatient and Outpatient Intestine Acquisition 17 Other Organ Acquisition 18 Title X VIII - Part B (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 10 Title XVIII - Part B (line 3 x line 6) 11 Title X VIII - Part A (line 3 x line 7) 11 Title X XII - Part B (line 3 x line 7) 11 Title XIX - Outpatient (line 3 x line 10) 15 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 16 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 16 Inpatient and Outpatient Meart Acquisition (line 3 x line 10) 16 Title XIX - Outpatient (line 3 x line 13) 17 Inpatient and Outpatient Meart Acquisitio	5 Title V - Outpatient				
8 Title XIX - Inpatient 9 Title XIX - Outpatient 9 Title XIX - Outpatient 10 Inpatient and Outpatient Kidney Acquisition 11 Inpatient and Outpatient Kidney Acquisition 12 Inpatient and Outpatient Liver Acquisition 13 Inpatient and Outpatient Lung Acquisition 14 Inpatient and Outpatient Restine Acquisition 15 Inpatient and Outpatient Intestine Acquisition 16 Inpatient and Outpatient Intestine Acquisition 17 Other Organ Acquisition 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 20 Title XVII - Part A (line 3 x line 6) 21 Title XVII - Part A (line 3 x line 6) 21 Title XVII - Part A (line 3 x line 6) 21 Title XVII - Part A (line 3 x line 6) 21 Title XVII - Part A (line 3 x line 7) 22 Title XVII - Part A (line 3 x line 10) 23 Title XXII - Inpatient (line 3 x line 10) 24 Inpatient and Outpatient Lure Acquisition (line 3 x line 11) 26 Inpatient and Outpatient Horestra Acquisition (line 3 x line 12) <	6 Title XVIII - Part A				
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10 Inpatient and Outpatient Liver Acquisition Impatient and Outpatient Liver Acquisition 11 Inpatient and Outpatient Liver Acquisition Impatient and Outpatient Heart Acquisition 13 Inpatient and Outpatient Plant Acquisition Impatient and Outpatient Plant Acquisition 14 Inpatient and Outpatient Plant Acquisition Impatient and Outpatient Intestine Acquisition 15 Inpatient and Outpatient Intestine Acquisition Impatient and Outpatient Intestine Acquisition 16 Inpatient and Outpatient Intestine Acquisition Impatient and Outpatient Intestine Acquisition 17 Other Organ Acquisition Impatient and Outpatient Intestine Acquisition 18 Title V - Inpatient (line 3 x line 4) Impatient and Intestine Acquisition 19 Title V - Outpatient (line 3 x line 6) Impatient Acquisition Intestine Acquisition (line 3 x line 7) 20 Title XVII - Part A (line 3 x line 7) Impatient and Outpatient (line 3 x line 7) Impatient and Outpatient (line 3 x line 7) 21 Title XVII - Part A (line 3 x line 10) Impatient and Outpatient (line 3 x line 10) Impatient and Outpatient Line Acquisition (line 3 x line 10) 21 Inpatient and Outpatient Line Acquisition (line 3 x line 12) Impatient and Outpatient Heart Acquisition (line 3 x line 12) Impatient and Outpatient He	8 Title XIX - Inpatient				
11 Inpatient and Outpatient Liver Acquisition 12 Inpatient and Outpatient Heart Acquisition 13 Inpatient and Outpatient Intestine Acquisition 14 Inpatient and Outpatient Intestine Acquisition 15 Inpatient and Outpatient Intestine Acquisition 16 Inpatient and Outpatient Intestine Acquisition 17 Other Organ Acquisition 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 10 Title XVIII - Part B (line 3 x line 6) 11 Title XVIII - Part B (line 3 x line 6) 11 Title XXU - Outpatient (line 3 x line 6) 11 Title XXU - Outpatient (line 3 x line 6) 12 Title XXU - Nupatient (line 3 x line 6) 13 Title XXU - Outpatient (line 3 x line 6) 14 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 19 Title XXU - Outpatient (line 3 x line 10) 10 Inpatient and Outpatient NearCostion (line 3 x line 12) 11 Inpatient and Outpatient NearCostion (line 3 x line 12) 10 Inpatient and Outpatient NearCostion (line 3 x line 13) 11 Inpatient and Outpatient NearCostion (line 3 x line 14) <td>9 Title XIX - Outpatient</td> <td></td> <td></td> <td></td> <td></td>	9 Title XIX - Outpatient				
12 Inpatient and Outpatient Heart Acquisition Impatient and Outpatient Lung Acquisition 13 Inpatient and Outpatient Pancreas Acquisition Impatient and Outpatient Pancreas Acquisition 15 Inpatient and Outpatient Intestine Acquisition Impatient and Outpatient Ister Acquisition 16 Inpatient and Outpatient Ister Acquisition Impatient and Outpatient Ister Acquisition 17 Other Organ Acquisition Impatient and Outpatient Ister Acquisition 18 Title V - Impatient (line 3 x line 4) Impatient and (line 3 x line 5) 19 Title V - Outpatient (line 3 x line 6) Impatient and Outpatient (line 3 x line 6) 11 Title XVIII - Part B (line 3 x line 6) Impatient and Outpatient (line 3 x line 6) 11 Title XVII - Part B (line 3 x line 7) Impatient and Outpatient (line 3 x line 7) 12 Title XVII - Part B (line 3 x line 7) Impatient and Outpatient Kidney Acquisition (line 3 x line 10) 15 Inpatient and Outpatient Liver Acquisition (line 3 x line 10) Impatient and Outpatient Pancreas Acquisition (line 3 x line 12) 12 Inpatient and Outpatient Heart Acquisition (line 3 x line 13) Impatient and Outpatient Pancreas Acquisition (line 3 x line 14) 19 Impatient and Outpatient Intestine Acquisition (line 3 x line 14) Impatient and Outpatie	10 Inpatient and Outpatient Kidney Acquisition				
13 Inpatient and Outpatient Lung Acquisition Impatient and Outpatient Pancreas Acquisition 14 Inpatient and Outpatient Intestine Acquisition Impatient and Outpatient Intestine Acquisition 15 Inpatient and Outpatient Islet Acquisition Impatient and Outpatient Islet Acquisition 17 Other Organ Acquisition Impatient Islet Acquisition HEALTH CARE PROGRAM REIMBURSABLE COST Itel V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 20 Title XVIII - Part A (line 3 x line 6) 21 Title XVIII - Part B (line 3 x line 7) 22 Title XIX - Inpatient (line 3 x line 7) 23 Title XIX - Inpatient (line 3 x line 7) 24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 25 Inpatient and Outpatient Liver Acquisition (line 3 x line 10) 26 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Pancreas Acquisition (line 3 x line 13) 28 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) 30 Inpatient and Outpatient Instex Acquisition (line 3 x line 17)	11 Inpatient and Outpatient Liver Acquisition				
14 Inpatient and Outpatient Pancreas Acquisition 1 15 Inpatient and Outpatient Intestine Acquisition 1 16 Inpatient and Outpatient Islet Acquisition 1 17 Other Organ Acquisition 1 18 Title V - Inpatient (line 3 x line 4) 1 19 Title V - Inpatient (line 3 x line 5) 1 20 Title V - Inpatient (line 3 x line 5) 1 21 Title XVIII - Part A (line 3 x line 6) 1 22 Title XXIII - Part A (line 3 x line 7) 1 22 Title XXI - Inpatient (line 3 x line 8) 1 23 Title XXI - Inpatient (line 3 x line 9) 1 24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 1 25 Inpatient and Outpatient Heart Acquisition (line 3 x line 11) 1 26 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 1 27 Inpatient and Outpatient Racquisition (line 3 x line 13) 1 28 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) 1 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) 1 31 Inpatient and Ou	12 Inpatient and Outpatient Heart Acquisition				
15 Inpatient and Outpatient Intestine Acquisition Inpatient and Outpatient Islet Acquisition 16 Inpatient and Outpatient Islet Acquisition Inpatient and Outpatient Islet Acquisition 17 Other Organ Acquisition Inpatient and Outpatient Islet Acquisition 18 Title V - Inpatient (line 3 x line 4) Inpatient and Outpatient (line 3 x line 5) 19 Title V - Outpatient (line 3 x line 6) Inpatient and Outpatient (line 3 x line 6) 11 Title XVIII - Part B (line 3 x line 6) Inpatient (line 3 x line 7) 21 Title XII - Inpatient (line 3 x line 9) Inpatient and Outpatient Line 3 x line 9) 23 Title XII - Inpatient (line 3 x line 9) Inpatient and Outpatient Line 3 x line 10) 24 Inpatient and Outpatient Line 3 x line 11) Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 24 Inpatient and Outpatient Heart Acquisition (line 3 x line 13) Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Inster Acquisition (line 3 x line 16) Inpatient and Outpatient Islet Acquisition (line 3 x line 16) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) Inpatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 13) <	13 Inpatient and Outpatient Lung Acquisition				
16 Inpatient and Ourpatient Islet Acquisition 17 Other Organ Acquisition 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Ourpatient (line 3 x line 5) 20 Title XVIII - Part A (line 3 x line 6) 21 Title XVIII - Part B (line 3 x line 7) 22 Title XIX - Inpatient (line 3 x line 8) 23 Title XIX - Outpatient (line 3 x line 8) 24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 25 Inpatient and Outpatient Kidney Acquisition (line 3 x line 11) 26 Inpatient and Outpatient Liver Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Part Acquisition (line 3 x line 13) 28 Inpatient and Outpatient Part Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 13) 20 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Islet Acquisition (line 3 x line 15) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 15) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 15) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Ou	14 Inpatient and Outpatient Pancreas Acquisition				
17 Other Organ Acquisition HEALTH CARE PROGRAM REIMBURSABLE COST 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Outpatient (line 3 x line 5) 20 Title XVIII - Part A (line 3 x line 6) 21 Title XVIII - Part B (line 3 x line 7) 22 Title XVIII - Part B (line 3 x line 6) 21 Title XVII - Part B (line 3 x line 7) 22 Title XIX - Inpatient (line 3 x line 8) 23 Title XIX - Outpatient (line 3 x line 9) 24 Inpatient and Outpatient Liver Acquisition (line 3 x line 10) 25 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 26 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) 28 Inpatient and Outpatient Pacreas Acquisition (line 3 x line 15) 30 Inpatient and Outpatient Islet Acquisition (line 3 x line 15) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)	15 Inpatient and Outpatient Intestine Acquisition				
HEALTH CARE PROGRAM REIMBURSABLE COST 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 10 110 11110 1110	16 Inpatient and Outpatient Islet Acquisition				L
HEALTH CARE PROGRAM REIMBURSABLE COST 18 Title V - Inpatient (line 3 x line 4) 19 Title V - Inpatient (line 3 x line 5) 10 110 11110 1110	17 Other Organ Acquisition				
19 Title V - Outpatient (line 3 x line 5) 20 Title XVIII - Part A (line 3 x line 6) 21 Title XVIII - Part B (line 3 x line 7) 22 Title XVIII - Part B (line 3 x line 7) 23 Title XIX - Inpatient (line 3 x line 7) 24 Inpatient and Outpatient (line 3 x line 9) 25 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 26 Inpatient and Outpatient Liver Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) 28 Inpatient and Outpatient Liver Acquisition (line 3 x line 12) 29 Inpatient and Outpatient I heart Acquisition (line 3 x line 12) 20 Inpatient and Outpatient I heart Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) 30 Inpatient and Outpatient Islet Acquisition (line 3 x line 16) 31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate			1	I	-
20 Title XVIII - Part A (line 3 x line 6) 21 Title XVIII - Part B (line 3 x line 7) 22 Title XX - Inpatient (line 3 x line 7) 23 Title XIX - Inpatient (line 3 x line 8) 24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 25 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 26 Inpatient and Outpatient Liver Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Heart Acquisition (line 3 x line 13) 28 Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) 30 Inpatient and Outpatient Islet Acquisition (line 3 x line 16) 31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate IVII					+
21 Title XVIII - Part B (line 3 x line 7) 22 Title XIX - Inpatient (line 3 x line 8) 23 Title XIX - Outpatient (line 3 x line 9) 24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) 25 Inpatient and Outpatient Liver Acquisition (line 3 x line 11) 26 Inpatient and Outpatient Liver Acquisition (line 3 x line 12) 27 Inpatient and Outpatient Heart Acquisition (line 3 x line 13) 28 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) 29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) 20 Inpatient and Outpatient Islet Acquisition (line 3 x line 16) 21 Inpatient and Outpatient Islet Acquisition (line 3 x line 17) Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate IV					
22 Title XIX - Inpatient (line 3 x line 6) Impatient and Outpatient (line 3 x line 7) 23 Title XIX - Outpatient (line 3 x line 6) Impatient and Outpatient Kidney Acquisition (line 3 x line 10) 24 Inpatient and Outpatient Liver Acquisition (line 3 x line 11) Impatient and Outpatient Heart Acquisition (line 3 x line 12) 26 Inpatient and Outpatient Heart Acquisition (line 3 x line 12) Impatient and Outpatient Lung Acquisition (line 3 x line 13) 27 Inpatient and Outpatient Intestine Acquisition (line 3 x line 14) Impatient and Outpatient Intestine Acquisition (line 3 x line 15) 29 Inpatient and Outpatient Islet Acquisition (line 3 x line 16) Impatient and Outpatient Islet Acquisition (line 3 x line 17) 31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) Impatient and 19, and transfer to Worksheet E-3, Part VII Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Impatient 20 to Worksheet E-3, Part I to IV as appropriate					_
23 Title XIX - Outpatient (line 3 x line 9)					
24 Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)					
25 Inpatient and Outpatient Liver Acquisition (line 3 x line 11)					
26 Inpatient and Outpatient Heart Acquisition (line 3 x line 12)					
27 Inpatient and Outpatient Lung Acquisition (line 3 x line 13)					
28 Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)					
29 Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)					
30 Inpatient and Outpatient Islet Acquisition (line 3 x line 16) 31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate					
31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate					
Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate					
Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate	31 Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)				
Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate	Transfor the survey in solution 2 or follows			1	
Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate					
		priate			
	Add lines 22 and 23 and transfer to Worksheet E-3 Part VII as appropr				

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

(Cont.)	T OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	FORM CMS-2552-	-10		PROVIDER CCN:	PERIOD:	WORKSHEET D-5,	09
TIONMEN	T OF COST FOR PHYSICIANS SERVICES IN A TEACHING HOSPITAL				PROVIDER CCN:	FROM	PART III	
						то	_	
II - REASOI	NABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST RE	PORTING PERIODS ENDING ON OR AFTER JU	JNE 30. 2014					
					Physician/		5 Percent	\top
Wkst. A		Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
Line #	Cost Center / Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
1	2	3	4	5	6	7	8	
								_
								_
								_
								_
								+
								+
	Total							+
	Total							_
		Cost of		Cost of			Adjust Cost	Τ
		Membership	Professional	Physician	Professional		of Physician's	
Wkst. A		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
Line #	Cost Center / Physician Identifier	Education	Share of Column 11	Insurance	Share of Column 13	RCE Limit	Surgical Services	
9	10	11	12	13	14	15	16	
								_
								\perp
								_
								_
								+
								+
								+
		I	1		1	1		

Total (transfer the amount in column 16, line 200, to Part IV, line 1)

10

200

10 200

APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD:	WORKSHEET D-5,
		FROM	PART IV
		то	
Check [] Hospita]			-

Check	[] Hospital
applicable	[] IPF
box:	[] IRF

1 Adjusted cost of physicians' direct medical and surgical services	1
2 Total inpatient days and outpatient visit days	2
3 Average per diem (line 1 ÷ line 2)	3
HEALTH CARE PROGRAM REIMBURSABLE DAYS	
4 Title V - Inpatient	4
5 Title V - Outpatient	5
6 Title XVIII - Part A	6
7 Title XVIII - Part B	7
8 Title XIX - Inpatient	8
9 Title XIX - Outpatient	9
10 Inpatient and outpatient kidney acquisition	10
11 Inpatient and outpatient liver acquisition	11
12 Inpatient and outpatient heart acquisition	12
13 Inpatient and outpatient lung acquisition	13
14 Inpatient and outpatient pancreas acquisition	14
15 Inpatient and outpatient intestine acquisition	15
16 Inpatient and outpatient islet acquisition	16
17	17
17.01 Inpatient allogeneic HSCT acquisition	17.01
17.02 Outpatient allogeneic HSCT acquisition	17.02
HEALTH CARE PROGRAM REIMBURSABLE COST	
18 Title V - Inpatient (line 3 x line 4)	18
19 Title V - Outpatient (line 3 x line 5)	19
20 Title XVIII - Part A (line 3 x line 6)	20
21 Title XVIII - Part B (line 3 x line 7)	21
22 Title XIX - Inpatient (line 3 x line 8)	22
23 Title XIX - Outpatient (line 3 x line 9)	23
24 Inpatient and outpatient kidney acquisition (line 3 x line 10)	24
25 Inpatient and outpatient liver acquisition (line 3 x line 11)	25
26 Inpatient and outpatient heart acquisition (line 3 x line 12)	26
27 Inpatient and outpatient lung acquisition (line 3 x line 13)	27
28 Inpatient and outpatient pancreas acquisition (line 3 x line 14)	28
29 Inpatient and outpatient intestine acquisition (line 3 x line 15)	29
30 Inpatient and outpatient islet acquisition (line 3 x line 16)	30
31	31
31.01 Inpatient allogeneic HSCT acquisition (line 3 x line 17.01)	31.01

31.02 Outpatient allogeneic HSCT acquisition (line 3 x line 17.01)

Transfer amounts as follows:

Add lines 18 and 19, and transfer to Worksheet E-3, Part VII, line 20 (title V hospital or component)

Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF);

Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (cost reimbursement)

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

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, line 20 (title XIX hospital or component)

Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

Line 31.01 to Worksheet D-6, Part III, line 5, col. 1

Line 31.02 to Worksheet D-6, Part III, line 5, col. 2

31.02

4090 (Cont.) FORM CMS-2552-10							04-23		
COMP	COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS						PERIOD:	WORKSHEET D-6,	
							FROM	PARTS I & II	
							то		
PART	I - INPATIENT ROUTINE AND AN	CILLARY SERVICE	ES CELL	ULAR THERAPY ACQU	JISITION COSTS			·	
		Routine Services			Inpatient				
		Acquisition		Per Diem Costs	Acquisition	Acquisition Costs			
Inpa	tient Routine Services	Charges		(see instructions)	Days	(col. 2 x col. 3)			
Acq	uisition Costs	1	D-1	2	3	4			
1	Adults and Pediatrics		38						1
2	Intensive Care		43						2
3	Coronary Care		44						3
4	Burn Intensive Care Unit		45						4
5	Surgical Intensive Care Unit		46						5
6	Other Special Care (specify)		47						6
7	Total (sum of lines 1 through 6)								7

				Inpatient	Outpatient	Inpatient	Outpatient	
			Ratio of Cost	Ancillary Services	Ancillary Services	Ancillary Services	Ancillary Services	
			to Charges	Acquisition	Acquisition	Acquisition	Acquisition	
		(f	rom Wkst. C, Pt. I, col. 9)	Charges	Charges	Cost	Cost	
	llary Services Acquisition Costs	С	1	2	3	4	5	
	Operating Room	50						8
9	Recovery Room	51						9
10	Labor Room & Delivery Room	52						10
11	Anesthesiology	53						11
12	Radiology-Diagnostic	54						12
	Radiology-Therapeutic	55						13
14	Radioisotope	56						14
15	Computed Tomography (CT) Scan	57						15
16	Magnetic Resonance Imaging (MRI)	58						16
17	Cardiac Catheterization	59						17
18	Laboratory	60						18
19	PBP Clinical Laboratory Services-Program Only	61						19
20	Whole Blood & Packed Red Blood Cells	62						20
21	Blood Storage, Processing, & Transfusing	63						21
22	IV Therapy	64						22
23	Electrocardiology	69						23
24	Medical Supplies Charged to Patients	71						24
25	Drugs Charged to Patients	73						25
26	ASC (non-distinct part)	75						26
27	Other Ancillary (specify)	76						27
28	Clinic	90						28
30	Total (sum of lines 8 through 28)							30

PART II - INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING PROGRAM CELLULAR THERAPY ACQUISITION COSTS

			Average Cost Per Day	Inpatient	Inpatient Part B		
			(from Wkst. D-2,	Acquisition	Acquisition Costs		
Inter	ns and Residents Not in Approved Teaching		Pt. I, col. 4)	Days	(col. 1 x col. 2)		
Prog	ram Acquisition Costs	D-2	1	2	3		
1	Adults & Pediatrics	2					1
2	Intensive Care Unit	3					2
3	Coronary Care Unit	4					3
4	Burn Intensive Care Unit	5					4
5	Surgical Intensive Care Unit	6					5
6	Other Special Care (specify)	7					6
7	Total (sum of lines 1 through 6)						7

FORM CMS-2552-10

2-24 FOR	M CMS-2552-10		4090	(Cont.)
OMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS	PROVID	ER CCN: PERIOD:	WORKSHEET D-6,	
		FROM	PART III	
		то		
ART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS		•	· ·	
		Amount		
1 Acquisition cost from Worksheet B, col. 26 (see instructions)				1
		Inpatient	Outpatient	
Acquisition Services Total Costs		1	2	
2 Routine and ancillary				2
3 Interns and residents				3
4 Apportionment of acquisition cost from line 1				4
5 Cost of physicians' services in a teaching hospital (see instructions)				5
6 Total acquisition cost (sum of lines 2 through 5)				6
		I		
	In	patient Outpatient	Total	
Determine Ratio of Medicare Transplants to Total Transplants		1 2	3	
7 Total transplants (see instructions)				7
8 Medicare transplants (see instructions)				8
9 Medicare ratio (line 8 ÷ line 7)				9
10 Medicare cost (see instructions)				10

4090	(Cont.)
40.00	

WORKSHEET E, PART A

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: COMPONENT CCN: PERIOD:

FROM

TO.

PART	pplicable box: [] Hospital [] PARHM Demonstration			
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS			
1	DRG amounts other than outlier payments			
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			1.0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1.02
	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			1.03
	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			1.04
	Outlier payments for discharges (see instructions)			2
	Outlier reconciliation amount			2.0
	Outlier payment for discharges for Model 4 BPCI (see instructions)			2.0
	Outlier payments for discharges occurring prior to October 1 (see instructions)			2.0
	Outlier payments for discharges occurring on or after October 1 (see instructions)			2.04
	Managed care simulated payments			
	Bed days available divided by number of days in the cost reporting period (see instructions)			
· · ·	Indirect Medical Education Adjustment Calculation for Hospitals			
5	TFTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			
	The count of unput reading the post and the first of the CAA 2021 (see instructions)			5.0
	FTE could for allopathic role and stepsing the grant built of the Critical for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			5.0
	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			6.2
				0.2
	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv(B)(1) ACA \$5520 addression amount to the IME cap as generified under 42 CFR 412.105(f)(1)(iv(B)(2)). If the cast senset standards have 1, 2011 cap instantiants			7.0
	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.			7.0
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated	a		7.0
	programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (inspanse on decrement) to the TTE count for allowable and extensible programs for affiliated managements in accordance			+
8	Adjustment (increase) to the FTE count for allopathic and osteopathic and osteopathic and and a steopathic a			
	with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			-
	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.0
	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)			8.0
	The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)			8.2
	The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023 (see instructions)			8.2
9	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8,			
	plus lines 8.01 through 8.28 (see instructions)			
10	FTE count for allopathic and osteopathic programs in the current year from your records			1
11	FTE count for residents in dental and podiatric programs			1
12	Current year allowable FTE (see instructions)			1
13	Total allowable FTE count for the prior year			1
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.			1
15	Sum of lines 12 through 14 divided by 3			1
16	Adjustment for residents in initial years of the program (see instructions)			1
	Adjustment for residents displaced by program or hospital closure			1
	Adjusted rolling average FTE count			1
	Current year resident to bed ratio (line 18 divided by line 4)			1
	Prior year resident to bed ratio (see instructions)			2
	Enter the lesser of lines 19 or 20 (see instructions)			2
	IME payment adjustment (see instructions)			2
	IME payment adjustment - Managed Care (see instructions)			22.0
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA			
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			2
	The FTE resident count over cap (see instructions)			2
	The prior to line 23 or line 24 (see instructions)			2
	Resident to be dratio (divide line 25 by line 4)			2
				2
	IME payments adjustment factor (see instructions) IME add-on adjustment amount (see instructions)			2
				28.0
	IME add-on adjustment amount - Managed Care (see instructions) Total IME navment (sum of lines 22 and 28)			28.0
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			29.0
				29.0
	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			
				3
	Percentage of Medicaid patient days to total patient days (see instructions)			3
	Sum of lines 30 and 31			3
	Allowable disproportionate share percentage (see instructions)			3
	Disproportionate share adjustment (see instructions)			3
	Uncompensated Care Payment Adjustment Prior to Octo	ober 1	On or after October 1	-
	Total uncompensated care amount (see instructions)			3
	Factor 3 (see instructions)			35.0
35.02	Hospital UCP, including supplemental UCP (see instructions)			35.0
	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)			35.0
	Pro rata share of the MDH's UCP, including supplemental UCP (see instructions)			35.0
35.04				
	Pro rata share of the SCH's UCP, including supplemental UCP (see instructions)			35.0

FORM CMS-2552-10 (12-2024) (INSTRUCTIONS FOR THIS WORKSHEET AR	E PUBLISHED IN CMS PUB. 15-2, SE	CTION 4030.1)		
40-584				Rev. 23
DRAFT	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT			FROM	PART A (Cont.)

