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

FORM APPROVED
OMB NO. 0938-0463

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronic filed cost report Date:_____ Time:_____ 2. [ ] Manually submitted cost report 3. If this is an amended report enter the number of times the provider resubmitted this cost report. _____	
Contractor use only:	4. [ ] Cost Report Status [1] As Submitted: [2] Settled without audit [3] Settled with audit [4] Reopened [5] Amended	5. Date Received _____ 6. Contractor No. _____ 7. [ ] First Cost Report for this Provider CCN 8. [ ] Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. If line 4, column 1 is "4": Enter number of times reopened _____ 11. Contractor Vendor Code _____

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDERS)

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

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name_____ Signed_____

Title_____ Date_____

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX	
		1	2	3	4	
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F-Mentally Retarded					3
4	SNF - BASED HHA					4
5	SNF - BASED RHC					5
6	SNF - BASED FQHC					6
7	SNF - BASED CMHC					7
100	TOTAL					100

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART I

Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

1	Street:	P.O. Box:			1
2	City:	State:	*ZIP* Code		2
3	County:	CBSA Code:	Urban / Rural:		3

SNF and SNF - Based Component Identification:

	Component	Component Name	Provider CCN	Date Certified	Payment System (P, O or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
4	S N F							4
5	Nursing Facility							5
6	I C F - Mentally Retarded							6
7	SNF-Based HHA							7
8	SNF-Based RHC							8
9	SNF-Based FQHC							9
10	SNF-Based CMHC							10
11	SNF-Based OLTC							11
12	SNF-Based HOSPICE							12
13	OTHER (specify)							13
14	Cost Reporting Period (mm/dd/yyyy)	From: To:						14
15	Type of Control (see instructions)							15

Type of Freestanding Skilled Nursing Facility		Y / N					
16	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						16
17	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?						17
18	Are there any costs included in Worksheet A *that* resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.						18

Miscellaneous Cost Reporting Information						
19	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.					19
19.01	If the response to line 19 is "Y", does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)					19.01

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.						
20	Straight Line					20
21	Declining Balance					21
22	Sum of the Year's Digits					22
23	Sum of line 20 through 22					23
24	If depreciation is funded, enter the balance as of the end of the period.					24
25	Were there any disposal of capital assets during the cost reporting period? (Y/N)					25
26	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					26
27	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y?N)					27
28	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					28

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM_____ TO_____	WORKSHEET S-2 PART I

	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.	Part A	Part B	Other	
29	Skilled Nursing Facility				29
30	Nursing Facility				30
31	I C F / M R				31
32	SNF-Based HHA				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
36	SNF-Based OLTC				36

		Y / N			
37	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients. (Y/N)				37
38	Are you legally required to carry malpractice insurance? (Y/N)				38
39	Is the malpractice a "claims-made" or "occurence" policy? If the policy is "claims-made," enter 1. If the policy is "occurence", enter 2.				39

		Premiums	Paid Losses	Self insurance	
41	List malpractice premiums and paid losses:				41

		Y / N					
42	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If "Y", check box, and submit supporting schedule listing cost centers and amounts.						42
43	*Are there any home office costs as defined in CMS Pub. 15-1, chapter 10?*						43
44	If line 43 = "Y", and there are costs for the home office, enter the applicable home office chain number in column 1.						44

If this facility is part of a chain organization, enter the name and address of the home office on the lines below.

45	Name:		Contractor Name:	Contractor Number:	45
46	Street:	P.O. Box:			46
47	City	State	*ZIP Code*		47

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART II

General Instruction: For all column 1 responses, enter in column 1, "Y" for Yes or "N" for No
For all dates responses, use the format mm/dd/yyyy.