COMPONENT CCN: TO _____

	pplicable box: [] Hospital [] PARHM Demonstration	
	A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)	
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)	
40	Total Medicare discharges (see instructions)	40
41	Total ESRD Medicare discharges (see instructions)	41
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	42
43	Total Medicare ESRD inpatient days (see instructions)	43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	44
45	Average weekly cost for dialysis treatments (see instructions)	45
46	Total additional payment (line 45 times line 44 times line 41.01)	46
47	Subtotal (see instructions)	47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)	48
49	Total payment for inpatient operating costs (see instructions)	49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)	50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)	51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).	52
53	Nursing and allied health managed care payment	53
54	Special add-on payments for new technologies	54
	Islet isolation add-on payment	54.01
55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)	55
55.01	Cellular therapy acquisition cost (see instructions)	55.01
56	Cost of physicians' services in a teaching hospital (see instructions)	56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35)	57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	58
59	Total (sum of amounts on lines 49 through 58)	59
60	Primary payer payments	60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	60
62	Deductibles billed to program beneficiaries	 62
62		62
64	Coinsurance billed to program beneficiaries	64
	Allowable bad debts (see instructions)	 65
65	Adjusted reimbursable bad debts (see instructions)	66
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	67
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	 67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)	
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)	69
70	Other adjustments (specify) (see instructions)	 70
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	 70.50
70.75	N95 respirator payment adjustment amount (see instructions)	70.75
70.76	Essential medicines payment adjustment amount (see instructions)	 70.76
70.87	Demonstration payment adjustment amount before sequestration	 70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	 70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	 70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	 70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	 70.91
70.92	Bundled Model 1 discount amount (see instructions)	 70.92
70.93	HVBP payment adjustment amount (see instructions)	 70.93
70.94	HRR adjustment amount (see instructions)	 70.94
70.95	Recovery of accelerated depreciation	 70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)	 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)	 70.97
70.99	HAC adjustment amount (see instructions)	 70.99
71	Amount due provider (see instructions)	 71
71.01	Sequestration adjustment (see instructions)	 71.01
71.02	Demonstration payment adjustment amount after sequestration	 71.02
71.03	Sequestration adjustment-PARHM pass-throughs	 71.03
72	Interim payments	 72
72.01	Interim payments-PARHM	72.01
73	Tentative settlement (for contractor use only)	73
73.01	Tentative settlement-PARHM (for contractor use only)	73.01
74	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)	74
74.01	Balance due provider/program-PARHM (see instructions)	74.01
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	 75

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.1) Rev. 40-585 4090 (Cont.) FORM CMS-2552-10 DRAFT CALCULATION OF REIMBURSEMENT PROVIDER CCN: PERIOD: WORKSHEET E, SETTLEMENT FROM_ PART A COMPONENT CCN: TO_
 Check applicable box:
 [] Hospital
 [] PARHM Demonstration

 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)

	O BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90 C	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			90
91 C	Capital outlier from Wkst. L, Pt. I, line 2			91
92 0	Derating outlier reconciliation adjustment amount (see instructions)			92
93 (Capital outlier reconciliation adjustment amount (see instructions)			93
94 7	4 The rate used to calculate the time value of money (see instructions)			94
95 T	ime value of money for operating expenses (see instructions)			95
96 1	ime value of money for capital related expenses (see instructions)			96
Н	SP Bonus Payment Amount	Prior to 10/1	On or After 10/1	
100 H	ISP bonus amount (see instructions)			100
Н	VBP Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
101 H	IVBP adjustment factor (see instructions)			101
102 H	IVBP adjustment amount for HSP bonus payment (see instructions)			102
Н	RR Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	
103 H	IRR adjustment factor (see instructions)			103
104 H	IRR adjustment amount for HSP bonus payment (see instructions)			104
R	ural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment			
200 I	s this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200
C	ost Reimbursement			
201 N	Adicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201
202 N	Aedicare discharges (see instructions)			202
203 0	Case-mix adjustment factor (see instructions)			203
C	omputation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204 N	Aedicare target amount			204
205 0	Case-mix adjusted target amount (line 203 times line 204)			205
206 N	Aedicare inpatient routine cost cap (line 202 times line 205)			206
A	djustment to Medicare Part A Inpatient Reimbursement			
207 F	rogram reimbursement under the §410A Demonstration (see instructions)			207
208 N	Aedicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208
209 A	Adjustment to Medicare IPPS payments (see instructions)			209
	teserved for future use			210
	otal adjustment to Medicare IPPS payments (see instructions)			211
	omparison of PPS versus Cost Reimbursement			
-	otal adjustment to Medicare Part A IPPS payments (from line 211)			212
	ow-volume adjustment (see instructions)			213
210 N	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218

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Form CMS-2552-10 (12-2022) (instructions for this worksheet are published in CMS pub. 15-2, section 4030.1) ${\rm Rev.}$

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

Check	[] Hospital [] Subprovider (Other)	
applicab		
box:	[] IRF [] PARHM Demonstration	
PART B	- MEDICAL AND OTHER HEALTH SERVICES	
1	Medical and other services (see instructions)	1
2		2
	OPPS or REH payments	3
	Outlier payment (see instructions)	4
	Outlier reconciliation amount (see instructions)	4.01
	Enter the hospital specific payment to cost ratio (see instructions)	5
-	Line 2 times line 5	6
7	Sum of lines 3, 4, and 4.01, divided by line 6	7
	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	8
	Organ acquisition	10
	Organ acquisition Total cost (sum of lines 1 and 10) (see instructions)	10
	Total cost (and of lines 1 and for (see instructions)	11
	Resonable charges	
	Ancillary service charges	12
	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)	13
	Total reasonable charges (sum of lines 12 and 13)	14
	Customary charges Customary charges	
15		15
16	Amounts that would have been realized from patients liable for payment for services on a charge	16
	basis had such payment been made in accordance with 42 CFR §413.13(e)	
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	17
18	Total customary charges (see instructions)	18
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19
	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	20
	Lesser of cost or charges (see instructions)	21
	Interns and residents (see instructions)	22
	Cost of physicians' services in a teaching hospital (see instructions)	23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	24
25	Deductibles and coinsurance amounts (see instructions)	25
	Deductibles and Coinsurance amounts (see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (see instructions)	25
20	Subtal [lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	20
-	Subtrat (times 21 and 24 minus the sum of times 22 and 25) (see instructions)	28
-	Effect graduat reaction pointer (non where 2 + me 50) REH facility payment amount (see instructions) REH facility payment amount (see instructions)	28.50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	29
	Subtotal (sum of lines 27, 28, 28.50, and 29)	30
-	Primary payer payments	31
	Subtotal (line 30 minus line 31)	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
	Composite rate ESRD (from Wkst. I-5, line 11)	33
34	Allowable bad debts (see instructions)	34
-	Adjusted reimbursable bad debts (see instructions)	35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	36
37		37
38	MSP-LC reconciliation amount from PS&R C	38
39	Other adjustments (specify) (see instructions)	39
	Pioneer ACO demonstration payment adjustment (see instructions)	39.50
39.75	N95 respirator payment adjustment amount (see instructions)	<u>39.75</u> 39.97
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	39.97
	Failed of the Creates received from manufactures for replaced devices (see instructions) Recovery of Accelerated depreciation	39.99
40		40
	Sequestration adjustment (see instructions)	40.01
	Demonstration payment adjustment amount after sequestration	40.02
	Sequestration adjustment-PARHM pass-throughs	40.03
	Interim payments Interim payments	41
	Interim payments-PARHM [10]	41.01
42		
42	Tentative settlement (for contractors use only)	42
42.01		42 42.01
42.01		
42.01 43 43.01	Tentative settlement-PARHM (for contractors use only)	42.01

FORM CMS-2552-10 (draft) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.2)				
		Rev.		
M CMS-2552-10		4090 (Cont.)		
PROVIDER CCN:	PERIOD:	WORKSHEET E,		
	FROM	PART B (Cont.)		
	M CMS-2552-10	M CMS-2552-10 PROVIDER CCN: PERIOD:		

Check	[] Hospital	[] Subprovider (Other)			
applicab	le [] IPF	[] SNF			
box:	[] IRF	[] PARHM Demonstration			
PART B	- MEDICAL AND OTHE	ER HEALTH SERVICES			
	TO BE COMPLETED BY	Y CONTRACTOR			
90	Original outlier amount (iginal outlier amount (see instructions) 90			
91	91 Outlier reconciliation adjustment amount (see instructions)				
92	92 The rate used to calculate the Time Value of Money				
93	Time Value of Money (s	see instructions)	93		
94	Total (sum of lines 91 and	d 93)	94		

AT VER OF	F PAYMENTS TO PRO						PROVIDER CCN:	PERIOD:	WORKSHEET E-1,	
	ES RENDERED	5 VIDERS					FROVIDER CCN.	FROM	PART I	
V SERVICE	5 KENDEKED						COMPONENT CCN:	ТО		
							COMPONENT CCN.	10	-	
ck	[] Hospital	[] Subprovider (Other)	[] PARHM Demonstration							
licable	[] IPF	[] SNF	[] PARHM CAH Swing-Bed SNF							
:	[]IRF	[] Swing-Bed SNF	[]] I'll dini Gill Swing Det Sivi							
•	[]	() o mig bed of d								
						Inpa	atient			
						Par		Р	art B	
					F	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Descripti	ion				F	1	2	3	4	-
	interim payments paid	to provider			_					+
2 Interin	m payments payable or	individual bills, either submitted or to be	submitted to the intermediary							+
for se	rvices rendered in the o	cost reporting period. If none, write "NON	E" or enter a zero							
3 List se	eparately each retroact	ve		Program to Provider	.01					+
lump	sum adjustment amour	t based		_	.02					+
on sul	bsequent revision of th	2			.03					\top
interir	m rate for the cost repo	rting period.			.04					+
Also s	show date of each payr	nent.			.05					+
If non	ne, write "NONE" or er	ter a zero. (1)		Provider to Program	.50					+
				_	.51					T
					.52					T
					.53					Т
					.54					T
		3.49 minus sum of lines 3.50-3.98)			.99					T
4 Total	interim payments (sum	of lines 1, 2, and 3.99)			_					Т
(trans	fer to Wkst. E or Wkst	. E-3, line								
and co	olumn as appropriate)									
	eparately each tentative			Program to Provider	.01					
	ent after desk review.	Also show			.02					
	of each payment.				.03					\perp
If non	ne, write "NONE" or er	iter a zero. (1)		Provider to Program	.50					
					.51					\perp
					.52					+
		5.49 minus sum of lines 5.50 -5.98)			.99					+
	mined net settlement a			Program to Provider	.01					\perp
	based on the cost report			Provider to Program	.02					+
	Medicare program liab	ulity (see instructions)								+
8 Name	e of Contractor					Contractor Number		NPR Date (Month/Da	y/Year)	

(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.

FORM CMS-2552-10

PERIOD:	WORKSHEET E-1,
FROM	PART I
то	

07-23		FORM CMS-2552-10		4090 (Cont.)
CALCULATIO	N OF REIMBURSEMENT	PROVIDE	R CCN: PERIOD:	WORKSHEET E-1,
SETTLEMENT	FOR HIT		FROM	PART II
		COMPONE	ENT CCN: TO	
Check	[] Hospital			

Oncen	[] Hopkin			
applicab	le []CAH			
box:				
HEALT	HINFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	1		
2	Medicare days (see instructions)	2		
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)			
4	Total inpatient days (see instructions)			
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	5		
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	6		
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	7		
8	Calculation of the HIT incentive payment (see instructions)			
9	Sequestration adjustment amount (see instructions)			
10	Calculation of the HIT incentive payment after sequestration (see instructions)	10		

INPATIENT HOSPITAL SERVICES UNDER THE IPPS &	CAH
INTATIENT HOST TIAL SERVICES ONDER THE ITTS G	. om

30	Initial/interim HIT payment(s).	30
31	Initial/interim HIT payment adjustments (see instructions)	31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	32

* This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may may complete this worksheet for a standard cost reporting period.

07-23

4090 (Cont.) CALCULATION OF REIMBURSEMENT

SETTLEMENT -	SWING BEDS
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PROVIDER CCN:	PERIOD:	WORKSHEET E-2
	FROM	
COMPONENT CCN:	TO	

Check	[] Title V	[] Swing-Bed SNF		
applicable	[] Title XVIII	[] Swing-Bed NF		
boxes:	[] Title XIX	[] PARHM CAH Swing-Bed SNF		
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COMPUTATION OF NET COST OF COVERED SERVICES 1 2 1 Inplater routice services - swing bed-NF (see instructions) 2 3 Ancillary services (from Wisk D-3, Co. 3, Line 200, for Part A; and sum of Wask. D, Pt. V, col. 6 and 7, line 200, for Part A; and sum of Wask. D, Pt. V, col. 6 and 7, line 200, for Part A; and sum of Wask. D, Pt. V, col. 6 and 7, line 200, for Part B) (For CAH and swing-bed pass-through, see instructions) 2 4 Per diem cost for interns and residents not in approved tackling program (see instructions) 2 2 5 Program days 2 2 6 Interns and residents not in approved tackling program (see instructions) 2 2 7 Utilization review - physica compensation - SNF optional method only. 2 2 10 Deductions review - physica compensation - SNF optional method only. 2 2 11 Deductions billed to program patterts (xeclude anounts applicable to physician professional services) 2 2 12 Subtoal (line 10 minus line 9) 1 2 2 2 13 Consume table to program patterts (xeclude anounts applicable to physician professional services) 2 1 14 80% of Part B costs (line 12 x 80%) 2 1 1			PART A	PART B	
1 Inputer notice service - swing bed-NF (see instructions) 3 Ancilary services (from Wist, D-3, on 3, line 200, for Part A; and ann of Wist, D, Pt, V, ocls, 6 and 7, line 200, for Part A; and scing-top-day services) Image: Control of Part B (for CA from A low Sing-body B, service) 30 Nursing and allied health payment-PAREM (see instructions) Image: Control of Part B (for CA from A low Sing-body B, service) 4 Per dire most for interns and residents not in approved tracking program (see instructions) Image: Control of Part B (for CA from CA low Sing-body B, service) 5 Ibitization review - physician componentsion : SNF optional method only Image: Control of Part B (for CA low B) (for CA l		COMBLITATION OF NET COST OF COVERED SERVICES	PARIA		4
2 Inpatient routine services - swing bed-NF (see instructions) 3 Actionary services (from Wisks DA, cot. 3, inite 200, for Part A; and sum of Wisk D, Pc V, cot. 5, and 7, line 200, for Part B) (for CAH and swing-bed pass-through, see instructions) Image: Control (CAH) 30 Nursing and line the baity portent PARIM (see instructions) Image: Control (CAH) Image: Control (CAH) 4 Per dem cost for interns and residents not in approved teaching program (see instructions) Image: Control (CAH) Image: Control (CAH) 6 Interns and residents not in approved teaching program (see instructions) Image: Control (CAH) Image: Control (CAH) 7 Utilization review - physician compersation - SNP optional method only Image: Control (CAH) Image: Control (CAH) 10 Deductible billed to program patients (ceclude anounts applicable to physician professional services) Image: Control (CAH) Image: Control (CAH) 11 Deductible billed to program patients (from provider records) (exclude consurance for physician professional services) Image: Control (CAH) Image: Control (CAH) 12 Subtoal (line 10 minus line 1) Image: Control (CAH) Image: Control (CAH) <td></td> <td></td> <td>1</td> <td>2</td> <td>1</td>			1	2	1
3 Ancillary services (from Wist. D.3, col. 3, ine 200, for Part A; and sum of Wist. D, Pt. V, col. 6: and 7, line 200, for Part B, 15 (or CAH and swinghed paiss-through, sei instructions) 301 Nursing and allied health payment-PAREIM (see instructions) 1 4 Per differencis for interpay and residents not in approved tracking program (see instructions) 1 5 Program days 1 6 Interna and residents not in approved tracking program (see instructions) 1 7 Utilization review - physician compensation - SNF optional method only 1 9 Primary payer payments (see instructions) 1 10 Storbul (sem of lines 1 Through 3 plan lines 6 and 7) 1 11 Deductibles hilled to program patients (conclust applicable to physician professional services) 1 12 Storbul (line 1 finning file) 1 13 Consurance billed to program patients (from provider records) (esclude coinsurance for physician professional services) 1 14 80% of Part B coss (find through a plan line services) 1 15 Storbul (see instructions) 1 16 Other adjuarment (see instructions) 1 17 Allowable bad debts (see instructions) 1 18 80% of Part B coss (find instructions) 1 19 80% of Part B coss (find instructions) 1 10 1 1 <t< td=""><td></td><td></td><td></td><td></td><td>2</td></t<>					2
cols. 6 and 7, Ine. 202, for Part BD, (For CAH and swing-bed pass-through, see instructions) Image: Cols. 6 and 7, Ine. 202, for Part BD, (For CAH and swing-bed pass-through, see instructions) Image: Cols. 6 and 7, Ine. 202, for Part BD, (For CAH and swing-bed pass-through, See instructions) Image: Cols. 7 and Part BD, (For CAH and Swing-Bed Part Part Part Part Part Part Part Part					3
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7 Utilization review - physician compensation - SNF optional method only Image: Subtool (sum of lines 1 through 3) [sub inse 6 and 7) 8 Subtool (sum of lines 1 through 3) [sub inse 6 and 7) Image: Subtool (line 8 minus line 9) 10 Bottool (line 8 minus line 5) Image: Subtool (line 10 minus line 11) 11 Deductibles billed to program patients (exclude amounts applicable to physician professional services) Image: Subtool (line 10 minus line 11) 12 Subtool (line 10 minus line 11) Image: Subtool (line 10 minus line 11) Image: Subtool (line 10 minus line 11) 13 Colinsurance billed to program patients (exclude coinsurance for physician professional services) Image: Subtool (line 10 minus line 11) 14 B0% of Part B costs (line 12 x 80%) Image: Subtool (line 10 minus line 11) Image: Subtool (line 10 minus line 11) 15 Subtool (gen instructions) Image: Subtool (line 10 minus line 11) Image: Subtool (line 10 minus line 11) 1655 Rural community hospital demonstration project (\$410A Demonstration) Image: Subtool (line 10 minus line 11) Image: Subtool (line 10 minus line (line sequestration on subtoot dual eligible beneficiarits (see instructions)	_				
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19.01 Sequestration adjustment (see instructions) 1 19.02 Demonstration payment adjustment amount after sequestration 1 19.03 Sequestration adjustment.PARHM pass-throughs 1 19.25 Sequestration for non-claims based amounts (see instructions) 1 20 Interim payments 2 1 20 Interim payments-PARHM 2 2 21 Tentative settlement (for contractor use only) 2 2 21.01 Tentative settlement.PARHM (for contractor use only) 2 2 22.01 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 2 22.01 Balance due provider/program.PARHM (see instructions) 2 2 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 2 20 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 2 2 201 Medicare swing-bed SNF inpatient noutine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-					19
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19.03 Sequestration adjustment-PARHM pass-throughs 1 19.25 Sequestration for non-claims based amounts (see instructions) 1 20 Interim payments 1 20.01 Interim payments-PARHM 2 21 Tentative settlement (for contractor use only) 2 21.01 Tentative settlement.PARHM (for contractor use only) 2 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 2 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 204 Medicare swing-bed SNF ischarges (see instructions) 2 203 Total (sum of Demonstration Target Amount Limit					19.02
19.25 Sequestration for non-claims based amounts (see instructions) 1 20 Interim payments 2 20.01 Interim payments-PARHM 2 21 Tentative settlement-PARHM (for contractor use only) 2 21.01 Tentative settlement-PARHM (for contractor use only) 2 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 2 Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 20 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 20 203 Total (sum of lines 201 and 202) 20 20 204 Medicare swing-bed SNF discharges (see instructions) 20 20					19.03
20 Interim payments					19.25
20.01 Interim payments-PARHM 2 21 Tentative settlement (for contractor use only) 2 21.01 Tentative settlement (for contractor use only) 2 22.101 Tentative settlement-PARHM (for contractor use only) 2 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 2 204 Medicare swing-bed SNF discharges (see instructions) 2 2 203 Computation of Demonstration (N/A in first year of the current 5-year demonstration period) 2 2					20
21 Tentative settlement (for contractor use only) 2 21.01 Tentative settlement-PARHM (for contractor use only) 2 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 2 Cost Reimbursement 2 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 204 Medicare Swing-bed SNF discharges (see instructions) 2 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 2					20.01
21.01 Tentative settlement-PARHM (for contractor use only) 2 22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 2 204 Medicare swing-bed SNF discharges (see instructions) 2 2 202 Otal (sum of lines 201 and 202) 2 2 203 Total (sum of lines Amount Limitation (N/A in first year of the current 5-year demonstration period) 2					
22 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 2 22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 23 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 2 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 2 Cost Reimbursement 20 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 204 Medicare swing-bed SNF discharges (see instructions) 2 203 Total (sum of lines 201 and 202) 2 204 Medicare swing-bed SNF discharges (see instructions) 2 205 2 2					21
22.01 Balance due provider/program-PARHM (see instructions) 2 23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Cost Reimbursement 201 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 2 Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 2 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 2 203 Total (sum of lines 201 and 202) 2 204 Medicare swing-bed SNF discharges (see instructions) 2 203 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 2					21.01
23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203 Total (sum of lines 201 and 202) 204 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					22
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203 Total (sum of lines 201 and 202) 204 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					22.01
200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 0 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 0 203 Total (sum of lines 201 and 202) 0 204 Medicare swing-bed SNF discharges (see instructions) 0 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 0	23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			23
200 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 0 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 0 203 Total (sum of lines 201 and 202) 0 204 Medicare swing-bed SNF discharges (see instructions) 0 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 0					
Cost Reimbursement 201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203 Total (sum of lines 201 and 202) 204 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
201 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) Image: Comparison of the service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) Image: Comparison of the service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203 Total (sum of lines 201 and 202) Image: Comparison of the service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) Image: Comparison compariso					200
202 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))					
203 Total (sum of lines 201 and 202) Image: Computation of Demonstration Computation of Demonstration Computation (N/A in first year of the current 5-year demonstration period)					201
204 Medicare swing-bed SNF discharges (see instructions) Image: Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)	202	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)	203	Total (sum of lines 201 and 202)			203
	204	Medicare swing-bed SNF discharges (see instructions)			204
205 Medicare swing bed SNE target amount		Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
200 Incucate Swing ocu Stat unget undulit	205	Medicare swing-bed SNF target amount			205
206 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)					206
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					<u> </u>
207 Program reimbursement under the §410A Demonstration (see instructions)					207
200 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)					208
200 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)					200
210 Reserved for future use					205
Comparison of PPS versus Cost Reimbursement					210
215 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)					215
The topological of Academic Swing of the payment (incless passing etc.) (Set instations)	213	Total equipment to Actuate 5 wing ord 5 or 110 payment (inte 200 plus inte 210) (see instructions)			

PERIOD: FROM ____

TO

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

1	Inpatient hospital services (see instructions)	1
1.01	Nursing and allied health managed care payment (see instructions)	1.01
2	Organ acquisition	2
3	Cost of physicians' services in a teaching hospital (see instructions)	3
4	Subtotal (sum of lines 1 through 3)	4
5	Primary payer payments	5
6	Subtotal (line 4 less line 5).	6
7	Deductibles	7
8	Subtotal (line 6 minus line 7)	8
9	Coinsurance	9
10	Subtotal (line 8 minus line 9)	10
11	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11
12	Adjusted reimbursable bad debts (see instructions)	12
13	Allowable bad debts for dual eligible beneficiaries (see instructions)	13
14	Subtotal (sum of lines 10 and 12)	14
15	Direct graduate medical education payments (from Wkst. E-4, line 49)	15
16	Other pass through costs (see instructions). DO NOT USE THIS LINE.	16
17	Other adjustments (specify) (see instructions)	17
	Pioneer ACO demonstration payment adjustment (see instructions)	17.50
17.99	Demonstration payment adjustment amount before sequestration	17.99
18	Total amount payable to the provider (see instructions)	18
18.01	Sequestration adjustment (see instructions)	18.01
18.02	Demonstration payment adjustment amount after sequestration	18.02
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program (line 18 minus lines 18.01, 18.02,19, and 20)	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	22

4090	(Cont.)	
4030	(Cont.)	

FORM CMS-2552-10

WORKSHEET E-3, PART II

CALCULATION OF REIMBURSEMENT SETTLEMENT

PERIOD:
FROM
то

Check [] Hospital applicable [] Subprovider IPF box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	
		1
	Net IPF PPS Outlier payment	2
	Net IPF PPS ECT payment	3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)	4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure,	4.01
	that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	
5	New teaching program adjustment (see instructions)	5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period	6
	of a "new teaching program" (see instructions)	
7	Current year unweighted I&R FTE count for residents within the new program growth period	7
	of a "new teaching program" (see instructions)	
	Intern and resident count for IPF PPS medical education adjustment (see instructions)	8
	Average daily census (see instructions)	9
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	10
	Teaching Adjustment (line 1 multiplied by line 10).	11
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3, and 11)	12
	Nursing and allied health managed care payment (see instructions)	13
14	Organ acquisition DO NOT USE THIS LINE	14
15	Cost of physicians' services in a teaching hospital (see instructions)	15
16	Subtotal (see instructions)	16
17	Primary payer payments	17
18	Subtotal (line 16 less line 17).	18
19	Deductibles	19
20	Subtotal (line 18 minus line 19)	20
21	Coinsurance	21
22	Subtotal (line 20 minus line 21)	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23
24	Adjusted reimbursable bad debts (see instructions)	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	25
	Subtotal (sum of lines 22 and 24)	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)	27
28	Other pass through costs (see instructions)	28
29	Outlier payments reconciliation	29
	Other adjustments (specify) (see instructions)	30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	30.50
	Demonstration payment adjustment amount before sequestration	30.99
	Total amount payable to the provider (see instructions)	31
	Sequestration adjustment (see instructions)	31.01
	Demonstration payment adjustment amount after sequestration	31.02
	Interim payments	32
	Tentative settlement (for contractor use only)	33
	Palance due provider/program (line 31 minus lines 31.01, 31.02, 32, and 33)	34
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	35
55	Treased anotano (non-movement contreport nemo) in accordance with Onto 1 do. 15 2, chapter 1, 3110.2	55

TO BE COMPLETED BY CONTRACTOR

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

04-20	FORM CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	

COMPONENT CCN: FROM _____

PROVIDER CCN:

PERIOD:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

	Net Federal PPS payment (see instructions)	
	Medicare SSI ratio (IRF PPS only) (see instructions)	
	Inpatient Rehabilitation LIP payments (see instructions)	
	Outlier payments	
	Unweighted intern and resident FTE count in the most recent cost reporting period ending	
	on or prior to November 15, 2004 (see instructions)	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital	5.0
	closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2)	
	New teaching program adjustment (see instructions)	
	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period	
	of a "new teaching program" (see instructions)	
	Current year unweighted I&R FTE count for residents within the new program growth period	
	of a "new teaching program" (see instructions)	
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	
	Average daily census (see instructions)	10
	Teaching Adjustment Factor (see instructions)	1
	Teaching Adjustment (see instructions)	12
	Total PPS Payment (see instructions)	13
	Nursing and allied health managed care payments (see instructions)	14
15	Organ acquisition DO NOT USE THIS LINE	1
16	Cost of physicians' services in a teaching hospital (see instructions)	1
17	Subtotal (see instructions)	1
18	Primary payer payments	18
19	Subtotal (line 17 less line 18)	19
20	Deductibles	20
21	Subtotal (line 19 minus line 20)	2
22	Coinsurance	2
23	Subtotal (line 21 minus line 22)	23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24
25	Adjusted reimbursable bad debts (see instructions)	2
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	2
27	Subtotal (sum of lines 23 and 25)	2
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)	2
29	Other pass through costs (see instructions)	29
30	Outlier payments reconciliation	3
31	Other adjustments (specify) (see instructions)	3
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	31.5
31.99	Demonstration payment adjustment amount before sequestration	31.9
32	Total amount payable to the provider (see instructions)	3
32.01	Sequestration adjustment (see instructions)	32.0
32.02	Demonstration payment adjustment amount after sequestration	32.0
33	Interim payments	3
34	Tentative settlement (for contractor use only)	3
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	3
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	3

 TO BE COMPLETED BY CONTRACTOR		
50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	50
51	Outlier reconciliation adjustment amount (see instructions)	51
52	The rate used to calculate the Time Value of Money (see instructions)	52
53	Time Value of Money (see instructions)	53

PERIOD: FROM ____

TO

WORKSHEET E-3, PART IV

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	1
1.01	Full standard payment amount	1.01
1.02	Short stay outlier standard payment amount	1.02
1.03	Site neutral payment amount - Cost	1.03
1.04	Site neutral payment amount - IPPS comparable	1.04
2	Outlier payments	2
3	Total PPS payments (sum of lines 1 and 2)	3
4	Nursing and allied health managed care payments (see instructions)	4
5	Organ acquisition DO NOT USE THIS LINE	5
6	Cost of physicians' services in a teaching hospital (see instructions)	6
7	Subtotal (see instructions)	7
8	Primary payer payments	8
9	Subtotal (line 7 less line 8)	9
10	Deductibles	10
11	Subtotal (line 9 minus line 10)	11
12	Coinsurance	12
13	Subtotal (line 11 minus line 12)	13
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14
15	Adjusted reimbursable bad debts (see instructions)	15
	Allowable bad debts for dual eligible beneficiaries (see instructions)	16
	Subtotal (sum of lines 13 and 15)	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)-	18
19	Other pass through costs (see instructions)	19
20	Outlier payments reconciliation	20
21	Other adjustments (specify) (see instructions)	21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	21.50
21.99	Demonstration payment adjustment amount before sequestration	21.99
	Total amount payable to the provider (see instructions)	22
22.01	Sequestration adjustment (see instructions)	22.01
22.02	Demonstration payment adjustment amount after sequestration	22.02
	r Pry	23
		24
	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23, and 24)	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	26

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3, PART V PROVIDER CCN: PERIOD: FROM то

Check applicable box:

[] Hospital [] PARHM Demonstration

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

1	Inpatient services	1
2	Nursing and allied health managed care payment (see instructions)	2
3	Organ acquisition	3
3.01		3.01
4	Subtotal (sum of lines 1 through 3.01)	4
5		5
6		6
	COMPUTATION OF LESSER OF COST OR CHARGES	
	Reasonable charges	
7	Routine service charges	7
8		8
9		9
10	Total reasonable charges	10
	Customary charges	
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis	11
12	Amounts that would have been realized from patients liable for payment for services on	12
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	13
14		14
15		15
16		16
17	Cost of physicians' services in a teaching hospital (see instructions)	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	Direct graduate medical education payments	18
19	Cost of covered services (sum of lines 6 and 17)	19
20	Deductibles (exclude professional component)	20
21	Excess reasonable cost (from line 16)	21
22	Subtotal (line 19 minus lines 20 and 21)	22
23	Coinsurance	23
24		24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25
26	Adjusted reimbursable bad debts (see instructions)	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	27
28		28
29	Other adjustments (specify) (see instructions)	29
29.50		29.50
29.99	Demonstration payment adjustment amount before sequestration	29.99
30	Subtotal (see instructions)	30
30.01	Sequestration adjustment (see instructions)	30.01
30.02	Demonstration payment adjustment amount after sequestration	30.02
30.03	Sequestration adjustment-PARHM	30.03
31		31
	Interim payments-PARHM	31.01
32	Tentative settlement (for contractor use only)	32
32.01		32.01
33		33
33.01		33.01
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	34

PERIOD:

FROM

TO

COMPONENT CCN.:

WORKSHEET E-3,

PART VI

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

	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)	
1	Resource Utilization Group (RUGS) payment	1
2	Routine service other pass through costs	2
3	Ancillary service other pass through costs	3
4	Subtotal (sum of lines 1 through 3)	4
	COMPUTATION OF NET COST OF COVERED SERVICES	
5	Medical and other services. Do not use this line. (see instructions)	5
6	Deductibles	6
7	Coinsurance	7
8	Allowable bad debts (see instructions)	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9
10	Adjusted reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	14.50
14.99	Demonstration payment adjustment amount before sequestration	14.99
15	Subtotal (see instructions)	15
15.01	Sequestration adjustment (see instructions)	15.01
15.02	Demonstration payment adjustment amount after sequestration	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	15.75
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

FORM CMS-2552-10

PERIOD:

FROM

PROVIDER CCN:

COMPONENT CCN.: TO

12-24 CALCULATION OF REIMBURSEMENT SETTLEMENT

Check	[] Title V	[] Hospital	[] NF	[] PPS	-	
applicable	[] Title XIX	[] Subprovider	[] ICF/IID	[] TEFRA		
boxes:		[] SNF		[] Other		

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

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

4090 (Cont.) FORM	CMS-2552-10				12-24
	GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRD	OUTPATIENT DIRECT MEDICAL			FROM	-	
	TION COSTS			TO	-	
Check	[] Title V [] Hospital		[] CAH-Based IPF			
applicab	le [] Title XVIII [] PARHM De	emonstration	[] CAH-Based IRF			
box:	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for c	cost reporting periods ending	g on or before Decembe	r 31, 1996		1
	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	1 01 0	,			1.01
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e	e) (see instructions)				2
	Rural track program FTE cap limitation adjustment after the cap-building wir	ndow closed under §127 of t	he CAA 2021 (see inst	ructions)		2.26
	Amount of reduction to Direct GME cap under §422 of MMA	CED 6440 50 () () (3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 for cost reporting periods straddling 7/1/2011)	CFR §413.79 (m). (see inst	ructions			3.01
3.02	for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural track FTE limitation	(s) for rural track programs	with a rural track Medic	are GMF		3.02
5.02	affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August	.,				5.02
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic pro-					4
	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost rep					4.01
	ACA §5506 number of additional direct GME FTE cap slots (see instruction		· · ·			4.02
	The amount of increase if the hospital was awarded FTE cap slots under §126 The amount of increase if the hospital was awarded FTE cap slots under §412					4.21 4.28
	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.			plus or minus		4.20
0	line 4, plus lines 4.01 through 4.28	is, minus mics s and storr, p	, in this of this time 5102,	pruo or minuo		5
6		he current year from your re	cords (see instructions)		6
7	Enter the lesser of line 5 or line 6					7
			Primary Care	Other	Total	
		6	1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program the current year	for				8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8	R times				9
5	the result of line 5 divided by the amount on line 6. For cost reporting periods beginning					5
	on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see in	nstructions.				
10	Weighted dental and podiatric resident FTE count for the current year					10
	Unweighted dental and podiatric resident FTE count for the current year					10.01
	Total weighted FTE count					11
12	Total weighted resident FTE count for the prior cost reporting year (see instr Total weighted resident FTE count for the penultimate cost reporting year (se					12
	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	ee ilisu.)				13
15						15
15.01	· · · ·					15.01
	Adjustment for residents displaced by program or hospital closure					16
16.01	Unweighted adjustment for residents displaced by program or hospital closur	e				16.01
	Adjusted rolling average FTE count			_		17
	Per resident amount Per resident amount under §131 of the CAA 2021					18 18.01
	Approved amount for resident costs					10.01
	Additional unweighted allopathic and osteopathic direct GME FTE resident c	cap slots received under 42 §	413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)	×.				21
22	· · · · · · · · · · · · · · · · · · ·					22
	Enter the locality adjustment national average per resident amount (see instru-	uctions)				23
24	1 5					24 25
25	Total direct Givie anount (sum of lines 19 and 24)	Inpatient Part A	Managed Care	Managed Care	Total	25
		inputient i ut i i	Prior to 1/1	On or after 1/1	Total	
	COMPUTATION OF PROGRAM PATIENT LOAD	1	2	2.01	3	
26	Inpatient days (see instructions)					26
	Total inpatient days (see instructions)					27
	Ratio of inpatient days to total inpatient days					28
	Program direct GME amount Percent reduction for MA DGME			+		29 29.01
	Reduction for direct GME payments for Medicare Advantage					30
	Net Program direct GME amount					31
-	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RAT	E - TITLE XVIII ONLY (N	URSING PROGRAM	AND	-	
	PARAMEDICAL EDUCATION COSTS)					
	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col)			32
	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of l Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	lines 74 and 94)				33 34
-	Medicare outpatient ESRD charges (see instructions)				+	34
	Medicare outpatient ESRD charges (see instructions)				1	36

FORM CMS-2552-10 (12-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4034)						
40-598				Rev. 23		
07-23	FORM CMS-2552-10			4090 (Cont.)		
DIRECT GRADUATE MEDICAL EDUCATION (GME)		PROVIDER CCN:	PERIOD:	WORKSHEET E-4		
& ESRD OUTPATIENT DIRECT MEDICAL			FROM			
		-	-			

EDUCA	TION COSTS			ТО			
Check	[] Title V	[] Hospital	[] CAH-Based IPF				
applicab	le [] Title XVIII	[] PARHM Demonstration	[] CAH-Based IRF				
box:	[] Title XIX						
	APPORTIONMENT OF MEDICARE REASONABLE CO	OST OF GME					
	Part A Reasonable Cost						
37	Reasonable cost (see instructions) 37						
38	Organ acquisition and HSCT acquisition costs (see instru-					38	
39	Cost of physicians' services in a teaching hospital (see ins	tructions)				39	
40	Primary payer payments (see instructions)					40	
41	Total Part A reasonable cost (sum of lines 37 through 39 r	ninus line 40)				41	
	Part B Reasonable Cost						
42	Reasonable cost (see instructions)					42	
43	Primary payer payments (see instructions)					43	
44	Total Part B reasonable cost (line 42 minus line 43)					44	
45	Total reasonable cost (sum of lines 41 and 44)					45	
46	Ratio of Part A reasonable cost to total reasonable cost (lin	,				46	
47	Ratio of Part B reasonable cost to total reasonable cost (lin	,				47	
	ALLOCATION OF MEDICARE DIRECT GME COSTS	BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)					48	
49	Part A Medicare GME payment (line 46 x 48) (title XVII					49	
50	Part B Medicare GME payment (line 47 x 48) (title XVII	only) (see instructions)				50	

(Cont.) FORM CMS-2552-10				07-23	
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-5	
			FROM		
			то		
TO BE COMPLETED BY CONTRACTOR					
1 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)					1
2 Capital outlier from Wkst. L, Pt. I, line 2					2
3 Operating outlier reconciliation adjustment amount (see instructions)					3
4 Capital outlier reconciliation adjustment amount (see instructions)					4
5 The rate used to calculate the time value of money (see instructions)					5
6 Time value of money for operating expenses (see instructions)	6 Time value of money for operating expenses (see instructions)				6
7 Time value of money for capital related expenses (see instructions)					7

PAYMENT ADJUSTMENT FOR ESTABLISHING AND MAINTAINING ACCESS TO	PROVIDER CCN:	PERIOD:	WORKSHEET E-90			
A BUFFER STOCK OF ESSENTIAL MEDICINES		FROM:				
A BOTTER STOCK OF ECOEMTINE MEDICINED		TO:				
PART I - ADDITIONAL RESOURCE COST OF ESSENTIAL MEDICINES						
1 COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - DIR	ECTLY INCURRED			1		
2 COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - CONTRACT						
3 TOTAL COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINI	S			3		
PART II - CALCULATION OF MEDICARE PAYMENT ADJUSTMENT FOR ESSENTIAL MEDIC	TINES					
1 MEDICARE ROUTINE/ANCILLARY COST				1		
2 MEDICARE ACQUISITION COST				2		
3 COST OF PHYSICIANS' SERVICES IN A TEACHING HOSPITAL				3		
4 TOTAL MEDICARE REASONABLE COST				4		
5 TOTAL FACILITY COST				5		
6 MEDICARE PERCENTAGE				6		
7 ESSENTIAL MEDICINES PAYMENT ADJUSTMENT				7		

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PAYMENT ADJUSTMENTS FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS			PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-95	
SURGICAL 195 RESPIRATORS				TO		
				10		
PART I - DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS PAYMEN	T ADJUSTMENT ELIC	GIBILITY AND DATA				
				DOMESTIC	NON-DOMESTIC	1
				RESPIRATORS	RESPIRATORS	
				1	2	-
1 Did the hospital or hospital healthcare complex purchase domestic (column 1)) or non-domestic (colu	mn 2) respirators? En	ter "Y" for yes or			
"N" for no in each column. If "Y" for either column, complete line 2.						
				•		
		DOMESTIC	RESPIRATORS	NON-DOMEST	IC RESPIRATORS	
		TOTAL	NUMBER	TOTAL	NUMBER	1
		COST	PURCHASED	COST	PURCHASED	
		1	2	3	4	
2 Enter the total cost of domestic respirators purchased in column 1 and the nur	nber of domestic					
respirators purchased in column 2.						
Enter the total cost of non-domestic respirators purchased in column 3 and the	e number of					
non-domestic respirators purchased in column 4.						
PART II - CALCULATION OF COST DIFFERENTIAL FOR DOMESTIC NIOSH-APP	ROVED SURGICAL N	95 RESPIRATORS	-			
			DOMESTIC	NON-DOMESTIC	COST	
			RESPIRATORS	RESPIRATORS	DIFFERENTIAL	
			1	2	3	
1 Total cost of NIOSH-approved surgical N95 respirators purchased						
2 Number of NIOSH-approved surgical N95 respirators purchased						
3 Average cost per respirator						
4 Hospital-specific unit cost differential for domestic respirators						
5 Total cost differential for domestic respirators						
PART III - CALCULATION OF PAYMENT ADJUSTMENT FOR DOMESTIC NIOSH-	APPROVED SURGICA	AL N95 RESPIRATORS		1	-T	
			IPF	IRF		
	HOSPITAL	HOSPITAL	SUBPROVIDER	SUBPROVIDER		
	PART A	PART B	PART B	PART B	TOTAL	_
	1	2	3	4	5	
1 Medicare routine/ancillary costs						
1.01 Medicare acquisition costs						1.0
1.02 Cost of physicians' services in a teaching hospital						1.0
1.15 Total Medicare reasonable costs						1.1
2 Total facility costs						
3 Medicare percentage						
A Demostic NIOSU approved surgical NOE respirators asymptote adjustment	1	1	1	1	1	

4090 (Cont.)	FORM CMS-255	2-10			DRAFT
BALAN	CE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you a	re nonproprietary and do not maintain fund-type			FROM	_	
accounti	ng records, complete the General Fund column only)			то	_	
			Specific			
		General	Purpose	Endowment	Plant	
	Assets	Fund	Fund	Fund	Fund	
	(Omit cents)	1	2	3	4	
	CURRENT ASSETS	•	•			
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Allowances for uncollectible notes and					6
	accounts receivable					
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10						10
11	Total current assets (sum of lines 1 through 10)					11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15						15
16						16
17						17
18						18
19	Fixed equipment					19
20						20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23						23
24						24
25						25
26	Accumulated depreciation					26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12 through 29)					30
	OTHER ASSETS				-	
-	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34						34
35	Total other assets (sum of lines 31 through 34)					35
36	Total assets (sum of lines 11, 30, and 35)					36

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4040)

40-600				Rev. XX
10-12	FORM CMS-2552-10			4090 (Cont.)
BALANCE SHEET	PROVIDE	ER CCN: F	PERIOD:	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		F	FROM	(CONT.)

counting records, complete the C	nting records, complete the General Fund column only)			то		
			Specific			
Liabilities and Fund		General	Purpose	Endowment	Plant	
Balances		Fund	Fund	Fund	Fund	_
(Omit cents)		1	2	3	4	
CURRENT LIABILITIES		1				
37 Accounts payable						
38 Salaries, wages, and fees	payable					
39 Payroll taxes payable						
40 Notes and loans payable	(short term)					
41 Deferred income						
42 Accelerated payments						
43 Due to other funds						
44 Other current liabilities						
45 Total current liabilities (s	sum of					
lines 37 thru 44)						
LONG TERM LIABILITIE	5					
46 Mortgage payable						
47 Notes payable						
48 Unsecured loans						
49 Other long term liabilitie	s					
50 Total long term liabilities						
lines 46 thru 49)	(
51 Total liabilities (sum of l	ines 45 and 50)					
				1 1		
CAPITAL ACCOUNTS 52 General fund balance						
53 Specific purpose fund						_
53 Specific purpose fund 54 Donor created - endowm						
balance - restricted	ent iunu					
55 Donor created - endowm						
	ent rund					
balance - unrestricted						
56 Governing body created	- endowment					
fund balance						
57 Plant fund balance - inve						_
58 Plant fund balance - rese						
improvement, replaceme						
59 Total fund balances (sum						
60 Total liabilities and fund	balances (sum of					
lines 51 and 59)						

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

01-22	FORM CMS-2552-10		4090 (Cont.)
STATEMENT OF PATIENT REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-2,
AND OPERATING EXPENSES		FROM	PARTS I & II
		TO	