Completed by All Skilled Nursing Facilities

		Y/N	Date	
Provider Organization and Operation		1	2	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", enter the date of the change in column 2. (see instructions)			1

		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare Program? If column 1 is "Y", enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Were costs claimed for nursing school? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)			6
7	Were costs claimed for allied health programs? (Y/N) (see instructions)			7
8	Were approvals and/or renewals obtained during the cost reporting period for nursing school and/or allied health program? (Y/N) (see instructions)			8

		Y/N	
Bad Debts		1	
9	Is the provider seeking reimbursement for bad debts? (Y/N) (see instructions)		9
10	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.		10
11	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.		11

Bed Complement

12	Have total beds available changed from prior cost reporting period? If "Y", see instructions.		12

		Y/N Part A	Date Part A	Y/N Part B	Date Part B	
PS&R Report Data		1	2	3	4	
13	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid-through date of the PS&R used to prepare this cost report in cols. 2 and 4 . (see Instructions)					13
14	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y", enter the paid-through date of the PS&R used to prepare this cost report in columns 2 and 4.					14
15	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see instructions.					15
16	If line 13 or 14 is "Y", were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.					16
17	If line 13 or 14 is "Y", were adjustments made to PS&R data for Other? Describe the other adjustments:_____					17
18	Was the cost report prepared only using the provider's records? If "Y", see instructions.					18

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART I

PART I - STATISTICAL DATA

	Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					Discharges					
				Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Facility													1
2	Nursing Facility													2
3	ICF-Mentally Retarded													3
4	Home Health Agency													4
5	Other Long Term Care													5
6	SNF-Based CMHC													6
7	Hospice													7
8	Total (sum of lines 1-7)													8

	Component	Average Length of Stay				Admissions					Full Time Equivalent		
		Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers	
		13	14	15	16	17	18	19	20	21	22	23	
1	Skilled Nursing Facility												1
2	Nursing Facility												2
3	ICF - Mentally Retarded												3
4	Home Health Agency												4
5	Other Long Term Care												5
6	SNF-Based CMHC												6
7	Hospice												7
8	Total (sum of lines 1-7)												8

SNF WAGE INDEX INFORMATION	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PARTS II & III

PART II - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
SALARIES							
1	Total salary (see instructions)						1
2	Physician salaries-Part A						2
3	Physician salaries-Part B						3
4	Home office personnel						4
5	Sum of lines 2 through 4						5
6	Revised wages (line 1 minus line 5)						6
7	Other Long Term Care						7
8	Home Health Agency						8
9	CMHC						9
10	Hospice						10
11	Other excluded areas						11
12	Subtotal excluded salary (sum of lines 7 through 11)						12
13	Total adjusted salaries (line 6 minus line 12)						13
OTHER WAGES AND RELATED COSTS							
14	Contract Labor: Patient Related & Mgmt						14
15	Contract Labor: Physician services-Part A						15
16	Home office salaries & wage related costs						16
WAGE RELATED COSTS							
17	Wage related costs core (see Pt. IV)						17
18	Wage related costs other (see Pt. IV)						18
19	Wage related costs (excluded units)						19
20	Physicians Part A - WRC						20
21	Physicians Part B - WRC						21
22	Total adjusted wage related cost (see instructions)						22

PART III - OVERHEAD COST - DIRECT SALARIES

		Amount Reported	Reclass. of Salaries from Wkst. A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1	2	3	4	5	
1	Employee Benefits						1
2	Administrative & General						2
3	Plant Operation, Maintenance & Repairs						3
4	Laundry & Linen Service						4
5	Housekeeping						5
6	Dietary						6
7	Nursing Administration						7
8	Central Services and Supply						8
9	Pharmacy						9
10	Medical Records & Medical Records Library						10
11	Social Service						11
12	Nursing and Allied Health Ed. Act.						12
13	Other General Service (specify _____)						13
14	Total (sum lines 1 through 13)						14

SNF WAGE RELATED COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART IV

PART IV - Wage Related Cost

	Part A - Core List	Amount Reported	
	RETIREMENT COST		
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organizations)		
5	401K/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accidental Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion)		16
	TAXES		
17	FICA - Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (sum of lines 1 -23)		24
	Part B Other than Core Related Cost		
25	Other Wage Related Costs (specify)_____		25