PART I - PATIENT REVENUES

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

PART II - OPERATING EXPENSES

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

_

4090 (Cont.)	FORM CMS-2552-10 (01-22
STATEMENT OF REVENUES	PROVIDER CCN: PERIOD: WORKSHEET G-3	
AND EXPENSES	FROM	
	то	

Description

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

OTHER INCOME

6	Contributions, donations, bequests, etc.	6
7	Income from investments	7
8	Revenues from telephone and other miscellaneous communication services	8
9	Revenue from television and radio service	9
10	Purchase discounts	10
11	Rebates and refunds of expenses	11
12	Parking lot receipts	12
	Revenue from laundry and linen service	13
14	Revenue from meals sold to employees and guests	14
	Revenue from rental of living quarters	15
16	Revenue from sale of medical and surgical supplies to other than patients	16
17	Revenue from sale of drugs to other than patients	17
18	Revenue from sale of medical records and abstracts	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)	19
20	Revenue from gifts, flowers, coffee shops, and canteen	20
21	Rental of vending machines	21
22	Rental of hospital space	22
23	Governmental appropriations	23
24	Other (specify)	24
24.50	COVID-19 PHE Funding	24.50
25	Total other income (sum of lines 6-24)	25
26	Total (line 5 plus line 25)	26
27	Other expenses (specify)	27
28	Total other expenses (sum of line 27 and subscripts)	28
29	Net income (or loss) for the period (line 26 minus line 28)	29

11-16				FO	RM CMS-2552	2-10					4090 (Cont.)
ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS								PROVIDER CCN:	PERIOD: FROM TO		RKSHEET H	<u> </u>
COST CENTER DE: (omit cen		SALARIES	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (see instructions) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS	TOTAL (sum of cols. 1 thru 5) 6	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9) 10	
GENERAL SERVICE COST	CENTERS			-								
1 Capital Related-Bldgs. and F												1
2 Capital Related-Movable Equ	uipment											2
3 Plant Operation & Maintenar												3
4 Transportation (see instructio	ons)											4
5 Administrative and General												5
HHA REIMBURSABLE SEI	RVICES											
6 Skilled Nursing Care												6
7 Physical Therapy												7
8 Occupational Therapy												8
9 Speech Pathology												9
10 Medical Social Services												10
11 Home Health Aide												11
12 Supplies (see instructions)												12
13 Drugs												13
14 DME												14
HHA NONREIMBURSABL	E SERVICES											
15 Home Dialysis Aide Services	3											15
16 Respiratory Therapy												16
17 Private Duty Nursing												17
18 Clinic												18
19 Health Promotion Activities												19
20 Day Care Program												20
21 Home Delivered Meals Progr	ram											21
22 Homemaker Service												22
23 All Others												23
24 Total (sum of lines 1 through	23)											24

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

4090 (Cont.)	FORM CMS-2552-10										
COST ALLOCATION - HHA GENERAL SERVICE COST										WORKSHEET H-1 PART I	
	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)		PITAL ED COSTS MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRAN PORTAT	-	SUBTOTA (cols. 0-4	L	ADMINIS- TRATIVE GENERAL	TOTAL (cols. 4a + 5)	
	0	1	2	3	4		4a	, <u> </u>	5	6	
GENERAL SERVICE COST CENTERS	Ű	-	-	5			iu.		5		
1 Capital Related-Bldgs. and Fixtures											1
2 Capital Related-Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General											5
HHA REIMBURSABLE SERVICES											
6 Skilled Nursing Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech Pathology											9
10 Medical Social Services											10
11 Home Health Aide											11
12 Supplies (see instructions)											12
13 Drugs											13
14 DME											14
HHA NONREIMBURSABLE SERVICES											
15 Home Dialysis Aide Services											15
16 Respiratory Therapy											16
17 Private Duty Nursing											17
18 Clinic											18
19 Health Promotion Activities											19
20 Day Care Program											20
21 Home Delivered Meals Program											21
22 Homemaker Service											22
23 All Others											23
24 Totals (sum of lines 1 through 23)											24

09-13	FORM CMS-2552		4090 (Cont.)				
COST ALLOCATION - HHA STATISTICAL BASIS			PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-1, PART II		
		PITAL ED COSTS EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATION & MAINTENANCE (SQUARE FEET) 3	TRANS- PORTATION (MILEAGE) 4	RECONCIL- IATION 5a	ADMINIS- TRATIVE & GENERAL (ACCUM. COST) 5	
GENERAL SERVICE COST CENTERS							
1 Capital Related-Bldgs. and Fixtures							1
2 Capital Related-Movable Equipment							2
3 Plant Operation & Maintenance							3
4 Transportation (see instructions)							4
5 Administrative and General							5
HHA REIMBURSABLE SERVICES							
6 Skilled Nursing Care							6
7 Physical Therapy							7
8 Occupational Therapy							8
9 Speech Pathology							9
10 Medical Social Services							10
11 Home Health Aide							11
12 Supplies (see instructions)							12
13 Drugs							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 Home Dialysis Aide Services							15
16 Respiratory Therapy							16
17 Private Duty Nursing							17
18 Clinic							18
19 Health Promotion Activities							19
20 Day Care Program							20
21 Home Delivered Meals Program							21
22 Homemaker Service							22
23 All Others							23
24 Total (sum of lines 1-23)							24
25 Cost To Be Allocated (per Worksheet H-1, Part I)							25
26 Unit Cost Multiplier							26

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

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

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

01-22							4090 ((Cont.)					
	ATION OF GENERAL SERVICE TO HHA COST CENTERS									PROVIDER CCN:	PERIOD: FROM TO		<u> </u>
		1	1	1									
	HHA COST CENTER (omit cents)	HOUSE			MAIN- TENANCE OF	NURSING ADMINIS-	CENTRAL SERVICES &		MEDICAL RECORDS &	SOCIAL	OTHER GENERAL	NON- PHYSICIAN ANES-	
		KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	SERVICE	THETISTS	1
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
	Skilled Nursing Care												2
	Physical Therapy												3
	Occupational Therapy												4
	Speech Pathology												5
	Medical Social Services												6
	Home Health Aide												7
	Supplies												8
	Drugs												9
-	DME												10
	Home Dialysis Aide Services												11
	Respiratory Therapy												12
	Private Duty Nursing												13
	Clinic												14
	Health Promotion Activities												15
	Day Care Program												16
	Home Delivered Meals Program												17
	Homemaker Service												18
	All Others												19
	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1, div												21
	line 20, minus column 26, line 1, rounded	to 6 decimal places											L

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

4090 (Cont.)			F	ORM CMS-2552-	10					01-22
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS							PROVIDER CCN: 	PERIOD: FROM TO	WORKSHEET H-2, PART I	
HHA COST CENTER (omit cents)	NURSING PROGRAM 20	INTERNS & SALARY AND FRINGES 21	RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL (sum of cols. 4a-23) 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	SUBTOTAL (cols. 23 ± 24) 26	ALLOCATED HHA A&G (see Part II) 27	TOTAL HHA COSTS 28	
1 Administrative and General				20					20	1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Home Health Aide										7
8 Supplies										8
9 Drugs										9
10 DME										10
11 Home Dialysis Aide Services										11
12 Respiratory Therapy										12
13 Private Duty Nursing										13
14 Clinic										14
15 Health Promotion Activities										15
16 Day Care Program										16
17 Home Delivered Meals Program										17
18 Homemaker Service										18
19 All Others										19
20 Totals (sum of lines 1-19) (2)										20
21 Unit Cost Multiplier: column 26, line 1, line 20, minus column 26, line 1, rounde		mn 26,								21

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

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

4090 (Cont.)			F	ORM CMS-2552	-10					09-13
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS							PROVIDER CCN: 	PERIOD: FROM TO	WORKSHEET H-2, PART II (CONT.)	
HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Home Health Aide										7
8 Supplies										8
9 Drugs										9
10 DME										10
11 Home Dialysis Aide Services										11
12 Respiratory Therapy										12
13 Private Duty Nursing										13
14 Clinic										14
15 Health Promotion Activities										15
16 Day Care Program										16
17 Home Delivered Meals Program										17
18 Homemaker Service										18
19 All Others										19
20 Totals (sum of lines 1-19)										20
21 Total cost to be allocated										21
22 Unit Cost Multiplier										22

01-22		FC	ORM CMS-2552-	-10				4090	(Cont.)
COSTS	ATION OF GENERAL SERVICE TO HHA COST CENTERS TICAL BASIS					PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-2, PART II (CONT.)	<u> </u>
	HHA COST CENTER	SOCIAL SERVICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME) 19	NURSING PROGRAM (ASSIGNED TIME) 20	INTERNS SALARY & FRINGES (ASSIGNED TIME) 21	& RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
	Drugs								9
	DME								10
	Home Dialysis Aide Services								11
	Respiratory Therapy								12
	Private Duty Nursing								13
	Clinic								14
	Health Promotion Activities								15
	Day Care Program								16
	Home Delivered Meals Program								17
	Homemaker Service								18
	All Others						_		19
	Totals (sum of lines 1-19)								20
	Total cost to be allocated								21
22	Unit Cost Multiplier								22

4090 (Cont.) APPORTIONMENT OF PATIENT SERVICE COSTS

FORM CMS-2552-10

01-22

Check applicable box: [] Title V [] Title XVIII [] Title XIX

PROVIDER CCN: PERIOD: FROM_ HHA CCN: TO

WORKSHEET H-3, Parts I & II

Check applicable box.		[] I luc

PART I - COMPUTATION OF THE AGGREGATE PROGE	RAM COST

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

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

Supplies	plies and Drugs Cost Program Covered Charges Cost of Services													
Computa	tions								Par	t B		Pai	rt B	
			Facility	Shared					Not Subject		1	Not Subject		
		From	Costs	Ancillary		Total			to	Subject to		to	Subject to	
		Wkst. H-2	(from	Costs	Total	Charges	Ratio		Deductibles	Deductibles		Deductibles	Deductibles	
		Part I,	Wkst. H-2,	(from	HHA Costs	(from HHA	(col. 3		&	&		&	&	
	Other Patient Services	col. 28,	Part I)	Part II)	(cols. 1 + 2)	Records)	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	
		line	1	2	3	4	5	6	7	8	9	10	11	
15	Cost of Medical Supplies	8												15
16	Cost of Drugs	9												16

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

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

12-22			FORM CMS-2	552-10		4090 (Cont.)
CALCULATION OF HHA	REIMBURSEMENT			PROVIDER CCN:	PERIOD:	WORKSHEET H-4,
SETTLEMENT					FROM	Parts I & II
				HHA CCN:	то	
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX	•	*	

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Allowable bad debts (from your records)			27
27.01	Adjusted reimbursable bad debts (see instructions)			27.01
28	Allowable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (see instructions)			29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
30.99	Demonstration payment adjustment amount before sequestration			30.99
	Subtotal (see instructions)			31
31.01	Sequestration adjustment (see instructions)			31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)			31.75
32	Interim payments (see instructions)			32
	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			35

4090 (Cont.)	FORM (CMS	-2552-10				12-22
ANALY	SIS OF PAYMENTS TO HOSPITAL-				PROVIDER CCN:	PERIOD:	WORKSHEET H-5	
BASED	HHAs FOR SERVICES					FROM		
RENDE	RED TO PROGRAM BENEFICIARIES				HHA CCN:	то		
							1	
				Pa	rt A	Pa	irt B	
	Description			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills eit	her submitted or						2
	to be submitted to the intermediary for services	rendered in the						
	cost reporting period. If none, write "NONE" of	r enter a zero.						
3	List separately each retroactive lump sum	Program	.01					3.01
	adjustment amount based on subsequent revision	to	.02					3.02
	of the interim rate for the cost reporting period.	Provider	.03					3.03
	Also show date of each payment. If none, write		.04					3.04
	"NONE" or enter a zero.(1)		.05					3.05
		Provider	.50					3.50
		to	.51					3.51
		Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum							

.99

TO BE COMPLETED BY INTERMEDIARY

Total interim payments (sum of lines 1, 2, and 3.99)

(transfer to Wkst. H-4, Part II, column as appropriate, line 32)

of lines 3.50-3.98)

4

5	List separately each tentative settlement paymen	Program	.01			5.
	after desk review. Also show date of each	to	.02			5.
	payment. If none, write "NONE" or enter	Provider	.03			5.
	a zero. (1)	Provider	.50			5.
		to	.51			5.
		Program	.52			5.
	Subtotal (sum of lines 5.01-5.49 minus sum					
	of lines 5.50-5.98)		.99			5.
6	Determine net settlement amount (balance due)	Program				
	based on the cost report (see instructions)	to	.01			
		Provider				6.
		Provider				
		to	.02			
		Program				6.
7	TOTAL MEDICARE PROGRAM LIABILITY					
	(see instructions)					
8	Name of Contractor	Contractor Number		NPR Date: Month, Day	y, Year	

(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.

3.99

4

12-24			FC	ORM CMS-255	2-10		4090	(Cont.)
ANALY	SIS OF RENAL D	IALYSIS DEPARTMENT COSTS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-1	
Check a	pplicable box:	[] Renal Dialysis Department	[] Home Program	Dialvsis			-	
	I			TOTAL			FTEs per	T
				COSTS	BASIS	STATISTICS	2080 Hours	
				1	2	3	4	-
1	Registered Nurses				Hours of Service			1
2	Licensed Practical				Hours of Service			2
3	Nurses Aides				Hours of Service			3
4	Technicians				Hours of Service			4
5	Social Workers				Hours of Service			5
6	Dieticians				Hours of Service			6
7	Physicians				Accumulated Cost			7
8	Non-patient Care	Salarv			Accumulated Cost			8
	Subtotal (sum of 1							9
10	Employee Benefit	s			Salary			10
		osts-Bldgs. & Fixtures			Square Feet			11
	Capital Related Co				Percentage of Time			12
	Machine Costs &				Percentage of Time			13
	Supplies	I			Requisitions			14
14.01	Pediatric Medical	Supplies			Requisitions			14.01
15	Drugs	TT			Requisitions			15
16					Accumulated Cost			16
17	Subtotal (sum of 1	ines 9-16)*						17
18	Capital Related Co	osts-Bldgs. & Fixtures			Square Feet			18
	Capital Related Co				Percentage of Time			19
20	Employee Benefit	s Department			Salary			20
21	Administrative an	d General			Accumulated Cost			21
22	Maint./Repairs-Or	peration-Housekeeping			Square Feet			22
23	<u> </u>				- 1			23
24	Central Services &				Requisitions			24
25		11			Requisitions			25
26	Other Allocated C	losts			Accumulated Cost			26
27	Subtotal (sum of 1							27
28	Laboratory (see in	<i>,</i>			Charges			28
		py (see instructions)			Charges			29
30	1 V				Charges			30
31	Total costs (sum o							31

* Line 17, column 1, should agree with Worksheet A, column 7 for line 74 or line 94, as appropriate, and line 27, column 1, should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94, as appropriate.

ALL/CANCOR DRAM. IDEALMENT MODALTING DEC. PAIL OF <	4090 (Cont.)				FOR	M CMS-255	2-10							12-24
Onck applicable bit: I plead bays: I	ALLOC	ATION OF RENAL DEPARTMENT CO	STS TO TREAT	MENT MODALIT	IES							PROVIDER CCN:	FROM	WORKSHEET I-2	
OUTBATIENT SERVICES CMPTLA AND ELATES COTS DIRECT PATIENT CARE SALARY ENPLOYER BINETISS PEDIATING MEDICAN BINETISS SUBTOTAL SUBTOTAL United MEDICANS TOTAL (u.g. 1) TOTAL (u.g. 2) 1 DULIDAG 1 2 3 4 5 6 7 7.0 8 3 0 1 (u.g. 3) 1 DULIDAG 1 2 3 4 5 6 7 7.0 8 3 0 1													ТО	_	
CMMUNTAIN CMPIL NIRCT ALTINT DIRCT ALTINT			is Department	[] Home Progr	am Dialysis				1	1	1	1	-	-	
Image: Norme: CARE SUMP RUMPN RUM			CAPIT	AL AND	DIRECT	PATIENT	EMPLOYEE			PEDIATRIC	ROUTINE	SUBTOTAL		TOTAL	
I has been parametan in a second se			RELATE	D COSTS	CARE S	ALARY	BENEFITS		MEDICAL	MEDICAL	ANCILLARY	(sum of		(col. 9 +	
			BUILDING	EQUIPMENT			DEPARTMENT	DRUGS					OVERHEAD		
MINTLAAKE International Internat			1		3	4	5	6	7	7.01	8		10	11	1
2 Henodalayis Image	1	Total Renal Department Costs													1
201 AK14benolalysis-Nedaric 201 201 201 201 Incenditor Periods 201 201 301 AK14benolalysis-Nedaric 201 201 301 AK14benolalysis-Nedaric 201 201 301 AK14benolalysis 201 201 401 Hendulysis-Polaric 201 201 401 Hendulysis-Polaric 201 201 501 IP0-Polaric 201 201 201 501 IP0-Polaric 201 201 201 501 IP0-Polaric 201 201 201 502 IP0-Polaric 201 201 201 501 IP0-Polaric 201 201 201 502 IP0-Polaric 201 201 201 503 IP0-Polaric 201 201 201 504 IP0-Polaric 201 201 201 504 IP0-Polaric 201 201		MAINTENANCE													
212 Hendulysis-Peduric Image: hermine reviewed Image: hermi	2	Hemodialysis													2
31 Identified Periods	2.01	AKI-Hemodialysis													
301 AK-Jatermitori Perional AK-Jatermitori Perional AK-Jatermitori Perional AK-Jatermitori Perional 312 PD-Perional AK-Jatermitori Perional A 44 Henodialysis-KKI A A 401 Henodialysis-KKI A A 42 Henodialysis-KKI A A 51 IPD-Perional A A 51 IPD-Perional B B B B B B A A 510 IPD-Perional B	2.02	Hemodialysis-Pediatric													2.02
332 IPD-Polaric IPD-Polaric <t< td=""><td>3</td><td>Intermittent Peritoneal</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>3</td></t<>	3	Intermittent Peritoneal													3
TRAINING Image: state of the	3.01	AKI-Intermittent Peritoneal													3.01
41 Henodalysis-Mataria International systematica Internatex Internati	3.02	IPD-Pediatric													3.02
401 Henodalysis-MX Image: Constraint of the second se		TRAINING													
442 Hemodalysis-Akl Image Image </td <td>4</td> <td>Hemodialysis</td> <td></td> <td>4</td>	4	Hemodialysis													4
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	4.01	Hemodialysis-Pediatric													4.01
501 IPD-Pediaric IM IM <td>4.02</td> <td>Hemodialysis-AKI</td> <td></td> <td>4.02</td>	4.02	Hemodialysis-AKI													4.02
502 IPD-AKI IM	5	Intermittent Peritoneal													5
6 CAPD Image: CAPD-Padaric Image: CAPD-Padaric <t< td=""><td>5.01</td><td>IPD-Pediatric</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>5.01</td></t<>	5.01	IPD-Pediatric													5.01
6.01 CAPD-Pediatric Image: CAPD-AKI Image: CAPD-	5.02	IPD-AKI													5.02
6.02 CAPb-AKI Image: constraint of the second	6	CAPD													6
7 CCPD Image: CPD-Pediatric Image: CPD-Akit	6.01	CAPD-Pediatric													6.01
7 CCPD Image: CPD-Pediatric Image: CPD-Akit	6.02	CAPD-AKI													6.02
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	7	CCPD													7
HOME Image: Marking in the state of the sta	7.01	CCPD-Pediatric													7.01
HOME Image: Marking in the state of the sta	7.02	CCPD-AKI													7.02
801 Henodialysis-Pediatric Image: Section of the sectin of the sectin of the sectin of the section of the sect		HOME													
8.02 Hemodialysis-AKI Image: Constraint Peritoneal Image: Constraintence Image: Constraint Peritoneal	8	Hemodialysis													8
9Internitent Peritoneal111 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>															
9Internitent Peritoneal111 <th< td=""><td>8.02</td><td>Hemodialysis-AKI</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8.02</td></th<>	8.02	Hemodialysis-AKI													8.02
9.02 IPD-AKI Image: construction of the set of th															
9.02 IPD-AKI Image: construction of the set of th	9.01	IPD-Pediatric													9.01
10 CAPD Image: CAPD-Pediatric Image: CAPD-Pediatric Image: CAPD-Pediatric Image: CAPD-AKI Image:	9.02	IPD-AKI													
10.01CAPD-PediatricImage: CAPD-AKIImage: CAPD-AKII															
10.02CAPD-AKIImage: Construction of the set															
11 CCPD Image: CPD - Pediatric Image: CPD - AKI															10.02
11.01 CCPD-Pediatric Image: Comparison of the system															
11.02 CCPD-AKI Image: CCPD-AKI </td <td></td> <td></td> <td>1</td> <td></td>			1												
OTHER BILLABLE SERVICES Image: Construction of the service of the															
12 Inpatient Dialysis Image: Construction of the system of the syst															<u> </u>
13 Method II Home Patient Image: Constraint of the system of the sy	12														12
14 ESAs (included in Renal Department) Image: Construction of the system of the s															
15 ARANESP (see instructions) Image: construction of the set	14	ESAs (included in Renal Department)													
16 Other Image: Constraint of the set of t	15	ARANESP (see instructions)													
17 Total (sum of lines 2 through 16) Image: Constant of the system of t															
18 Medical Educational Program Costs 0 0 0 0 0 18									1						

Rev. 23

12-24				FOR	M CMS-25	52-10						4090	(Cont.)
	` AND INDIRECT RENAL DIALYSIS COST ALI TICAL BASIS	LOCATION -								PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-3	
Check a	oplicable box: [] Renal Dialysis Departmen	nt []Hom	Program Dialysi								10	-	
Check a	[] Kellai Dialysis Departitier		AL AND	\$ 							1		T
			D COSTS EQUIPMENT	DIRECT CARE S		EMPLOYEE BENEFITS		MEDICAL	PEDIATRIC MEDICAL	ROUTINE ANCILLARY		OVERHEAD	
	COMPOSITE PAYMENT SERVICES	(SQUARE FEET)	(% OF TIME)	RNs (HOURS)	OTHERS (HOURS) 4	DEPARTMENT (SALARY)	DRUGS (REQUIST.)	SUPPLIES (REQUIST.) 7	SUPPLIES (REQUIST.)	SERVICES (CHARGES)	SUB- TOTAL	(ACCUM. COST)	_
1	Total Renal Department Costs	1	2	3	4	5	6	/	7.01	8	9	10	1
1	MAINTENANCE												<u> </u>
	Hemodialysis												2
	AKI-Hemodialysis												2.01
	Hemodialysis-Pediatric												2.01
	Intermittent Peritoneal												3
	AKI- Intermittent Peritoneal												3.01
	IPD-Pediatric												3.01
3.02													3.02
<u> </u>	TRAINING												<u> </u>
	Hemodialysis												4
	Hemodialysis-Pediatric												4.01
	Hemodialysis-AKI												4.02
	Intermittent Peritoneal												5
	IPD-Pediatric												5.01
	IPD-AKI												5.02
	CAPD												6
	CAPD-Pediatric												6.01
	CAPD-AKI												6.02
	CCPD												7
	CCPD-Pediatric												7.01
7.02	CCPD-AKI												7.02
	HOME												
8	Hemodialysis												8
	Hemodialysis-Pediatric												8.01
8.02	Hemodialysis-AKI												8.02
	Intermittent Peritoneal												9
	IPD-Pediatric												9.01
9.02	IPD-AKI												9.02
10	CAPD												10
10.01	CAPD-Pediatric												10.01
10.02	CAPD-AKI												10.02
11	CCPD	1											11
	CCPD-Pediatric	1											11.01
	CCPD-AKI												11.02
	OTHER BILLABLE SERVICES												
12	Inpatient Dialysis Treatments												12
	Method II Home Patient												13
	ESAs												14
	ARANESP (see instructions)												15
	Other												16
	Total Statistical Basis												17
	Unit Cost Multiplier (line 1 ÷ line 17)												18
	our cost multiplet (line 1 · line 1/)												1 10

4090 (Cont.)				FOR	M CMS-25	52-10								12-24
COMPUTATION OF AVERAGE COST PER TREATMENT									PROVIDER C	CN:	PERIOD:		WORKSHEET	I-4
FOR OUTPATIENT RENAL DIALYSIS											FROM			
											то			
Check applicable box: [] Renal Dialysis Department	[] Home Progra	m Dialysis												
		ý	Average Cost				Total				Average			
		Total Cost	of				Program				Payment	Average	Average	
	Number	(from	Treatments	Number	Number	Number	Expenses	Total	Total	Total	Rate	Payment Rate	Payment Rate	
	of Total	Wkst. I-2,	(col. 2 ÷	of Program	of Program	of Program	(see	Program	Program	Program	(col. 6 ÷	(col. 6.01 ÷	(col. 6.02 ÷	
	Treatments	col. 11)	col. 1)	Treatments	Treatments	Treatments	instructions)	Payment	Payment	Payment	col. 4)	col. 4.01)	col. 4.02)	
	1	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	
1 Maintenance - Hemodialysis														1
1.01 Maintenance - AKI Hemodialysis														1.01
2 Maintenance - Peritoneal Dialysis														2
2.01 Maintenance - AKI Peritoneal Dialysis														2.01
3 Training - Hemodialysis														3
3.01 Training - AKI Hemodialysis														3.01
4 Training - Peritoneal Dialysis														4
4.01 Training - AKI Peritoneal Dialysis														4.01
5 Training - CAPD														5
5.01 Training - AKI CAPD														5.01
6 Training - CCPD														6
6.01 Training - AKI CCPD														6.01
7 Home Program - Hemodialysis														7
7.01 Home Program - AKI Hemodialysis														7.01
8 Home Program - Peritoneal Dialysis														8
8.01 Home Program - AKI Peritoneal Dialysis														8.01
	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								
9 Home Program - CAPD														9
9.01 Home Program - AKI CAPD														9.01
10 Home Program - CCPD														10
10.01 Home Program - AKI CCPD														10.01
11 Totals (sum of lines 1 through 8, cols. 1 and 4)														11
(sum of lines 1 through 10, cols. 2, 5, and 6)														
(see instructions)														
12 Total treatments (sum of lines 1 through 8														12
plus (sum of lines 9 and 10 times 3))														
(see instructions)														

12-22	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSABLE	PROVIDER CCN:	PERIOD:	WORKSHEET I-5
BAD DEBTS - TITLE XVIII - PART B		FROM	
		ТО	

Description

1 Total ex	xpenses related to care of program beneficiaries (see instructions)			
		1	2	
2 Total pr	ayment due (from Wkst. I-4, col. 6, line 11) (see instructions)	1	2	
	ayment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.
1	ayment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)			
1				2.
1	ayment due (see instructions)		_	2.
2.04 Outlier	payments			2.
3 Deducti	ibles billed to Medicare (Part B) patients (see instructions)			
	ibles billed to Medicare (Part B) patients (see instructions)			3.
	ibles billed to Medicare (Part B) patients (see instructions)			3.
	eductibles billed to Medicare (Part B) patients (see instructions)			3.
	rance billed to Medicare (Part B) patients (see instructions)			
	rance billed to Medicare (Part B) patients (see instructions)			4.
	rance billed to Medicare (Part B) patients (see instructions)			4.
	oinsurance billed to Medicare (Part B) patients (see instructions)			4.
	bts for deductibles and coinsurance, net of bad debt recoveries			4.
				5.
	ion period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.
	s rendered on or after 1/1/2011 but before 1/1/2012			
	ion period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.
	s rendered on or after 1/1/2012 but before 1/1/2013			
	ion period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for			5.
	s rendered on or after 1/1/2013 but before 1/1/2014			
	PPS bad debts for deductibles and coinsurance net of bad debt recoveries for			5.
	s rendered on or after 1/1/2014			
	ble bad debts (sum of lines 5 through line 5.04)			5.
	ed reimbursable bad debts (see instructions)			
	ble bad debts for dual eligible beneficiaries (see instructions)			
8 Net ded	ductibles and coinsurance billed to Medicare (Part B) patients (see instructions)			
9 Program	m payment (see instructions)			
10 Unreco	vered from Medicare (Part B) patients (see instructions)			
11 Reimbu	ursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)			
APT II - CAL	CULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
	llowable expenses (see instructions)			
	omposite costs (from Wkst. I-4, col. 2, line 11)			_
	y specific composite cost percentage (line 13 divided by line 12)			
14 Facility	specific composite cost percentage (inte 15 divided by inte 12)			
	RD PAYMENTS - INFORMATION ONLY			
	plume payment amount (see instructions)			
16 TDAPA				
17 TPNIES	•			
18 CRA T				
19 HDPA				
20 PPA				

4090 (Cont.)			F	ORM CMS-2552	2-10					12-22
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART I	
PART I - ALLOCATION OF GENERAL SERVICE CO	STS TO COMMUNITY	MENTAL DEALTH	PENTER COST CENT	TEDC						
PART I - ALLOCATION OF GENERAL SERVICE CO	NET	MENTAL REALTRY	JEINTER COST CENT	EK5		1				<u> </u>
COMPONENT COST CENTER	EXPENSES FOR COST	RELATE	ITAL D COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
(omit cents)	ALLOCATION (see instru.)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	& LINEN SERVICE	
	0	1	2	4	4A	5	6	7	8	1
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)(1)										22
23 Unit Cost Multiplier (see instructions)										23

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

01-22				FO	RM CMS-25	52-10					4090	(Cont.)
ALLOCATION OF GENERAL SERVICE COSTS T COMMUNITY MENTAL HEALTH CENTERS	ГО								PROVIDER CCN:	PERIOD: FROM		<u> </u>
									COMPONENT CCN:	то	-	
PART I - ALLOCATION OF GENERAL SERVICE	COSTS TO COM	IMUNITY MENT	AL HEALTH CEN	TER COST CENT	TERS	•						<u> </u>
				MAIN-		CENTRAL		MEDICAL			NON-	
COMPONENT COST CENTER				TENANCE	NURSING	SERVICES		RECORDS		OTHER	PHYSICIAN	
(omit cents)	HOUSE-			OF	ADMINIS-	&		&	SOCIAL	GENERAL	ANES-	
(onite cents)	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	SERVICE	THETISTS	
	9	10	11	12	13	14	15	16	17	18	19	1
1 Administrative and General										10	10	1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological Services												8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Therapies												11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)(1)												22
23 Unit Cost Multiplier (see instructions)												23

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

4090 (Cont.)			F	FORM CMS-255	2-10					01-22
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART I	
PART I - ALLOCATION OF GENERAL SERVICE CO	STS TO COMMUNITY	MENTAL HEALTH	CENTER COST CENT	ERS						
COMPONENT COST CENTER (omit cents)	NURSING PROGRAM	INTERNS & SALARY & FRINGES	RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION	SUBTOTAL (sum of	INTERN & RESIDENT COST & POST STEPDOWN ADJ.	SUBTOTAL (sum of cols.	ALLOCATED COMPONENT A&G (see	TOTAL (sum of cols. 26 ± 27)	
	20	21	22	(SPECIFY) 23	cols. 4A-23) 24	25	24 ± 25) 26	Part II) (2) 27	28	-
1 Administrative and General	20	21	22	23	24	23	20	27	20	1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)(1)										22
23 Unit Cost Multiplier (see instructions)										23

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

09-13			F	ORM CMS-2552-	-10				4090	(Cont.)
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET J-1, PART II	
PART II - ALLOCATION OF GENERAL SERVICE COS	TS TO COMMUN	NITY MENTAL HEALT	TH CENTER COST CEN	TERS - STATISTICAL	BASIS					
CMHC COST CENTER (omit cents)		CAP RELATI BLDGS & FIXTURES (SQUARE FEET)	ITAL ED COST MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
1 Administrative and General	0	1	2	4	4A	5	6	7	8	1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

4090 (Cont.)		FORM CMS-2552-10										09-13	
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS										PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART II (CONT.)	
										COMPONENT CCN:	то	-	
PART I	I - ALLOCATION OF GENERAL SERVICE CC	STS TO COMM	JNITY MENTA	L HEALTH CEN	TER COST CENT	TERS - STATISTIC	CAL BASIS						
					MAIN-							NON-	
					TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
		HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
	CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
(omit cents)		(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
		SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
	Medical Supplies												17
	Medical Appliances												18
	Durable Medical Equipment-Rented												19
	Durable Medical Equipment-Sold												20
	All Others												21
	Totals (sum of lines 1-21)												22
	Total Cost to be Allocated												23
_	Unit Cost Multiplier (see instructions)	1											24

01-22			F	ORM CMS-2552-	-10				4090	(Cont.)
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS)						PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-1, PART II (CONT.)	
							COMPONENT CCN:	то		
					10					
PART II - ALLOCATION OF GENERAL SERVICE O	LOSIS TO COMMUNITY	T MENTAL HEALTH C	ENTER COST CENTER	PARA-	15			1		
		INTERNS & RESIDENTS		MEDICAL						
	NURSING	SALARY &	PROGRAM	EDUCATION						
CORF COST CENTER	PROGRAM	FRINGES	COSTS	(SPECIFY)						
(omit cents)	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED						
	TIME)	TIME)	TIME)	TIME)						
	20	21	22	23	24	25	26	27	28	
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

4090 (Cont.)	FORM CMS-2552-10									
COMPUTATION OF COMMUNITY MENTAL HEA	ALTH CENTER PROV	IDER COSTS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET J-2, PART I	
							COMPONENT CCN:	то	-	
PART I - APPORTIONMENT OF CMHC COST CEN	NTERS									
	(From		Ratio of		Title V		Title XVIII		Title XIX	
	Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
	Pt. I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
	col. 28)	Charges	(col. 1 ÷ col. 2)	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	_
	1	2	3	4	5	6	7	8	9	<u> </u>
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapy										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 All Others (1)										19
20 Totals (sum of lines 1 through19)										20

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

4090 (Cont.)

FORM CMS-2552-10

01-22

1	1	_^	17	

FORM CMS-2552-10

4090 (Cont.)

COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

		1000 (000
PROVIDER CCN:	PERIOD:	WORKSHEET J-2,
	FROM	PART II
COMPONENT CCN:	то	

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

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

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

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

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

4090 (Cont.)	FORM CMS-2552-10	1.	1-17
CALCULATION OF REIMBURSEMENT SETTLEMENT COMMUNITY	PROVIDER CCN: PERIOD: W	VORKSHEET J-3	
MENTAL HEALTH CENTER PROVIDER SERVICES	FROM		
	COMPONENT CCN: TO		

Check	[] Title V
applicable	[] Title VIII
box:	[] Title XIX

box:	[] Title XIX	PROGRAM	
		COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 29)		1
2	PPS payments received excluding outliers		2
	Outlier payments		3
4	Primary payer payments		4
	Total reasonable cost (see instructions)		4
6	Total charges for program services		6
6	CUSTOMARY CHARGES		6
	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge		8
	basis had such payment been made in accordance with 42 CFR 413.13(e)		8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
	Total customary charges (see instructions)		10
11			11
12			12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
	Total reasonable cost (from line 5)		13
14	The D deddedole office to program patients		14
	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Allowable bad debts (from provider records) (see instructions)		21
22	Adjusted reimbursable bad debts (see instructions)		22
23	Allowable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		25.50
25.99	Demonstration payment adjustment amount before sequestration		25.99
26	Total cost (see instructions)		26
26.01	Sequestration adjustment (see instructions)		26.01
26.02	Demonstration payment adjustment amount after sequestration	1	26.02
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		29
30			30

11-16	FORM CMS-2552-10						
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY M	ENTAL HEALTH P	PROVIDER CON:	[:	PERIOD:	WORKSHEET J-4		
CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARI	ES			FROM			
		COMPONENT CO	CN:	то			

Check applicable

[] Title XVIII

					Part	В	
DESCRIPTION					1	2	7
					mm/dd/yyyy	Amount	
	ents paid to providers						
	ayable on individual bills, either						
	ubmitted to the intermediary, for						
	the cost reporting periods. If						
none, write "NONE							
3 List separately each				.01			3.
lump sum adjustme			Program	.02			3.
based on subsequer			to	.03			3.
the interim rate for			Provider	.04			3.
cost reporting perio				.05			3.
date of each payme				.50			3.
If none, write "NOI	νЕ",		Provider	.51			3.
or enter zero (1).			to	.52			3.
			Program	.53			3.
			.54			3.	
Subtotal (sum of lir							
minus sum of lines				.99			3.
	ents (sum of lines 1, 2, and 3.99)						
(transfer to Worksh	eet J-3, line 27)						
	D BY INTERMEDIARY						
5 List separately each			Program	.01			5.
settlement payment			to	.02			5.
			Provider	.03			
If none Aurite "NOI		so show date of each payment. none, write "NONE,"					5.
	NE,		Provider	.50			5.
or enter zero (1).	NE,		Provider to	.50 .51			5. 5. 5.
or enter zero (1).			Provider	.50			5. 5. 5.
or enter zero (1). Subtotal (sum of lir	es 5.01-5.49 minus		Provider to	.50 .51 .52			5. 5. 5.
or enter zero (1). Subtotal (sum of lir sum of lines 5.50-5	es 5.01-5.49 minus 98)		Provider to Program	.50 .51			5. 5. 5.
 or enter zero (1). Subtotal (sum of lin sum of lines 5.50-5 Determine net settle 	es 5.01-5.49 minus 98) ment amount		Provider to Program Program	.50 .51 .52			5. 5. 5.
or enter zero (1). Subtotal (sum of lir sum of lines 5.50-5 6 Determine net settle (balance due) based	es 5.01-5.49 minus 98) ment amount on the cost		Provider to Program Program to	.50 .51 .52 .99			5. 5. 5. 5.
 or enter zero (1). Subtotal (sum of lin sum of lines 5.50-5 Determine net settle 	es 5.01-5.49 minus 98) ment amount on the cost		Provider to Program to Provider	.50 .51 .52			5. 5. 5.
or enter zero (1). Subtotal (sum of lir sum of lines 5.50-5 6 Determine net settle (balance due) based	es 5.01-5.49 minus 98) ment amount on the cost		Provider to Program to Provider Provider	.50 .51 .52 .99			5. 5. 5. 5.
or enter zero (1). Subtotal (sum of lir sum of lines 5.50-5 6 Determine net settle (balance due) based	es 5.01-5.49 minus 98) ment amount on the cost		Provider to Program to Provider	.50 .51 .52 .99 .01			5. 5. 5. 5.
or enter zero (1). Subtotal (sum of lin sum of lines 5.50-5 Determine net settl (balance due) based report (see instruction	es 5.01-5.49 minus 98) ment amount on the cost ons). (1)		Provider to Program to Provider Provider	.50 .51 .52 .99			5. 5. 5. 5.
or enter zero (1). Subtotal (sum of lin sum of lines 5.50-5 6 Determine net settl (balance due) based report (see instruction) 7 7	es 5.01-5.49 minus 98) ment amount on the cost ons). (1)		Provider to Program to Provider Provider to	.50 .51 .52 .99 .01			5. 5. 5. 5. 5. 6.
or enter zero (1). Subtotal (sum of line sum of lines 5.50-5 6 Determine net settle (balance due) basec report (see instruction) 7 Total Medicare liabit (see instructions)	es 5.01-5.49 minus 98) ment amount on the cost ons). (1) illity		Provider to Program to Provider Provider to Program	.50 .51 .52 .99 .01			5. 5. 5. 5. 5. 6.
or enter zero (1). Subtotal (sum of lin sum of lines 5.50-5 6 Determine net settl (balance due) based report (see instruction) 7 7	es 5.01-5.49 minus 98) ment amount on the cost ons). (1) illity	Contractor Numbe	Provider to Program to Provider Provider to Program	.50 .51 .52 .99 .01	e (Month, Day, Year)		5. 5. 5. 5. 5. 6.

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

4090 (Cont.)				FORM CM	IS-2552-10						11-16
ANALYSIS OF HOSPITAL-BASED								PROVIDER CCN:	PERIOD:	WORKSHEET K	
HOSPICE COSTS									FROM	_	
								COMPONENT CCN:	то		
		EMPLOYEE		CONTRACTED							
	SALARIES	BENEFITS	TRANSPOR-	SERVICES				SUBTOTAL		TOTAL	
COST CENTER DESCRIPTIONS	(from	(from	TATION	(from		TOTAL	RECLASSI-	(col. 6	ADJUST-	(col. 8	
	Wkst. K-1)	Wkst. K-2)	(see inst.)	Wkst. K-3)	OTHER	(cols. 1-5)	FICATION	± col. 7)	MENTS	± col. 9)	
	1	2	3	4	5	6	7	8	9	10	-
GENERAL SERVICE COST CENTERS	1	-	5		5	0	/	0	3	10	
1 Capital Related Costs-Bldg and Fixt.											1
2 Capital Related Costs-Movable Equip.											2
3 Plant Operation and Maintenance											3
4 Transportation - Staff											4
5 Volunteer Service Coordination											5
6 Administrative and General											6
INPATIENT CARE SERVICE											
7 Inpatient - General Care											7
8 Inpatient - Respite Care											8
VISITING SERVICES											
9 Physician Services											9
10 Nursing Care											10
11 Nursing Care-Continuous Home Care											11
12 Physical Therapy											11
13 Occupational Therapy											12
14 Speech/ Language Pathology											13
15 Medical Social Services											14
16 Spiritual Counseling											15
17 Dietary Counseling											10
18 Counseling - Other											17
19 Home Health Aide and Homemaker											18
20 HH Aide & Homemaker - Cont. Home Care											20
20 HH Alde & Homemaker - Cont. Home Care 21 Other											20
OTHER HOSPICE SERVICE COSTS											
22 Drugs, Biological and Infusion Therapy											22
23 Analgesics											23
24 Sedatives / Hypnotics											25
25 Other - Specify											
26 Durable Medical Equipment/Oxygen											26
27 Patient Transportation											27
28 Imaging Services											28
29 Labs and Diagnostics											29
30 Medical Supplies											30
31 Outpatient Services (including E/R Dept.)											31
32 Radiation Therapy											32
33 Chemotherapy											33
34 Other											34
HOSPICE NONREIMBURSABLE SERVICE											
35 Bereavement Program Costs											35
36 Volunteer Program Costs											36
37 Fundraising											37
38 Other Program Costs											38
39 Total (sum of lines 1 thru 38)											39

11-16	FORM CMS-2552-10						4090 (Cont.)				
HOSPICE COMPENSATION ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-1	<u> </u>	
SALARIES AND WAGES								FROM	_		
							COMPONENT CCN:	то	_		
			MEDICAL								
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL					
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)		
	1	2	3	4	5	6	7	8	9		
GENERAL SERVICE COST CENTERS											
 Capital Related Costs-Bldg and Fixt. 										1	
2 Capital Related Costs-Movable Equip.										2	
3 Plant Operation and Maintenance										3	
4 Transportation - Staff										4	
5 Volunteer Service Coordination										5	
6 Administrative and General										6	
INPATIENT CARE SERVICE											
7 Inpatient - General Care										7	
8 Inpatient - Respite Care										8	
VISITING SERVICES											
9 Physician Services										9	
10 Nursing Care										10	
11 Nursing Care-Continuous Home Care										11	
12 Physical Therapy										12	
13 Occupational Therapy										13	
14 Speech/ Language Pathology										14	
15 Medical Social Services										15	
16 Spiritual Counseling										16	
17 Dietary Counseling										17	
18 Counseling - Other										18	
19 Home Health Aide and Homemaker										19	
20 HH Aide & Homemaker - Cont. Home Care										20	
21 Other										21	
OTHER HOSPICE SERVICE COSTS											
22 Drugs, Biological and Infusion Therapy										22	
23 Analgesics										23	
24 Sedatives / Hypnotics										24	
25 Other - Specify										25	
26 Durable Medical Equipment/Oxygen										26	
27 Patient Transportation										27	
28 Imaging Services										28	
29 Labs and Diagnostics										20	
30 Medical Supplies										30	
31 Outpatient Services (including E/R Dept.)										31	
32 Radiation Therapy										32	
33 Chemotherapy										33	
34 Other									1	34	
HOSPICE NONREIMBURSABLE SERVICE										- 34	
35 Bereavement Program Costs										35	
36 Volunteer Program Costs										36	
37 Fundraising										37	
38 Other Program Costs								<u> </u>		38	
39 Total (sum of lines 1 thru 38)										39	
								I		39	

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

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4058)

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4090 (Cont.)			FORM CMS-2552-10							
HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)				PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-2				
DEVENTS (TATROLE RELATED)							COMPONENT CCN:	то	-	
			MEDICAL							
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR 1	DIRECTOR 2	WORKERS 3	VISORS 4	NURSES 5	THERAPISTS 6	AIDES	ALL OTHER 8	TOTAL (1) 9	-
GENERAL SERVICE COST CENTERS	1	-	5		5	0	,	0	3	
 Capital Related Costs-Bldg and Fixt. 										1
2 Capital Related Costs-Movable Equip.										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff										4
5 Volunteer Service Coordination										5
6 Administrative and General										(
INPATIENT CARE SERVICE										
7 Inpatient - General Care										
8 Inpatient - Respite Care										1
VISITING SERVICES										
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care-Continuous Home Care										1
12 Physical Therapy										1
13 Occupational Therapy										1
14 Speech/ Language Pathology										1
15 Medical Social Services										1
16 Spiritual Counseling										10
17 Dietary Counseling										1
18 Counseling - Other										1
19 Home Health Aide and Homemaker										1
20 HH Aide & Homemaker - Cont. Home Care										2
21 Other										2
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy										2
23 Analgesics										2
24 Sedatives / Hypnotics										2
24 Sedatives / Hyphones 25 Other - Specify										2
26 Durable Medical Equipment/Oxygen										2
27 Patient Transportation										2
27 Patient Hansportation 28 Imaging Services										21
29 Labs and Diagnostics										20
30 Medical Supplies										3
30 Medical Supplies 31 Outpatient Services (including E/R Dept.)										3
31 Outpatient Services (including E/R Dept.) 32 Radiation Therapy										3
32 Radiation Therapy 33 Chemotherapy										32
33 Chemotherapy 34 Other										33
HOSPICE NONREIMBURSABLE SERVICE										34
35 Bereavement Program Costs										3
36 Volunteer Program Costs										30
37 Fundraising										
38 Other Program Costs										38
39 Total (sum of lines 1 thru 38) (1) Transfer the amount in column 9 to Wkst. K. column 2										39

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

09-13		FORM CMS-2552-10						4090 (Cont.				
HOSPICE COMPENSATION ANALYSIS							PROVIDER CCN:	PERIOD:	WORKSHEET K-3	<u>, </u>		
CONTRACTED SERVICES/PURCHASED SERVICE	ES							FROM	_			
							COMPONENT CCN:	то	_			
			MEDICAL									
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL						
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)			
	1	2	3	4	5	6	7	8	9			
GENERAL SERVICE COST CENTERS												
1 Capital Related Costs-Bldg and Fixt.										1		
2 Capital Related Costs-Movable Equip.										2		
3 Plant Operation and Maintenance										3		
4 Transportation - Staff										4		
5 Volunteer Service Coordination										5		
6 Administrative and General										6		
INPATIENT CARE SERVICE												
7 Inpatient - General Care										7		
8 Inpatient - Respite Care										8		
VISITING SERVICES												
9 Physician Services										9		
10 Nursing Care										10		
11 Nursing Care-Continuous Home Care										11		
12 Physical Therapy										12		
13 Occupational Therapy										13		
14 Speech/ Language Pathology										14		
15 Medical Social Services										15		
16 Spiritual Counseling										16		
17 Dietary Counseling										17		
18 Counseling - Other										18		
19 Home Health Aide and Homemaker										19		
20 HH Aide & Homemaker - Cont. Home Care										20		
21 Other										21		
OTHER HOSPICE SERVICE COSTS												
22 Drugs, Biological and Infusion Therapy										22		
23 Analgesics										23		
24 Sedatives / Hypnotics										24		
25 Other - Specify										25		
26 Durable Medical Equipment/Oxygen										26		
27 Patient Transportation										27		
28 Imaging Services										28		
29 Labs and Diagnostics										20		
30 Medical Supplies										30		
31 Outpatient Services (including E/R Dept.)										31		
32 Radiation Therapy										32		
33 Chemotherapy										33		
34 Other										34		
HOSPICE NONREIMBURSABLE SERVIC	E									- 34		
35 Bereavement Program Costs	-									35		
36 Volunteer Program Costs										36		
37 Fundraising										37		
38 Other Program Costs									+	38		
39 Total (sum of lines 1 thru 38)										39		
(1) Transfer the amount in column 9 to Wkst. K, colum	n /									33		