SNF REPORTING OF DIRECT CARE EXPENDITURES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART V

	OCCUPATIONAL CATEGORY	Amount Reported 1	Fringe Benefits 2	Adjusted Salaries (col. 1 + col. 2) 3	Paid Hours Related to Salary in col. 3 4	Average Hourly Wage (col. 3 ÷ col. 4) 5	
Direct Salaries							
	Nursing Occupations						
1	Registered Nurses (RNs)						1
2	Licensed Practical Nurses (LPNs)						2
3	Certified Nursing Assistants/Nursing Assistants/Aides						3
4	Total Nursing (sum of lines 1 through 3)						4
5	Physical Therapists						5
6	Physical Therapy Assistants						6
7	Physical Therapy Aides						7
8	Occupational Therapists						8
9	Occupational Therapy Assistants						9
10	Occupational Therapy Aides						10
11	Speech Therapists						11
12	Respiratory Therapists						12
13	Other Medical Staff						13
Contract Labor							
	Nursing Occupations						
14	Registered Nurses (RNs)						14
15	Licensed Practical Nurses (LPNs)						15
16	Certified Nursing Assistants/Nursing Assistants/Aides						16
17	Total Nursing (sum of lines 14 through 16)						17
18	Physical Therapists						18
19	Physical Therapy Assistants						19
20	Physical Therapy Aides						20
21	Occupational Therapists						21
22	Occupational Therapy Assistants						22
23	Occupational Therapy Aides						23
24	Speech Therapists						24
25	Respiratory Therapists						25
26	Other Medical Staff						26

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SNF - BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER CCN: HHA *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

1	County		1

	DESCRIPTION	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	
2	Home Health Aide Hours						2
3	Unduplicated Census Count (see instructions)						3

	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)	Staff	Contract	Total	
		1	2	3	
4	Enter the number of hours in your normal work week				4
5	Administrator and Assistant Administrator(s)				5
6	Directors and Assistant Director(s)				6
7	Other Administrative Personnel				7
8	Direct Nursing Service				8
9	Nursing Supervisor				9
10	Physical Therapy Service				10
11	Physical Therapy Supervisor				11
12	Occupational Therapy Service				12
13	Occupational Therapy Supervisor				13
14	Speech Pathology Service				14
15	Speech Pathology Supervisor				15
16	Medical Social Service				16
17	Medical Social Service Supervisor				17
18	Home Health Aide				18
19	Home Health Aide Supervisor				19
20	Other (specify)				20

HOME HEALTH AGENCY CBSA CODES

21	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		21
22	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 contains the first code).		22

	PPS ACTIVITY DATA	Full Episodes		LUPA Episodes	PEP only Episodes	Total (cols. 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
23	Skilled Nursing Visits						23
24	Skilled Nursing Visit Charges						24
25	Physical Therapy Visits						25
26	Physical Therapy Visit Charges						26
27	Occupational Therapy Visits						27
28	Occupational Therapy Visit Charges						28
29	Speech Pathology Visits						29
30	Speech Pathology Visit Charges						30
31	Medical Social Service Visits						31
32	Medical Social Service Visit Charges						32
33	Home Health Aide Visits						33
34	Home Health Aide Visit Charges						34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)						35
36	Other Charges						36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)						37
38	Total Number of Episodes (standard/non outlier)						38
39	Total Number of Outlier Episodes						39
40	Total Non-Routine Medical Supply Charges						40

SNF - BASED RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	PROVIDER CCN: COMPONENT *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET S-5

Check applicable box: [ ] RHC [ ] FQHC

Clinic Address and Identification:

1	Street:		County:	1
2	City:	State:	Zip Code:	2
3	Designation (for FQHC's only) - "U" for urban or "R" for rural			3

Source of Federal funds:		Grant Award	Date	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look - Alikes			8
9	Other (specify)			9

		1	2	
10	Does the facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.			10

Facility hours of operations (1)