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

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FORM CMS-2552-10

IST ALLOCATION - HOSPICE GENERAL SERVICE	COST						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET K-4, PART I	
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	LATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICES COORDI- NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
GENERAL SERVICE COST CENTERS	0	1	2	3	4	5	5A	6	7	┿
1 Capital Related Costs-Bldg and Fixt.										-
2 Capital Related Costs-Movable Equip.										
3 Plant Operation and Maintenance										
4 Transportation - Staff										-
5 Volunteer Service Coordination										
6 Administrative and General										
										+-
INPATIENT CARE SERVICE										4-
7 Inpatient - General Care										+
8 Inpatient - Respite Care										+-
VISITING SERVICES										4-
9 Physician Services										_
10 Nursing Care										_
11 Nursing Care-Continuous Home Care										_
12 Physical Therapy										\perp
13 Occupational Therapy										
14 Speech/ Language Pathology										
15 Medical Social Services										
16 Spiritual Counseling										
17 Dietary Counseling										
18 Counseling - Other										
19 Home Health Aide and Homemaker										
20 HH Aide & Homemaker - Cont. Home Care										Т
21 Other										
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy										T
23 Analgesics										\top
24 Sedatives / Hypnotics										+
25 Other - Specify										+
26 Durable Medical Equipment/Oxygen										+
27 Patient Transportation										+
28 Imaging Services										+
29 Labs and Diagnostics										+
30 Medical Supplies										+
31 Outpatient Services (including E/R Dept.)										+
32 Radiation Therapy										+
33 Chemotherapy										+
34 Other										+
HOSPICE NONREIMBURSABLE SERVICE										+
35 Bereavement Program Costs										1
36 Volunteer Program Costs								1		+
37 Fundraising										+
38 Other Program Costs										+
39 Total (sum of lines 1 thru 38)										+

09-13		FORM CM	AS-2552-10				4090	(Cont.)
COST ALLOCATION - HOSPICE STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM	WORKSHEET K-4, PART II	
					COMPONENT CCN:	то	_	
	CAPITAL RE	LATED COST	PLANT		VOLUNTEER		ADMINIS-	T
	BUILDINGS	MOVABLE	OPERATION	TRANS-	SERVICES		TRATIVE &	
COST CENTER DESCRIPTIONS	& FIXTURES	EQUIPMENT	& MAINT.	PORTATION	COORDINATOR	RECONCIL-	GENERAL	
	(SQ. FT.)	(\$ VALUE)	(SQ. FT.)	(MILEAGE)	(HOURS)	IATION	(ACC. COST)	_
GENERAL SERVICE COST CENTERS	1	2	3	4	5	6A	6	<u> </u>
1 Capital Related Costs-Bldg and Fixt.								1
2 Capital Related Costs-Movable Equip.								2
3 Plant Operation and Maintenance								3
4 Transportation - Staff								5
5 Volunteer Service Coordination								5
6 Administrative and General								(
INPATIENT CARE SERVICE								
7 Inpatient - General Care								5
8 Inpatient - Respite Care								8
VISITING SERVICES								
9 Physician Services								9
10 Nursing Care								10
11 Nursing Care-Continuous Home Care								11
12 Physical Therapy								12
13 Occupational Therapy								13
14 Speech/ Language Pathology								14
15 Medical Social Services								1
16 Spiritual Counseling								16
17 Dietary Counseling								17
18 Counseling - Other								18
19 Home Health Aide and Homemaker								19
20 HH Aide & Homemaker - Cont. Home Care								2
21 Other								2
OTHER HOSPICE SERVICE COSTS								
22 Drugs, Biological and Infusion Therapy								22
23 Analgesics								23
24 Sedatives / Hypnotics								24
25 Other - Specify								- 25
26 Durable Medical Equipment/Oxygen								2
27 Patient Transportation								22
28 Imaging Services								28
29 Labs and Diagnostics								29
30 Medical Supplies								30
31 Outpatient Services (including E/R Dept.)								3
32 Radiation Therapy								32
33 Chemotherapy								33
34 Other								34
HOSPICE NONREIMBURSABLE SERVICE								<u> </u>
35 Bereavement Program Costs								35
36 Volunteer Program Costs								36
37 Fundraising								3
38 Other Program Costs								3
39 Cost To be Allocated (per Wkst. K-4, Part I)								3
40 Unit Cost Multiplier								4

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

Rev. 4

4090 (Cont.)			FC	ORM CMS-2552-	-10					09-13
	ATION OF GENERAL SERVICE TO HOSPICE COST CENTERS							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART I	
DADTI	- ALLOCATION OF GENERAL SERVICE COST	S TO HOSDICE C	OST CENTEDS						10	-	
FARTI	- ALLOCATION OF GENERAL SERVICE COST.		OSI CENTERS								<u> </u>
ł	IOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7,	HOSPICE TRIAL BALANCE (1)		ITAL D COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		line	0	1	2	4	4A	5	6	7	
	Administrative and General	6									1
	Inpatient - General Care	7									2
	Inpatient - Respite Care	8									3
	Physician Services	9									4
	Nursing Care	10									5
	Nursing Care-Continuous Home Care	11									6
	Physical Therapy	12									7
	Occupational Therapy	13									8
	Speech/ Language Pathology	14									9
	Medical Social Services	15									10
	Spiritual Counseling	16									11
	Dietary Counseling	17									12
	Counseling - Other	18									13
	Home Health Aide and Homemaker	19									14
	HH Aide & Homemaker - Cont. Home Care	20									15
16	Other	21									16
17	Drugs, Biological and Infusion Therapy	22									17
18	Analgesics	23									18
	Sedatives / Hypnotics	24									19
	Other - Specify	25									20
	Durable Medical Equipment/Oxygen	26									21
	Patient Transportation	27									22
	Imaging Services	28									23
	Labs and Diagnostics	29									24
	Medical Supplies	30									25
	Outpatient Services (including E/R Dept.)	31									26
	Radiation Therapy	32									27
	Chemotherapy	33									28
	Other	34									29
	Bereavement Program Costs	35									30
	Volunteer Program Costs	36									31
	Fundraising	37									32
	Other Program Costs	38									33
34	Totals (sum of lines 1-33) (2)										34
35	Unit Cost Multiplier (see instructions)										35

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

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

	-		-
- 1	n	1	<u> </u>
_ L	v	- 1	2

ALLOCATION OF GENERAL SERVICE

COSTS TO HOSPICE COST CENTERS

FORM CMS-2552-10

PERIOD: WORKSHEET K-5, FROM_

COMPONENT CCN:

PROVIDER CCN:

PART I (Cont.) TO_

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	8	9	10	11	12	13	14	15	16	17	\square
1 Administrative and General											
2 Inpatient - General Care											—
3 Inpatient - Respite Care											
4 Physician Services											
5 Nursing Care											
6 Nursing Care-Continuous Home Care											
7 Physical Therapy											
8 Occupational Therapy											
9 Speech/ Language Pathology											
10 Medical Social Services											
11 Spiritual Counseling											
12 Dietary Counseling											
13 Counseling - Other											
14 Home Health Aide and Homemaker											
15 HH Aide & Homemaker - Cont. Home Ca	re										
16 Other											
17 Drugs, Biological and Infusion Therapy											
18 Analgesics											
19 Sedatives / Hypnotics											
20 Other - Specify											
21 Durable Medical Equipment/Oxygen											
22 Patient Transportation											
23 Imaging Services											
24 Labs and Diagnostics											1
25 Medical Supplies											
26 Outpatient Services (including E/R Dept.)											
27 Radiation Therapy											
28 Chemotherapy											1
29 Other											
30 Bereavement Program Costs											
31 Volunteer Program Costs											
32 Fundraising											+
33 Other Program Costs											+
34 Totals (sum of lines 1-33) (2)		1	1		1		1				F
35 Unit Cost Multiplier (see instructions)											

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

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

1000	(\cap)
	(Cont.)

ALLOCATION OF GENERAL SERVICE

COSTS TO HOSPICE COST CENTERS

WORKSHEET K-5, PROVIDER CCN: PERIOD: FROM _ PART I (Cont.)

COMPONENT CCN:

TO_

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

			NON-				PARA-		INTERN & RESIDENT		ALLOCATED	TOTAL	\square
	HOSPICE COST CENTER	OTHER	PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL		COST & POST		HOSPICE	HOSPICE	
	(omit cents)	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION	SUBTOTAL	STEPDOWN	SUBTOTAL	A&G (see	COSTS	
	(onne cents)	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)	ADJUST.	$(cols. 24 \pm 25)$	Part II)	(cols. 26 ± 27)	
		`8	19	20	21	22	23	24	25	26	27	28	-
1	Administrative and General	0	10	20			20			20		20	1
2	Inpatient - General Care												2
3	Inpatient - Respite Care												3
4	Physician Services												4
5	Nursing Care												5
6	Nursing Care-Continuous Home Care												6
7	Physical Therapy												7
	Occupational Therapy												8
9	Speech/ Language Pathology												9
10	Medical Social Services												10
11	Spiritual Counseling												11
12	Dietary Counseling												12
13	Counseling - Other												13
	Home Health Aide and Homemaker												14
15	HH Aide & Homemaker - Cont. Home Care												15
16	Other												16
17	Drugs, Biological and Infusion Therapy												17
	Analgesics												18
19	Sedatives / Hypnotics												19
20	Other - Specify												20
21	Durable Medical Equipment/Oxygen												21
22	Patient Transportation												22
23	Imaging Services												23
	Labs and Diagnostics												24
25	Medical Supplies												25
26	Outpatient Services (including E/R Dept.)												26
	Radiation Therapy												27
28	Chemotherapy												28
	Other												29
30	Bereavement Program Costs												30
31	Volunteer Program Costs												31
	Fundraising												32
	Other Program Costs												33
	Totals (sum of lines 1-33) (2)												34
	Unit Cost Multiplier (see instructions)												35

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

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

09-13		FC	ORM CMS-2552-	-10				4090 ((Cont.)
	ATION OF GENERAL SERVICE COSTS TO E COST CENTERS STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART II	<u> </u>
PART II	- ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STA	TISTICAL BASIS							
Н	OSPICE COST CENTER	CAP RELATE BLDGS. & FIXTURES (SQUARE FEET) 1	ITAL ED COST EQUIPMENT (DOLLAR VALUE) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 5A	ADMINIS- TRATIVE & GENERAL (ACCUM. COST) 5	MAIN- TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
	Physician Services								4
5	Nursing Care								5
6	Nursing Care-Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
10	Medical Social Services								10
	Spiritual Counseling								11
	Dietary Counseling								12
13	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biological and Infusion Therapy								17
	Analgesics								18
	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services					1		1	23
	Labs and Diagnostics							1	24
	Medical Supplies								25
	Outpatient Services (including E/R Dept.)							1	26
	Radiation Therapy							1	27
	Chemotherapy								28
	Other							1	29
	Bereavement Program Costs						1	1	30
	Volunteer Program Costs								31
	Fundraising							1	32
	Other Program Costs						1	1	33
	Totals (sum of lines 1-33) (2)								34
	Total cost to be allocated								35
	Unit Cost Multiplier (see instructions)								36

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

Rev. 4

10-12	FORM CM	4S-2552-10					4090	(Cont.)
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET K-5, PART II	
PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS								
			NON- PHYSICIAN		INTERNS &	RESIDENTS	PARA- MEDICAL	
HOSPICE COST CENTER	SOCIAL SERVICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	ANES- THETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	SALARY & FRINGES (ASSIGNED TIME) 21	PROGRAM COSTS (ASSIGNED TIME) 22	EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
1 Administrative and General								1
2 Inpatient - General Care								2
3 Inpatient - Respite Care								3
4 Physician Services								4
5 Nursing Care								5
6 Nursing Care-Continuous Home Care								6
7 Physical Therapy								7
8 Occupational Therapy								8
9 Speech/ Language Pathology								9
10 Medical Social Services								10
11 Spiritual Counseling								11
12 Dietary Counseling								12
13 Counseling - Other								13
14 Home Health Aide and Homemaker								14
15 HH Aide & Homemaker - Cont. Home Care								15
16 Other								16
17 Drugs, Biological and Infusion Therapy								17
18 Analgesics								18
19 Sedatives / Hypnotics								19
20 Other - Specify								20
21 Durable Medical Equipment/Oxygen								21
22 Patient Transportation								22
23 Imaging Services								23
24 Labs and Diagnostics								24
25 Medical Supplies								25
26 Outpatient Services (including E/R Dept.)	1							26
27 Radiation Therapy								20
28 Chemotherapy								28
29 Other	1							20
30 Bereavement Program Costs								30
31 Volunteer Program Costs								31
32 Fundraising	+							31
33 Other Program Costs	+		+		+	+		33
34 Totals (sum of lines 1-33) (2)	+				+			34
34 Totals (sum of lines 1-33) (2) 35 Total cost to be allocated								34
36 Unit Cost Multiplier (see instructions)								35
50 Unit Cost Multiplier (see instructions)		I			1			36

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

07-23		FORM CMS-2552-10		4090 (Cont.)				
CALCU	LATION OF HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET K-6			
	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER 3	TOTAL 4			
1	Total cost (see instructions)					1		
2	Total unduplicated days (Worksheet S-9, column 6, line 5)					2		
3	Average cost per diem (line 1 divided by line 2)					3		
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)					4		
5	Aggregate Medicare cost (line 3 times line 4)					5		
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)					6		
7	Aggregate Medicaid cost (line 3 times line 6)					7		
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8		
9	Aggregate SNF cost (line 3 times line 8)					9		
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10		
11	Aggregate NF cost (line 3 times line 10)					11		
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)					12		
13	Aggregate cost for other days (line 3 times line 12)					13		

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

4090 (Cont.)	FORM CMS-2552-10 07-2				07-23	
CALCULATION	CULATION OF CAPITAL PAYMENT			PROVIDER CCN:	PERIOD:	WORKSHEET L	
					FROM		
				COMPONENT CCN:	то		
<u></u>	[]] TN-1- 17		[] PPS				
Check	[] Title V	[] Hospital	. ,				
applicable	[] Title XVIII, Part A	[] PARHM Demonstration	[] Cost Met	nod			
boxes:	[] Title XIX						
	Y PROSPECTIVE METHOD AL FEDERAL AMOUNT						
	I DRG other than outlier						1 1
	4 BPCI Capital DRG other than outl	ior					1.01
	1 DRG outlier payments	lei					2
1	4 BPCI Capital DRG outlier payments	ato.					2.01
		lays in the cost reporting period (see in	astructions)				3
	er of interns & residents (see instruct		istructions)				4
	t medical education percentage (see						5
	t medical education adjustment (see						6
	, , ,	,	The Proof A Bar 20	()			7
		Medicare Part A patient days (Workshe	et E, Part A line 30)	(see instructions)			8
	tage of Medicaid patient days to tota f lines 7 and 8	a days (see instructions)					9
	able disproportionate share percentag						10
1	portionate share adjustment (see ins	,					
	prospective capital payments (see ins						12
	MENT UNDER REASONABLE CO						
	m inpatient routine capital cost (see						1
	m inpatient ancillary capital cost (se	,					2
	npatient program capital cost (line 1						3
	l cost payment factor (see instruction						4
	npatient program capital cost (line 3						5
	IPUTATION OF EXCEPTION PAY						
	m inpatient capital costs (see instruc						1
		inary circumstances (see instructions)					2
	ogram inpatient capital costs (line 1 r						3
	able exception percentage (see instru-						4
	l cost for comparison to payments (li						5
	tage adjustment for extraordinary cir						6
		vel for extraordinary circumstances (lir	ne 2 x line 6)				7
	l minimum payment level (line 5 plus						8
	t year capital payments (from Part I,	11 /					9
		m payment level to capital payments (li	ine 8 less line 9)				10
	ver of accumulated capital minimum						11
	prior year Worksheet L, Part III, line						
		nt level to capital payments (line 10 plu					12
		is positive, enter the amount on this line	e)				13
		payment level over capital payment					14
	following period (if line 12 is negati						
	t year allowable operating and capit						15
	t year operating and capital costs (se						16
17 Curren	t year exception offset amount (see	instructions)					17

02-24				FORM CMS-25	4090 (Cont.)					
	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES						PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I	
		EXTRA- ORDINARY		ITAL D COSTS					_	
	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	GENERAL SERVICE COST CENTERS	0	1	2	2A	4	5	6	7	
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Dundings and Fixtures				-					2
	Employee Benefits Department						-			4
	Administrative and General							-		5
	Maintenance and Repairs						+		-	6
	Operation of Plant						+			7
	Laundry and Linen Service									8
	Housekeeping									9
	Dietary									10
	Cafeteria									10
	Maintenance of Personnel									12
	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy									15
	Medical Records & Medical Records Library									16
	Social Service									17
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing Program									20
	Intern & Res. Service-Salary & Fringes (Approved)									20
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Ed. Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
41	Subprovider IRF									40
	Subprovider									42
	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility									45
	Other Long Term Care									46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2	2, SECTION 4065.1)			
Rev. 22				40-647
4690 (Cont.)	FORM CMS-2552-10			02-24
ALLOCATION OF ALLOWABLE COSTS FOR		PROVIDER CCN:	PERIOD:	WORKSHEET L-1,

EXTRAORDINARY	CIRCUMSTANCES							FROM TO	PART I	
		EXTRA- ORDINARY	-	ITAL D COSTS						
		CAPITAL	DI DOG A	NOVADA	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-	OPERATION	
Cost Center D	escriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION	
		COSTS	FIXTURES	EQUIPMENT	cols. 0-2) 2A	DEPARTMENT	GENERAL	REPAIRS	OF PLANT	4
ANCILLAR	Y SERVICE COST CENTERS	0	1	2	2A	4	5	6	7	
50 Operating Ro										50
51 Recovery Ro										51
	and Delivery Room									52
53 Anesthesiolo										53
54 Radiology-D										54
55 Radiology-T										55
56 Radioisotope										56
	omography (CT) Scan									50
	sonance Imaging (MRI)									
									_	58
59 Cardiac Cath	leterization								-	59
60 Laboratory										60
	Laboratory Service-Program Only									61
	l & Packed Red Blood Cells									62
	g, Processing, & Trans.									63
64 Intravenous										64
65 Respiratory										65
66 Physical The										66
67 Occupationa										67
68 Speech Path										68
69 Electrocardie										69
70 Electroencep										70
	plies Charged to Patients									71
72 Implantable	Devices Charged to Patients									72
73 Drugs Charg										73
74 Renal Dialys										74
75 ASC (Non-E										75
76 Other Ancill	ary (specify)									76
77 Allogeneic F										77
78 CAR T-Cell										78
OUTPATIEN	T SERVICE COST CENTERS									
88 Rural Health										88
89 Federally Qu	alified Health Center (FQHC)									89
90 Clinic	/									90
91 Emergency										91
92 Observation	Beds									92
93 Other Outpat										93
	italization Program									93.99

FORM CMS-2552-10 (01-2024) (INSTRUCTIONS FOR THIS WOR	KSHEET ARE PUBLISHED IN	CMS PUB. 15-2, SECTION 4065.1)					
40-648						F	Rev. 22
12-22		FORM CMS	-2552-10			4090	(Cont.)
ALLOCATION OF ALLOWABLE COSTS FOR				PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
EXTRAORDINARY CIRCUMSTANCES					FROM	PART I	
					то		
	EXTRA-	CAPITAL					

		ORDINARY	RELATE	D COSTS						1
		CAPITAL			SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED	BLDGS. &	MOVABLE	(sum of	BENEFITS	TRATIVE &	TENANCE &	OPERATION	
		COSTS	FIXTURES	EQUIPMENT	cols. 0-4)	DEPARTMENT	GENERAL	REPAIRS	OF PLANT 7	4
	OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	7	
	Home Program Dialysis									94
	Ambulance Services									94
	Durable Medical Equipment-Rented									95
	Durable Medical Equipment-Sold									96
	Other Reimbursable (specify)									97
	Outpatient Rehabilitation Provider (specify)									98
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
	Opioid Treatment Program									102
	SPECIAL PURPOSE COST CENTERS									<u> </u>
	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition									108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1 through 117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross Foot Adjustments									200
201	Negative Cost Centers									201
	Total (sum of line 118 and lines 190 through 201)									202
203	Total Statistical Basis									203
	Unit Cost Multiplier									204
	1			ł						

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) Rev. 18

4090 (Cont.)				FORM CM	1S-2552-10						12-22
	ATION OF ALLOWABLE COSTS FOR ORDINARY CIRCUMSTANCES			1	1	1	1	1	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
	GENERAL SERVICE COST CENTERS	0	5	10		12	15	14	15	10	17	<u> </u>
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment											2
	Employee Benefits Department											4
	Administrative and General											5
	Maintenance and Repairs											6
	Operation of Plant											7
	Laundry and Linen Service											8
	Housekeeping			1								9
	Dietary				1							10
	Cafeteria											11
12	Maintenance of Personnel											12
	Nursing Administration							1				13
	Central Services and Supply								1			14
	Pharmacy									1		15
16	Medical Records & Medical Records Library										-	16
	Social Service											17
18	Other General Service (specify)											18
	Nonphysician Anesthetists											19
20	Nursing Program											20
21	Intern & Res. Service-Salary & Fringes (Approved)											21
22	Intern & Res. Other Program Costs (Approved)											22
	Paramedical Ed. Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
	Burn Intensive Care Unit											33
	Surgical Intensive Care Unit											34
	Other Special Care Unit (specify)											35
	Subprovider IPF											40
	Subprovider IRF											41
	Subprovider											42
43	Nursery											43
	Skilled Nursing Facility											44
	Nursing Facility											45
	Other Long Term Care											46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB.	15-2, SECTION 4065.1)			
40-650				Rev. 18
02-24	FORM CMS-2552-10			4090 (Cont.)
ALLOCATION OF ALLOWABLE COSTS FOR		PROVIDER CCN:	PERIOD:	WORKSHEET L-1,

EXTRA	ORDINARY CIRCUMSTANCES			_	_			_		FROM	PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	3	10	11	12	15	14	15	10	17	
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
	PBP Clinical Laboratory Service-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
	Allogeneic HSCT Acquisition											77
	CAR T-Cell Immunotherapy											78
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic											90
	Emergency											91
	Observation Beds											92
	Other Outpatient (specify)											93
93.99	Partial Hospitalization Program											93.99

FORM CMS-2552-10 (01-2024) (INSTRUCTIONS FOR THIS V	WORKSHEET ARE	PUBLISHED IN C	MS PUB. 15-2, SEC	CTION 4065.1)							
Rev. 22											40-651
4090 (Cont.)				FORM CM	IS-2552-10						02-24
ALLOCATION OF ALLOWABLE COSTS FOR								PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
EXTRAORDINARY CIRCUMSTANCES									FROM	PART I (Cont.)	
									ТО		
											Τ
							l			1	

Cost Center Descriptions		LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
OTHER REIMBURSABLE CC	ST CENTEDS	0	9	10	11	12	15	14	15	10	17	
94 Home Program Dialysis	JI CENTERS											94
95 Ambulance Services												95
96 Durable Medical Equipment-R	ented											96
97 Durable Medical Equipment-S												97
98 Other Reimbursable (specify)	old											98
99 Outpatient Rehabilitation Provi	ider (specify)											99
100 Intern-Resident Service (not ap												100
101 Home Health Agency	pvd. tening. prgni.)											100
102 Opioid Treatment Program												101
SPECIAL PURPOSE COST CH	INTERS											102
105 Kidney Acquisition	INTERS			-	-							105
106 Heart Acquisition												105
107 Liver Acquisition												100
108 Lung Acquisition												107
109 Pancreas Acquisition												100
110 Intestinal Acquisition												110
111 Islet Acquisition												110
112 Other Organ Acquisition (spec	if _y)											111
115 Ambulatory Surgical Center (E												112
116 Hospice	istilict rait)											115
117 Other Special Purpose (specify)											110
118 SUBTOTALS (sum of lines 1 t												117
NONREIMBURSABLE COST												110
190 Gift, Flower, Coffee Shop, & C												190
191 Research	Janteen											190
192 Physicians' Private Offices												191
193 Nonpaid Workers												192
194 Other Nonreimbursable (specif												193
200 Cross Foot Adjustments	<i>y</i>)											200
200 Cross Foot Adjustments 201 Negative Cost Centers												200
202 Total (sum of line 118 and line	c 100 through 201)											201
202 Total (sum of line 118 and line 203 Total Statistical Basis	s 190 uitougii 201)											202
203 Total Statistical Basis 204 Unit Cost Multiplier												203
204 Unit Cost Multiplier												204

FORM CMS-2552-10 (12-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1) 40-652

02-24				FORM CMS-2	552-10					(Cont.)
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES							PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART I (Cont.)	
Cost Center Descriptions	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY & FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS	10	10				20			20	
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department	1									4
5 Administrative and General	1									5
6 Maintenance and Repairs	1									6
7 Operation of Plant	1									7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary	1									10
11 Cafeteria	1									11
12 Maintenance of Personnel										12
13 Nursing Administration	1									13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing Program										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Ed. Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit							_			31
32 Coronary Care Unit							_			32
33 Burn Intensive Care Unit							_			33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF							-			41
42 Subprovider										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15	5-2, SECTION 4065.1)			
Rev. 22				40-653
4690 (Cont.)	FORM CMS-2552-10			02-24
ALLOCATION OF ALLOWABLE COSTS FOR		PROVIDER CCN:	PERIOD:	WORKSHEET L-1,

²⁴

EXTRAORDINARY CIRCUMSTANCES								FROM TO	PART I (Cont.)	
Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
ANCILLARY SERVICE COST CENTERS	10	15	20	21	22	25	24	23	20	
50 Operating Room	-									5
51 Recovery Room										5
52 Labor Room and Delivery Room										5
53 Anesthesiology										5
54 Radiology-Diagnostic										5
55 Radiology-Therapeutic										5
56 Radioisotope										5
57 Computed Tomography (CT) Scan										5
58 Magnetic Resonance Imaging (MRI)										5
59 Cardiac Catheterization										5
60 Laboratory										6
61 PBP Clinical Laboratory Service-Program Only										6
62 Whole Blood & Packed Red Blood Cells										6
63 Blood Storing, Processing, & Trans.										6
64 Intravenous Therapy										6
65 Respiratory Therapy										6
66 Physical Therapy										6
67 Occupational Therapy										6
68 Speech Pathology										6
69 Electrocardiology										6
70 Electroencephalography										7
71 Medical Supplies Charged to Patients										7
72 Implantable Devices Charged to Patients										7
73 Drugs Charged to Patients										7
74 Renal Dialysis										7
75 ASC (Non-Distinct Part)										7
76 Other Ancillary (specify)										7
77 Allogeneic HSCT Acquisition										7
78 CAR T-Cell Immunotherapy										7
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										8
89 Federally Qualified Health Center (FQHC)										8
90 Clinic										9
91 Emergency										9
92 Observation Beds										9
93 Other Outpatient (specify)										9
93.99 Partial Hospitalization Program										93.9

FORM CMS-2552-10 (01-2024) (INSTRUCTIONS FOR THIS	WORKSHEET ARE P	UBLISHED IN CMS	PUB. 15-2, SECTION	4065.1)					
40-654								F	Rev. 22
01-22				FORM CMS-2	552-10			4090	(Cont.)
ALLOCATION OF ALLOWABLE COSTS FOR						PROVIDER CCN:	PERIOD:	WORKSHEET L-1,	
EXTRAORDINARY CIRCUMSTANCES							FROM	PART I (Cont.)	
							то		
							INTERN &		

	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 19	NURSING PROGRAM 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	-								-	
94	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
	Opioid Treatment Program										102
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1 through 117)										118
	NONREIMBURSABLE COST CENTERS										
	Gift, Flower, Coffee Shop, & Canteen										190
	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
	Cross Foot Adjustments										200
	Negative Cost Centers										201
	Total (sum of line 118 and lines 190 through 201)										202
	Total Statistical Basis										203
204	Unit Cost Multiplier										204

 $\overline{\text{FORM CMS-2552-10} (12-2022)} \text{ (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4065.1)} \\ Rev. 18$

4090 (FC	ORM CMS-2552-	-10					12-22
	ITATION OF PROGRAM INPATIENT ROUTINE SERVICE AL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART II	
Check applicable box:	[] Title V [] Title XVIII, Part A [] Title XIX							-	
	Cost Center Description	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Swing Bed Adjustment	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	INPATIENT ROUTINE SERVICE	1	2	3	4	5	6	7	<u> </u>
	COST CENTERS								<u> </u>
30	Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
200	Total (sum of lines 30-199)								200

(A) Worksheet A line numbers

02-24 FORM CMS-255		4090 (Cont				
COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART III	<u> </u>
Check [] Hospital [] Title V applicable [] Title XVIII, Part A boxes: [] Title XIX						
Cost Center Description (A) ANCILLARY SERVICE COST CENTERS	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) 1	Total Charges (from Wkst. C, Part I, col. 6) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Program Extraordinary Capital Cost (col. 3 x col. 4) 5	
50 Operating Room						50
50 Optiming Room 51 Recovery Room						51
52 Labor Room and Delivery Room						52
53 Anesthesiology						53
54 Radiology-Diagnostic						54
55 Radiology-Therapeutic						55
56 Radioisotope						56
57 Computed Tomography (CT) Scan						57
58 Magnetic Resonance Imaging (MRI)						58
59 Cardiac Catheterization						59
60 Laboratory						60
61 PBP Clinical Laboratory Service-Program Only						61
62 Whole Blood & Packed Red Blood Cells						62
63 Blood Storing, Processing, & Trans.						63
64 Intravenous Therapy						64
65 Respiratory Therapy						65
66 Physical Therapy						66
67 Occupational Therapy						67
68 Speech Pathology						68
69 Electrocardiology						69
70 Electroencephalography						70
71 Medical Supplies Charged to Patients						71
72 Implantable Devices Charged to Patients						72
73 Drugs Charged to Patients						73
74 Renal Dialysis						74
75 ASC (Non-Distinct Part)						75
76 Other Ancillary (specify)						76
77 Allogeneic Stem Cell Acquisition						77

(A) Worksheet A line numbers

FORM CMS-2552-10 (01-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC	CTIONS 4065.3)			
Rev. 22				40-657
4090 (Cont.)	FORM CMS-2552-10			02-24
COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE		PROVIDER CCN:	PERIOD:	WORKSHEET L-1,

CAPITAL COSTS F	OR EXTRAORDINAR	RY CIRCUMSTANCES			FROM TO	PART III (CONT.)	
Check	[] Hospital	[] Title V		1		•	
applicable		[] Title XVIII, Part A					
boxes:		[] Title XIX					
			Capital Cost for				

		Capital Cost for					
		Extraordinary				Program	
		Circumstances	Total Charges	Ratio of Cost		Extraordinary	
	Cost Center Description	(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
		Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)		1	2	3	4	5	1
	OUTPATIENT SERVICE COST CENTERS						
	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency						91
92	Observation Beds						92
93	Other Outpatient (specify)						93
93.99	Partial Hospitalization Program						93.99
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)						200

(A) Worksheet A line numbers

02-24	F	ORM CMS-2552-	·10					(Cont.
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET M-1	
						10		
Check applicable box: [] Hospital-based RHC [] Hospital-based FQI	IC						•	
					RECLASSIFIED		NET EXPENSES	
					TRIAL		FOR	
	COMPEN-		TOTAL	RECLASS-	BALANCE		ALLOCATION	
	SATION	OTHER COSTS	(col. 1 + col. 2)	IFICATIONS	(col. 3 + col. 4)	ADJUSTMENTS	(col. 5 + col. 6)	_
FACILITY HEALTH CARE STAFF COSTS	1	2	3	4	5	6	7	
1 Physician								
2 Physician Assistant								
3 Nurse Practitioner								
4 Visiting Nurse								
5 Other Nurse								
6 Clinical Psychologist								
7 Clinical Social Worker								
7.10 Marriage and Family Therapist								7.
7.11 Mental Health Courselor								7.1
8 Laboratory Technician								
9 Other Facility Health Care Staff Costs								
10 Subtotal (sum of lines 1-9)								1
COSTS UNDER AGREEMENT								
11 Physician Services Under Agreement								1
12 Physician Supervision Under Agreement								1
13 Other Costs Under Agreement								1
14 Subtotal (sum of lines 11-13)								1
OTHER HEALTH CARE COSTS								
15 Medical Supplies								1
16 Transportation (Health Care Staff)								1
17 Depreciation-Medical Equipment								1
18 Professional Liability Insurance								1
19 Other Health Care Costs								1
20 Allowable GME Costs								2
21 Subtotal (sum of lines 15-20)								2
22 Total Cost of Health Care Services								2
(sum of lines 10, 14, and 21)								_
COSTS OTHER THAN RHC/FQHC SERVICES								-
23 Pharmacy								2
24 Dental								2
25 Optometry								2
25.01 Telehealth								25.0 25.0
25.02 Chronic Care Management 26 All other nonreimbursable costs								25.0
26 All other nonreimbursable costs 27 Nonallowable GME costs								2
28 Total Nonreimbursable Costs (sum of lines 23-27)								2
FACILITY OVERHEAD								
29 Facility Costs								2
30 Administrative Costs								3
31 Total Facility Overhead (sum of lines 29 and 30)		1						3
32 Total facility costs (sum of lines 22, 28 and 30)					1			3

The net expenses for cost allocation on Worksheet A for the hospital-based RHC/FQHC cost center line must equal the total facility costs in column 7, line 32, of this worksheet.

4090 (090 (Cont.) FORM CMS-2552-10						
ALLOC	ATION OF OVERHEAD	WORKSHEET M-2					
TO HOS	PTIAL-BASED RHC/FQHC SERVICES		FROM				
				COMPONENT CCN:	ТО		
Check a	pplicable box: [] Hospital-based RHC [] H	ospital-based FQHC			1		
	AND PRODUCTIVITY	1 (
		Number			Minimum	Greater of	
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
		Personnel	Visits	Standard (1)	x col. 3)	col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1 through 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7.04
8	Total FTEs and Visits (sum of lines 4 through 7)						8
9	Physician Services Under Agreements						9
DETER	MINATION OF ALLOWABLE COST APPLICABLE TO H	IOSPITAL-BASED	RHC/FQHC SERVIC	ES			
10	Total costs of health care services (from Worksheet M-1, co	olumn 7, line 22)					10
11	Total nonreimbursable costs (from Worksheet M-1, column	17, line 28)					11
12	2 Cost of all services (excluding overhead) (sum of lines 10 and 11)						12
13	Ratio of hospital-based RHC/FQHC services (line 10 divide		13				
14	Total hospital-based RHC/FQHC overhead (from Workshe		14				
15	15 Parent provider overhead allocated to facility (see instructions)						
16	16 Total overhead (sum of lines 14 and 15)						
17							
18	Enter the amount from line 16						18
19	Overhead applicable to hospital-based RHC/FQHC services	s (line 13 x line 18)					19
20	20 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						

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

12-24	4 FORM CMS-2552-10					
CALCULATIO	CALCULATION OF REIMBURSEMENT PROVIDER CCN: PERIOD: V					
SETTLEMEN	T FOR HOSPITAL-BASED RHC/FQHC SERVI	CES		FROM		
			COMPONENT CCN:	то		
Check	[] Hospital-based RHC	[] Title V				
applicable	[] Hospital-based FQHC	[] Title XVIII				
boxes:	oxes: [] Title XIX					
DETERMINA	TION OF RATE FOR HOSPITAL-BASED RHC	/FQHC SERVICES				
1 Total	l allowable cost of hospital-based RHC/FQHC ser	vices (from Worksheet M-2, line 20)				1
2 Cost	of injections/infusions and their administration (fi	rom Worksheet M-4, line 15)				2
3 Total	3 Total allowable cost excluding injections/infusions (line 1 minus line 2)					
4 Total	4 Total visits (from Worksheet M-2, column 5, line 8)					
5 Phys	5 Physicians visits under agreement (from Worksheet M-2, column 5, line 9)					
6 Total	6 Total adjusted visits (line 4 plus line 5)					
7 Adju	sted cost per visit (line 3 divided by line 6)					7

			Calculation of Limit ⁽¹⁾		1
		Payment Limit	Payment Limit	Payment Limit	
		Period 1	Period 2	Period 3	
		1	2	3	-
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6, or your contractor)				8
	Rate for Program covered visits (see instructions)				9
	LATION OF SETTLEMENT	i			
	Program covered visits excluding mental health services (from contractor records)				10
	Program cost excluding costs for mental health services (line 9 x line 10)				11
	Program covered visits for mental health services (from contractor records)				12
	Program covered cost from mental health services (line 9 x line 12)				13
	Limit adjustment for mental health services (see instructions)				14
	Graduate Medical Education pass-through cost (see instructions)				15
16	Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)				16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)				16.04
16.05	Total program cost (see instructions)				16.05
17	Primary payer amounts				17
18	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19
20	Net program cost excluding injections/infusions (see instructions)				20
21	Program cost of injections/infusions and their administration (from Worksheet M-4, line 16)				21
21.50	Total program IOP OPPS payments (see instructions)				21.50
		Program IOP Visits	Program IOP Costs		
		1	2		
21.55	Total program IOP visits and costs (see instructions)				21.55
	Program IOP deductible and coinsurance (see instructions)				21.60
22	Total reimbursable program cost (sum of lines 20, 21, 21.50, minus line 21.60)				22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				25.50
25.99	Demonstration payment adjustment amount before sequestration				25.99
26	Net reimbursable amount (see instructions)				26
26.01	Sequestration adjustment (see instructions)				26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments				27
28	Tentative settlement (for contractor use only)				28
	Balance due component/program line 26 minus lines 26.01, 26.02, 27, and 28				29
30	Protested amounts (nonallowable cost report items) in accordance with CMS				30
	Pub. 15-2, chapter 1, section 115.2				

⁽¹⁾ Lines 8 through 14: Fiscal year providers use columns 1 and 2 (and column 3, if applicable). Calendar year providers with one rate in effect for the entire cost reporting period use column 2 only.

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4090 (Cont.) COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

- 10		-	
	PROVIDER CCN:	PERIOD:	WORKSHEET M-4
		FROM	

COMPONENT CCN: TO _

	[] Hospital-based RHC	[] Title V
2	[] Hospital-based FQHC	[] Title XVIII
		[] Title XIX

Check	[] Hospital-based RHC	[] Title V					
applicable	[] Hospital-based FQHC	[] Title XVIII					
boxes:		[] Title XIX					
	•					MONOCLONAL	
			PNEUMOCOCCAL	INFLUENZA	COVID-19	ANTIBODY	
			VACCINES	VACCINES	VACCINES	PRODUCTS	
			1	2	2.01	2.02	
1	Health care staff cost (from Worksheet M-1, column 7,	line 10)					1
2	Ratio of injection/infusion staff time to total	,					2
	health care staff time						
3	Injection/infusion health care staff cost (line 1 x line 2)						3
	Injections/infusions and related medical supplies costs						4
	(from your records)						
5	Direct cost of injections/infusions (line 3 plus line 4)						5
	Total direct cost of the hospital-based RHC/FQHC (from	n					6
	Worksheet M-1, column 7, line 22)						
7	Total overhead (from Worksheet M-2, line 19)						7
8	Ratio of injection/infusion direct cost to total direct						8
	cost (line 5 divided by line 6)						
9	Overhead cost - injection/infusion (line 7 x line 8)						9
10	Total injection/infusion costs and their						10
	administration costs (sum of lines 5 and 9)						
11	Total number of injections/infusions						11
	(from your records)						
12	Cost per injection/infusion (line 10/line 11)						12
13	Number of injection/infusion administered						13
	to Program beneficiaries						
13.01	Number of COVID-19 vaccine injections/infusions						13.01
	administered to MA enrollees						
14	Program cost of injections/infusions and their administr	ation					14
	costs (line 12 times the sum of lines 13 and 13.01, as ap	plicable)					
•	· · · · · · · · · · · · · · · · · · ·	-		COST OF			
				INJECTIONS /			
				INFUSIONS AND			
				ADMINISTRATION			
			1	2			
15	Total cost of injections/infusions and their						15
	administration costs (sum of columns 1, 2, 2.01, and 2.0	02, line 10)					
	(transfer this amount to Worksheet M-3, line 2)						
16	Total Program cost of injections/infusions and their						16
	administration costs (sum of columns 1, 2, 2.01, and 2.0	02, line 14)					
	(transfer this amount to Worksheet M-3, line 21)						

02-24 FORM CMS-2552-10 4090						
ANALY	SIS OF PAYMENTS TO HOSPITAL-BASED	PROVIDER CCN:		ERIOD:	WORKSHEET M-5	<u> </u>
RHC/FQ	HC FOR SERVICES RENDERED		F	ROM		
TO PRO	GRAM BENEFICIARIES	COMPONENT	CCN: T	0		
Check ar	oplicable box: [] Hospital-based RHC [] Hospital-based FQF	нс				
1					Part B	
	DESCRIPTION			1	2	1
				mm/did/ivy	Amount	
1	Total interim payments paid to hospital-based RHC/FQHC					1
2	Interim payments payable on individual bills, either					2
	submitted or to be submitted to the intermediary, for					
	services rendered in the cost reporting periods. If					
2	none, write "NONE", or enter zero. List separately each retroactive		01			2.01
3	lump sum adjustment amount	Due succes	.01			3.01
	based on subsequent revision of	Program to	.02			3.02
	the interim rate for the	Provider	.03			3.03
	cost reporting period. Also show	riovider	.04			3.05
	date of each payment.		.50			3.50
	If none, write "NONE",	Provider	.51			3.51
	or enter zero ⁽¹⁾ .	to	.52			3.52
		Program	.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)					4
	(transfer to Worksheet M-3, line 27)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative	Program	.01			5.01
	settlement payment after desk review.	to	.02			5.02
	Also show date of each payment.	Provider	.03			5.03
	If none, write "NONE,"	Provider	.50			5.50
	or enter zero (1).	to Program	.51			5.51
		.52		_	5.52	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount	Program				
	(balance due) based on the cost report (see instructions). (1)	to Provider	.01			6.01
	report (see instructions). (1)	Provider	.01			0.01
		to				
		Program	.02			6.02
7	Total Medicare liability (see instructions)	• •				7
8	Name of Contractor		Contrac	tor Number	NPR Date (Month/Day/Year)	8

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

4090 (Cont.)	F	ORM CMS-2552	-10					02-24
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES FOR HOSPITAL-BASED FQHC					PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET N-1	
COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
GENERAL SERVICE COST CENTERS								
1 Cap Rel Costs-Bldg and Fix								1
2 Cap Rel Costs-Mvble Equip								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation and Maintenance								5
6 Janitorial								6
7 Medical Records								7
8 Subtotal - Administrative Overhead								8
9 Pharmacy								9
10 Medical Supplies								10
11 Transportation								11
12 Other General Service								12
13 Subtotal - Total Overhead								13
DIRECT CARE COST CENTERS								
23 Physician								23
24 Physician Services Under Agreement								24
25 Physician Assistant								25
26 Nurse Practitioner								26
27 Visiting Registered Nurse								27
28 Visiting Licensed Practical Nurse								28
29 Certified Nurse Midwife								29
30 Clinical Psychologist								30
31 Clinical Social Worker								31
31.10 Marriage and Family Therapist								31.10
31.11 Mental Health Counselor								31.11
32 Laboratory Technician								32
33 Reg Dietician/Cert DSMT/MNT Educator								33
34 Physical Therapist		t i i i i i i i i i i i i i i i i i i i						34
35 Occupational Therapist								35
36 Other Allied Health Personnel		1			1		1	36
37 Subtotal - Direct Patient Care Services		1			1	1	1	37
o, babbaa Direct ruleit our octriced		1		1		1	1	

FORM CMS-2552-10 (02-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN	CMS PUB. 15-2, SECTION 4071)			
40-664				Rev. 22
02-24	FORM CMS-2552-10			4090 (Cont.)
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES		PROVIDER CCN:	PERIOD:	WORKSHEET N-1

FOR HOSPIT	AL-BASED FQHC					COMPONENT CCN:	FROM: TO:		
				I	1				
	NTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
REIMBURSA	BLE PASS THROUGH COSTS	-	_	-		-			
	umococcal Vaccines & Med Supplies								47
	Jenza Vaccines & Med Supplies								48
48.10 COV	VID-19 Vaccine & Med Supplies								48.10
48.11 Mon	noclonal Antibody Products								48.11
49 Subt	total - Reimbursable Pass through Costs								49
OTHER FQH	C SERVICES								
	licare Excluded Services								60
	gnostic & Screening Lab Tests								61
	iology - Diagnostic								62
	thetic Devices								63
	able Medical Equipment								64
	oulance Services								65
66 Tele									66
	gs Charged to Patients								67
	onic Care Management								68
69 Othe									69
	total - Other FQHC Services								70
	JRSABLE COST CENTERS								
	il Pharmacy								77
	er Nonreimbursable								78
	total - Non-Reimbursable Costs								79
100 TOT	TAL (sum of lines 13, 37, 49, 70, and 79)								100

ALCULATION OF HOSPITAL-BASED FQHC CO	ST PER VISIT										PROVII	DER CCN:	PERIC		WORKSHEET N-2	
												NENT CCN:		M O	-	
													1	0	-	
		ſ				1	Ī	i			1				•	
			_		Medical,	Other Direct Care						-				
	Wkst. N-1,		ect Cost actitioner		al Health, DP Visits	Costs & Pharmacy Costs	Genera	Service Cost	Tota	al Costs		rage Cost er Visit				
	col. 7,		Wkst. N-1		actitioner	(see instructions)		nstructions)		actitioner		ractitioner				
Positions	line:		1	<u> </u>	2	3	Ì	4	5	5	, in the second	6				
1 Physician	23															1
2 Physician Services Under Agreement	24															2
3 Physician Assistant	25															3
4 Nurse Practitioner	26															4
5 Visiting Registered Nurse	27															5
6 Visiting Licensed Practical Nurse	28															(
7 Certified Nurse Midwife	29															7
8 Clinical Psychologist	30															8
9 Clinical Social Worker	31															9
9.10 Marriage and Family Therapist	31.10															9.1
9.11 Mental Health Counselor	31.11															9.1
10 Reg Dietician/Cert DSMT/MNT Educator	33															10
11 Totals																11
12 Unit Cost Multiplier																12
13 Total Cost Per Visit																13
	1					1						1				_
			Total Vis	sits				Title XVIII	Visits					Title XVIII Costs		_
			Mental He					Mental H						Mental Health		
	Medical V		(Non IOP)		IOP Vi			(Non IOP)		IOP V		Medical Vis		(Non IOP) Visits	IOP Visits	
	by Practiti	ioner	by Practiti	oner	by Practit			by Practiti	oner	by Practi		by Practition	ner	by Practitioner	by Practitioner	_
Positions	7		8		8.01	9)	10		10.0	1	11		12	12.01	
1 Physician																1
2 Physician Services Under Agreement																2
3 Physician Assistant																3
4 Nurse Practitioner																4
5 Visiting Registered Nurse																5
6 Visiting Licensed Practical Nurse																(
7 Certified Nurse Midwife																5
8 Clinical Psychologist																8
9 Clinical Social Worker																ç
9.10 Marriage and Family Therapist																9.1
9.11 Mental Health Counselor																9.1
10 Reg Dietician/Cert DSMT/MNT Educator																10
11 Totals																11
12 Unit Cost Multiplier			_							_						12
13 Total Cost Per Visit																13