	Type of Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation).
List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?			12
13	Is this a consolidated cost report in accordance with IOM CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14	Provider Name:	CCN Number:		14

SKILLED NURSING FACILITY BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REAHBILITATION PROVIDER STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-6

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

Enter the number of hours in your normal workweek _____

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

		Staff	Contract	Total (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
8	Occupational Therapy Service				8
9	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
19	Other (specify)				19

PROSPECTIVE PAYMENT FOR SNF STATOSTOCA; DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-7

	GROUP	Days	
	1	2	
1	RUX		1
2	RUL		2
3	RVX		3
4	RVL		4
5	RHX		5
6	RHL		6
7	RMX		7
8	RML		8
9	RLX		9
10	RUC		10
11	RUB		11
12	RUA		12
13	RVC		13
14	RVB		14
15	RVA		15
16	RHC		16
17	RHB		17
18	RHA		18
19	RMC		19
20	RMB		20
21	RMA		21
22	RLB		22
23	RLA		23
24	ES3		24
25	ES2		25
26	ES1		26
27	HE2		27
28	HE1		28
29	HD2		29
30	HD1		30
31	HC2		31
32	HC1		32
33	HB2		33
34	HB1		34
35	LE2		35
36	LE1		36
37	LD2		37
38	LD1		38
39	LC2		39
40	LC1		40
41	LB2		41
42	LB1		42
43	CE2		43
44	CE1		44
45	CD2		45
46	CD1		46
47	CC2		47
48	CC1		48
49	CB2		49
50	CB1		50

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-7

	GROUP	Days	
	1	2	
51	CA2		51
52	CA1		52
53	SE3		53
54	SE2		54
55	SE1		55
56	SSC		56
57	SSB		57
58	SSA		58
59	IB2		59
60	IB1		60
61	IA2		61
62	IA1		62
63	BB2		63
64	BB1		64
65	BA2		65
66	BA1		66
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PA1		76
99	AAA		99
100	Total		100

A notice published in the "Federal Register" Vol. 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 101 through 106: Enter in column 1 the amount of 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 1 column3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (see instructions)

		Expenses	Percentage	Y/N	
		1	2	3	
101	Staffing				101
102	Recruitment				102
103	Retention of employees				103
104	Training				104
105	Other (Specify)				105
106	Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)				106

HOSPICE IDENTIFICATION DATA	PROVIDER CCN: HOSPICE *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET S - 8

PART I - ENROLLMENT DAYS

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

PART II - CENSUS DATA

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

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

		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	B	C	1	2	3	4	5	6	7	A
GENERAL SERVICE COST CENTERS										
1	0100	Capital-Related Costs - Buildings & Fixtures								1
2	0200	Capital-Related Costs - Moveable Equipment								2
3	0300	Employee Benefits								3
4	0400	Administrative and General								4
5	0500	Plant Operation, Maintenance and Repairs								5
6	0600	Laundry and Linen Service								6
7	0700	Housekeeping								7
8	0800	Dietary								8
9	0900	Nursing Administration								9
10	1000	Central Services and Supply								10
11	1100	Pharmacy								11
12	1200	Medical Records and Library								12
13	1300	Social Service								13
14	1400	Nursing and Allied Health Education								14
15		Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS										
30	3000	Skilled Nursing Facility								30
31	3100	Nursing Facility								31
32	3200	ICF - Mentally Retarded								32
33	3300	Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS										
40	4000	Radiology								40
41	4100	Laboratory								41
42	4200	Intravenous Therapy								42
43	4300	Oxygen (Inhalation) Therapy								43
44	4400	Physical Therapy								44
45	4500	Occupational Therapy								45
46	4600	Speech Pathology								46
47	4700	Electrocardiology								47