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)2-24	FOF	RM CMS-2552-10)		4090 ((Cont.)
COMPU	TATION OF HOSPITAL-BASED FQHC VACCINE COST		PROVIDER CCN:	PERIOD: FROM:	WORKSHEET N-3	
			COMPONENT CCN:	TO:		
		1	I	I		
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1	2	2.01	2.02	1
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)					1
2	Ratio of injection/infusion staff time to total health care staff time					2
3	Injection/infusion health care staff cost (line 1 x line 2)					3
4	Injections/infusions and related medical supplies cost (from Worksheet N-1, column 7, lines 47, 48, 48.10, and 48.11, respectively)					4
5	Direct cost of injections/infusions (line 3 + line 4)					5
6	Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8)					(
7	Total administrative overhead (from Worksheet N-1, column 7, line 8)					<u> </u>
8	Ratio of injection/infusion direct cost to total direct cost (line 5 / line 6)					8
9	Overhead cost - injections/infusions (line 7 x line 8)					
	Total cost of injections/infusions and their administration (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from your records)					1
12	Cost per injection/infusion (line 10 / line 11)					12
13	Number of injections/infusions administered to Medicare beneficiaries					13

to Medicare beneficiaries 13.01 Number of COVID-19 vaccine injections/infusions

 administered to MA emones

 14
 Cost of injections/infusions and their administration costs furnished to Medicare/MA beneficiaries

16 Total Medicare cost of injections/infusions and their

(transfer this amount to Worksheet N-4, line 2)

(line 12 times the sum of lines 13 and 13.01, as applicable)

15 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10)

administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14)

administered to MA enrollees

13.01

14

15

16

4090 (Cont.)	FORM CMS-2552-1)			02-24
CALCULATION OF HOSPITAL-BASE	ED FQHC REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET N-4	
			FROM:		
		COMPONENT CCN:	TO:		

1	FQHC PPS amount (see instructions)	1
2	Medicare cost of injections/infusions and administration (From Worksheet N-3, line 16)	2
3	Medicare advantage supplemental payments (for information only)	3
4	Total (sum of lines 1 and 2)	4
5	Primary payer payments	5
6	Total amount payable for program beneficiaries (line 4 minus line 5)	6
7	Coinsurance billed to program beneficiaries	7
8	Net Medicare reimbursement excluding bad debts (line 6 minus line 7)	8
9	Allowable bad debts (see instructions)	9
10	Adjusted reimbursable bad debts (see instructions)	10
11	Allowable bad debts for dual eligible beneficiaries (see instructions)	11
12	Subtotal (line 8 plus line 10)	12
13	Other adjustments (specify) (see instructions)	13
13.99	Demonstration payment adjustment amount before sequestration	13.99
14	Amount due hospital-based FQHC prior to the sequestration adjustment (see instructions)	14
15	Sequestration adjustment (see instructions)	15
15.25	Sequestration for non-claims based amounts (see instructions)	15.25
16	Amount due hospital-based FQHC after sequestration adjustment (see instructions)	16
16.01	Demonstration payment adjustment amount after sequestration	16.01
17	Interim payments (from Worksheet N-5, col. 2, line 4)	17
18	Tentative settlement (for contractor use only)	18
19	Balance due hospital-based FQHC/program (line 16 minus lines 16.01, 17 and 18)	19
20	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	20

10-18	FORM CMS-25		4090 ((Cont.)	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FO	HC FOR SERVICES RENDERED	PERIOD: FROM: TO:	WORKSHEET N-5		
			Par	rt B	

		1 410	D	
		mm/dd/yyyy	Amount	
Description		1	2	
1 Total interim payments paid to hospital-based FQHC				
2 Interim payments payable on individual bills, either subr	nitted or to be submitted to the contractor			
for services rendered in the cost reporting period. If nor	e, write "NONE" or enter a zero			
3 List separately each retroactive		.01		
lump sum adjustment amount based		.02		
on subsequent revision of the	Program to	.03		
interim rate for the cost reporting period.	Provider	.04		
Also show date of each payment.		.05		
If none, write "NONE" or enter a zero. (1)		.50		
		.51		
	Provider to	.52		
	Program	.53		
		.54	-	
Subtotal (sum of lines 3.01 through 3.49 minus sum of li	nes 3.50 through 3.98)	.99		
4 Total interim payments (sum of lines 1, 2, and 3.99)			-	
(transfer to Wkst. N-4, line 17)				
TO BE COMPLETED BY CONTRACTOR				
5 List separately each tentative settlement	Program to	.01		
payment after desk review. Also show	Provider	.02		
date of each payment.		.03		
If none, write "NONE" or enter a zero. (1)		.50		
	Provider to	.51		
	Program	.52		
Subtotal (sum of lines 5.01 through 5.49 minus sum of li	nes 5.50 through 5.98)	.99		
6 Determine net settlement amount (balance	Program to provider	.01		
due) based on the cost report (1)	Provider to program	.02		
7 Total Medicare program liability (see instructions)				

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

4090 (Cont.)	FC	ORM CMS-2552	-10					10-18
ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
CENED	AL SERVICE COST CENTERS	1	2	3	4	5	6	7	<u> </u>
	Cap Rel Costs-Bldg & Fixt*						-		1
	Cap Rel Costs-Myble Equip*					-			2
	Employee Benefits Department*								3
	Administrative & General *								4
	Plant Operation and Maintenance*								5
	Laundry & Linen Service*								6
	Housekeeping*								7
	Dietary*								8
	Nursing Administration*								9
	Routine Medical Supplies*								10
	Medical Records*								11
	Staff Transportation*								12
	Volunteer Service Coordination*								13
	Pharmacy*								14
	Physician Administrative Services*								15
	Other General Service*								16
	Patient/Residential Care Services								17
	PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care-Contracted**								25
	Physician Services**								26
27	Nurse Practitioner**								27
28	Registered Nurse**								28
29	LPN/LVN**								29
30	Physical Therapy**								30
	Occupational Therapy**								31
32	Speech/ Language Pathology**								32
	Medical Social Services**								33
	Spiritual Counseling**								34
	Dietary Counseling**								35
	Counseling - Other**								36
37	Hospice Aide and Homemaker Services**								37
	Durable Medical Equipment/Oxygen**								38
39	Patient Transportation**								39

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

FORM CMS-2552-10 (10-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC	TION 4072)		
40-670			Rev. 15
03-18	FORM CMS-2552-10		4090 (Cont.)
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		PROVIDER CCN: P	VERIOD: WORKSHEET O

							FROM	1	
						HOSPICE CCN:	то		
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	1
	PATIENT CARE SERVICE COST CENTERS (Cont.)								
	Imaging Services**								40
	Labs and Diagnostics**								41
	Medical Supplies-Non-routine**								42
	Drugs Charged to Patients**								42.50
	Outpatient Services**								43
	Palliative Radiation Therapy**								44
	Palliative Chemotherapy**								45
	Other Patient Care Services**								46
	IMBURSABLE COST CENTERS								
	Bereavement Program *								60
	Volunteer Program *								61
	Fundraising*								62
	Hospice/Palliative Medicine Fellows*								63
	Palliative Care Program*								64
	Other Physician Services*								65
66	Residential Care *								66
	Advertising*								67
	Telehealth/Telemonitoring*								68
	Thrift Store*								69
	Nursing Facility Room & Board*								70
71	Other Nonreimbursable*								71
100	Total								100

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate. ** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

4090 (Cont.)	FG	ORM CMS-2552	-10					03-18
ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS E CONTINUOUS HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-1	
		SALARIES	OTHER 2	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS 4	SUBTOTAL	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6) 7	
DIREC	F PATIENT CARE SERVICE COST CENTERS	1	-	5		5	0	,	
	Inpatient Care - Contracted								25
	Physician Services								26
	Nurse Practitioner								27
	Registered Nurse								28
29	LPN/LVN								29
	Physical Therapy								30
	Occupational Therapy								31
	Speech/ Language Pathology								32
	Medical Social Services								33
34	Spiritual Counseling								34
	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

10-18			4090 (Cont.)						
	SIS OF HOSPITAL-BASED HOSPICE COSTS DE ROUTINE HOME CARE					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET O-2	
		SALARIES 1	OTHER 2	SUBTOTAL (col. 1 plus col. 2) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6) 7	
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
27	Nurse Practitioner								27
	Registered Nurse								28
29	LPN/LVN								29
	Physical Therapy								30
	Occupational Therapy								31
32	Speech/ Language Pathology								32
	Medical Social Services								33
	Spiritual Counseling								34
35	Dietary Counseling								35
	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

4090 (Cont.)	FG	ORM CMS-2552	-10					10-18
ANALY	SIS OF HOSPITAL-BASED HOSPICE COSTS CE INPATIENT RESPITE CARE					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET O-3	
		SALARIES	OTHER 2	SUBTOTAL (col. 1 plus col. 2) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6) 7	
DIRECT	F PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

10-18		FO	DRM CMS-2552	-10				4090	(Cont.)
	SIS OF HOSPITAL-BASED HOSPICE COSTS CE GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET O-4	
		SALARIES 1	OTHER 2	SUBTOTAL (col. 1 plus col. 2) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6) 7	
	PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care - Contracted								25
	Physician Services								26
27	Nurse Practitioner								27
	Registered Nurse								28
29	LPN/LVN								29
	Physical Therapy								30
	Occupational Therapy								31
32	Speech/ Language Pathology								32
	Medical Social Services								33
	Spiritual Counseling								34
35	Dietary Counseling								35
	Counseling - Other								36
	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

4090 (Co	nt.) FORM	FORM CMS-2552-10						
COST ALL	OCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NSES FOR ALLOCATION	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET O-5				
			10					
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B, PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)				
	Descriptions	1	2	3				
	SERVICE COST CENTERS							
	p Rel Costs-Bldg & Fixt				1			
	p Rel Costs-Mvble Equip				2			
	nployee Benefits				3			
	ministrative & General				4			
	nt Operation and Maintenance				5			
	undry & Linen Service				6			
7 Ho	usekeeping				7			
8 Die					8			
	rsing Administration				9			
	utine Medical Supplies				10			
	edical Records				11			
	Iff Transportation				12			
13 Vo	lunteer Service Coordination				13			
14 Pha	armacy				14			
15 Phy	ysician Administrative Services				15			
	her General Service				16			
17 Pat	tient/Residential Care Services				17			
LEVEL OF	CARE							
50 Ho	spice Continuous Home Care				50			
51 Ho	spice Routine Home Care				51			
52 Ho	spice Inpatient Respite Care				52			
53 Ho	spice General Inpatient Care				53			
NONREIME	BURSABLE COST CENTERS							
60 Bei	reavement Program				60			
61 Vo	lunteer Program				61			
62 Fu	ndraising				62			
63 Ho	spice/Palliative Medicine Fellows				63			
64 Pal	liative Care Program				64			
	her Physician Services				65			
66 Res	sidential Care				66			
67 Ad	vertising				67			
68 Tel	lehealth/Telemonitoring				68			
	rift Store				69			
70 Nu	rsing Facility Room & Board				70			
	her Nonreimbursable				71			
99 Ne	gative Cost Center				99			
100 Tot	tal				100			

11-17				FO	RM CMS-2552	2-10					4090	(Cont.)
COST A	LLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE C	OSTS		PROVIDER CCN:		PERIOD:		WORKSHEET O-6			
							FROM			_	PART I	
							HOSPICE CCN:		то			
			CAP REL	CAP REL	EMPLOYEE		ADMINIS-	PLANT	LAUNDRY	HOUSE-	DIETARY	
		TOTAL	BLDG	MVBLE	BENEFITS		TRATIVE &	OP &	& LINEN	KEEPING		
		EXPENSES	& FIX	EQUIP	DEPARTMENT	SUBTOTAL	GENERAL	MAINT	-	7		4
CENED	Descriptions AL SERVICE COST CENTERS	0	1	2	3	3A	4	5	6	/	8	
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Bidg & Fixt Cap Rel Costs-Mvble Equip				-							2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance								-			5
	Laundry & Linen Service											6
	Housekeeping										-	7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies											10
	Medical Records											10
	Staff Transportation											11
	Volunteer Service Coordination											12
	Pharmacy											13
	Physician Administrative Services											14
	Other General Service											16
10	Patient/Residential Care Services											10
I EVEI	OF CARE											17
	Hospice Continuous Home Care											50
	Hospice Continuous Home Care											51
	Hospice Inpatient Respite Care											52
	Hospice General Inpatient Care											53
	IMBURSABLE COST CENTERS											
	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
99	Negative Cost Center											99
	Total											100

FORM CMS-2552-10 (11-2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2,	SECTION 4072.3)			
Rev. 12				40-677
4090 (Cont.)	FORM CMS-2552-10			11-17
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		PROVIDER CCN:	PERIOD:	WORKSHEET O-6

.....

						HOSPICE CCN:		FROM TO		PART I	
	NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /	TOTAL	
	ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMIN	GENERAL	RESIDENT		
Descriptions	TRATION 9	SUPPLIES 10	11	PORTATION 12	DINATION 13	14	SERVICES 15	SERVICE 16	CARE SVCS 17	18	-
GENERAL SERVICE COST CENTERS	9	10	11	12	15	14	15	10	1/	10	<u> </u>
1 Cap Rel Costs-Bldg & Fixt								-			1
2 Cap Rel Costs-Myble Equip	-										2
3 Employee Benefits	-										3
4 Administrative & General	-										4
5 Plant Operation and Maintenance	-										5
6 Laundry & Linen Service											6
	-										7
7 Housekeeping 8 Dietary	_										8
											9
9 Nursing Administration 10 Routine Medical Supplies			ł								10
11 Medical Records											10
					-						
12 Staff Transportation						-					12 13
13 Volunteer Service Coordination							4				13
14 Pharmacy	-							_			
15 Physician Administrative Services									-		15
16 Other General Service (specify)										4	16 17
17 Patient/Residential Care Services LEVEL OF CARE											1/
											50
50 Continuous Home Care											50
51 Routine Home Care											51
52 Inpatient Respite Care											52
53 General Inpatient Care											53
NONREIMBURSABLE COST CENTERS											
60 Bereavement Program											60
61 Volunteer Program											61
62 Fundraising											62
63 Hospice/Palliative Medicine Fellows											63
64 Palliative Care Program											64
65 Other Physician Services											65
66 Residential Care											66
67 Advertising											67
68 Telehealth/Telemonitoring											68
69 Thrift Store											69
70 Nursing Facility Room & Board											70
71 Other Nonreimbursable (specify)											71
99 Negative Cost Center											99
100 Total											100

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS PROVIDER CCN HOSPICE CAP REL CAP REL CAP REL EMPLOYEE ADMINIS- BENEFITS ADMINIS- TRATIVE & Cost Center Descriptions 1 2 3 4A 4 GENERAL SERVICE COST CENTERS IATION Cost) 1 Cap Rel Costs-Bidg & Fixt Cost Center Descriptions 1 2 3 4A 4 GENERAL SERVICE COST CENTERS 1 2 3 4A 4 1 Cap Rel Costs-Bidg & Fixt 1 2 3 4A 4 2 Cap Rel Costs-Myble Equip 1 2 3 4 4 Administrative & General 1 1 2 5 Plant Operation and Maintenance 1 1 6 Laundry & Linen Service 1 1 7 House		PERIOD: FROM TO LAUNDRY & LINEN (In-Facil- ity Days) 6	- HOUSE- KEEPING (Square Feet) 7	WORKSHEET O- PART II DIETARY (In-Facil- ity Days)	(Cont.) H-6
CAP REL CAP REL EMPLOYEE ADMINIS- TRATIVE & BLDG MVBLE BENEFITS TRATIVE & & FIX EQUIP DEPARTMENT GENERAL (Square (Dollar (Gross RECONCIL- (Square (Dollar (Gross RECONCIL- Cost Center Descriptions 1 2 3 4A GENERAL SERVICE COST CENTERS 1 2 3 4A 1 Cap Rel Costs-Bidg & Fixt	PLANT OP & MAINT (Square Feet)	TO LAUNDRY & LINEN (In-Facil- ity Days)	HOUSE- KEEPING (Square Feet)	DIETARY (In-Facil-	
BLDG MVBLE BENEFITS TRATIVE & & FIX EQUIP DEPARTMENT GENERAL (Square (Dollar (Gross RECONCIL- (Accum. (Square Value) Salaries) IATION Cost Cost Center Descriptions 1 2 3 4A 4 GENERAL SERVICE COST CENTERS 1 2 3 4A 4 1 Cap Rel Costs-Bilg & Fixt	OP & MAINT (Square Feet)	& LINEN (In-Facil- ity Days)	KEEPING (Square Feet)	(In-Facil-	
Cost Center Descriptions 1 2 3 4A 4 GENERAL SERVICE COST CENTERS Image: Cost Service Servic				ity Days)	1
GENERAL SERVICE COST CENTERS Image: Cost-Bidg & Fixt Image: Cost-Bidg & Fi	5	6	7		
1 Cap Rel Costs-Bidg & Fixt Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 3 Employee Benefits Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 4 Administrative & General Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 5 Plant Operation and Maintenance Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 6 Laundry & Linen Service Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 7 Housekeeping Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 8 Dietary Image: Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip				8	
2 Cap Rel Costs-Mvble Equip Image: Cap Rel Costs-Mvble Equip 3 Employee Benefits Image: Cap Rel Costs-Mvble Equip 4 Administrative & General Image: Cap Rel Costs-Mvble Equip 5 Plant Operation and Maintenance Image: Cap Rel Costs-Mvble Equip 6 Laundry & Linen Service Image: Cap Rel Costs-Mvble Equip 7 Housekeeping Image: Cap Rel Costs-Mvble Equip 8 Dietary Image: Cap Rel Costs-Mvble Equip				_	
3 Employee Benefits Image: Constraint of the second secon					
4 Administrative & General Image: Constraint of the second secon	_				2
5 Plant Operation and Maintenance Image: Constraint of the service 6 Laundry & Linen Service Image: Constraint of the service 7 Housekeeping Image: Constraint of the service 8 Dietary Image: Constraint of the service					3
6 Laundry & Linen Service Image: Constraint of the service 7 Housekeeping Image: Constraint of the service 8 Dietary Image: Constraint of the service		_			4
7 Housekeeping Image: Constraint of the second sec					5
8 Dietary				_	6
					7
9 Nursing Administration					8
					9
10 Routine Medical Supplies					10
11 Medical Records 12 Staff Transportation					11
13 Volunteer Service Coordination					12
13 Volunteer Service Coordination					13
14 Pharmacy 15 Physician Administrative Services					14
16 Other General Service					15
17 Patient/Residential Care Services					16
LEVEL OF CARE					1/
50 Hospice Continuous Home Care					50
50 Hospice Continuous Home Care					50
51 Hospice Routine Home Care 52 Hospice Inpatient Respite Care					51
53 Hospice General Inpatient Care					53
NONREIMBURSABLE COST CENTERS					53
INDIVIDUATION DATABLE COST CENTERS 60 Bereavement Program					60
61 Volunteer Program					60
62 Fundraising					61
63 Hospice/Palliative Medicine Fellows					63
64 Palliative Care Program					63
G5 Other Physical Services					65
00 Other Physician Services 66 Residential Care					66
67 Advertising	-				67
68 Telehealth/Telemonitoring					68
- oo recentato reministring 69 Thrift Store					69
70 Nursing Facility Room & Board					70
70 Pursing racing koon to board					70
99 Negative Cost Center					99
30 Regardle Cost Cost Cost Cost Cost Cost Cost Cost					100
101 Cost of a notatic (per wase 56, rat 1)					

4090 (Cont.)			FO	RM CMS-2552	2-10						11-17
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GE	ENERAL SERVICE O	COSTS STATISTIC	AL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET O PART II	-6
							HOSPICE CCN:		то			
		NURSING ADMINIS- TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS- PORTATION (Mileage)	VOLUNTEER SVC COOR- DINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMIN SERVICES (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENT CARE SVCS (In-Facil- ity Days)	TOTAL	
С	ost Center Descriptions	9	10	11	12	13	14	15	16	17	18	1
	AL SERVICE COST CENTERS								-			
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Myble Equip											2
	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
	Laundry & Linen Service											6
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
10	Routine Medical Supplies											10
	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination						1					13
14	Pharmacy							1				14
15	Physician Administrative Services								1			15
16	Other General Service											16
17	Patient/Residential Care Services										1	17
LEVEL	OF CARE				1							
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
	IMBURSABLE COST CENTERS											
60	Bereavement Program											60
	Volunteer Program											61
	Fundraising											62
	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
68												68
69												69
												70
	Other Nonreimbursable											71
	Negative Cost Center											99
	Cost to be allocated (per Wkst. O-6, Part I)											100
101	Unit cost multiplier											101

40-680

1	1	_	1	6

FORM CMS-2552-1

4090 (Cont.)

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

PROVIDER CCN: PERIOD: WORKSHEET 0-7 HOSPICE CCN: TO _____

	Wkst. C,	Cost to	Cl	Charges by LOC (from Provider Records)				Shared Service	Costs by LOC		
	Pt. I, col. 9,	Charge					HCHC	HRHC	HIRC	HGIP	1
	line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	1
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	66										
2 Occupational Therapy	67										
3 Speech/ Language Pathology	68										
4 Drugs, Biological and Infusion Therapy	73										
5 Durable Medical Equipment/Oxygen	96										
6 Labs and Diagnostics	60										
7 Medical Supplies	71										
8 Outpatient Services (including E/R Dept.)	93										
9 Radiation Therapy	55										
10 Other	76										
11 Totals (sum of lines 1 through 10)											

4090 (Cont.)	FORM CMS-2552-10				11-16
CALCU	LATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-8	
			HOSPICE CCN:	то		
			TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
			1	2	3	-
HOSPIC	E CONTINUOUS HOME CARE		-	-	5	
1	Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 2	11)				1
2	Total unduplicated days (Wkst. S-9, col. 4, line 10)	,				2
	Total average cost per diem (line 1 divided by line 2)					3
4	Unduplicated program days (Wkst. S-9, col. as appropriate, line 10)					4
	Program cost (line 3 times line 4)					5
HOSPIC	E ROUTINE HOME CARE					
6	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line	11)				6
7	Total unduplicated days (Wkst. S-9, col. 4, line 11)	,				7
8	Total average cost per diem (line 6 divided by line 7)					8
9	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)					9
10	Program cost (line 8 times line 9)					10
HOSPIC	E INPATIENT RESPITE CARE					
11	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line	11)				11
12	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12
13	Total average cost per diem (line 11 divided by line 12)					13
14	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)					14
	Program cost (line 13 times line 14)					15
HOSPIC	E GENERAL INPATIENT CARE					
16	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line	11)				16
17	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17
	Total average cost per diem (line 16 divided by line 17)					18
19	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)					19
	Program cost (line 18 times line 19)					20
	HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)					21
	Total unduplicated days (Wkst. S-9, col. 4, line 14)					22
23	Average cost per diem (line 21 divided by line 22)					23