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

		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase /Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	B	C	1	2	3	4	5	6	7	
48	4800	Medical Supplies Charged to Patients								48
49	4900	Drugs Charged to Patients								49
50	5000	Dental Care - Title XIX only								50
51	5100	Support Surfaces								51
52		Other Ancillary Service Cost								52
OUTPATIENT SERVICE COST CENTERS										
60	6000	Clinic								60
61	6100	Rural Health Clinic (RHC)								61
62	6200	FQHC								62
63		Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS										
70	7000	Home Health Agency Cost								70
71	7100	Ambulance								71
72		Outpatient Rehabilitation (specify)								72
73	7300	CMHC								73
74		Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS										
80	8000	Malpractice Premiums & Paid Losses							-0-	80
81	8100	Interest Expense							- 0 -	81
82	8200	Utilization Review							- 0 -	82
83	8300	Hospice								83
84		Other Special Purpose Cost								84
89		SUBTOTALS (sum of lines 1 through 84)								89
NON REIMBURSABLE COST CENTERS										
90	9000	Gift, Flower, Coffee Shops and Canteen								90
91	9100	Barber and Beauty Shop								91
92	9200	Physicians' Private Offices								92
93	9300	Nonpaid Workers								93
94	9400	Patients' Laundry								94
95		Other Nonreimbursable Cost								95
100		TOTAL								100

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

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

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

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 7 minus line 8)								9

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

	Description (1)	Basis for Adjustment (2)	Amount	Expense Classification on Wkst. A to/from which the amount is to be adjusted		
				Cost Center	Line No.	
	0	1	2	3	4	
1	Investment income on restricted funds (Chapter 2)					1
2	Trade, quantity and time discounts on purchases (Chapter 8)					2
3	Refunds and rebates of expenses Chapter 8)					3
4	Rental of provider space by suppliers Chapter 8)					4
5	Telephone services (pay stations excluded) (Chapter 21)					5
6	Television and radio service (Chapter 21)					6
7	Parking lot (Chapter 21)					7
8	Remuneration applicable to provider-based physician adjustment	Worksheet A-8-2				8
9	Home office costs (Chapter 21)					9
10	Sale of scrap, waste, etc. (Chapter23)					10
11	Nonallowable costs related to certain Capital expenditures (Chapter 24)					11
12	Adjustment resulting from transactions with related organizations (Chapter 10)	Worksheet A-8-1				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (Chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Utilization review--physicians' compensation (Chapter 21)			Utilization Review- SNF	82	22
23	Depreciation--buildings and fixtures			Capital Related Cost- Building	1	23
24	Depreciation--movable equipment			Capital Related Cost-Movable	2	24
25	Other Adjustment					25
100	TOTAL (sum of lines 1 through 99) (transfer to Wkst. A, col. 6, line 100)					100

(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

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

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

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount Included in Wkst. A., col. 5	Adjustments (col. 4 minus col. 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS (sum of lines 1-9) (Transfer column 6, line 10 to Wkst. A-8, col. 3, line 12)						10

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

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

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

				Related Organization(s)			
	(1) Symbol	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

(1) Use the followings 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 organization.
E. Individual is director, officer, administrator or key person of provider and related organization.
F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial or non-financial) specify _____
_____

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

	Wkst. A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

	Wkst. A Line No.	Cost Center / Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of Col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of Col. 14	Adjusted R C E Limit	R C E Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B PART I	
Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS-TRATIVE & GENERAL	
	0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							1
2 Capital-Related Costs - Moveable Equipment							2
3 Employee Benefits							3
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							5
6 Laundry and Linen Service							6
7 Housekeeping							7
8 Dietary							8
9 Nursing Administration							9
10 Central Services and Supply							10
11 Pharmacy							11
12 Medical Records and Library							12
13 Social Service							13
14 Nursing and Allied Health Education							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - Mentally Retarded							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							46
47 Electrocardiology							47
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							49
50 Dental Care - Title XIX only							50
51 Support Surfaces							51
52 Other Ancillary Service Cost							52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	3	3 A	4	
	OUTPATIENT SERVICE COST CENTERS							
60	Clinic							60
61	Rural Health Clinic (RHC)							61
62	FQHC							62
63	Other Outpatient Service Cost							63
	OTHER REIMBURSABLE COST CENTERS							
70	Home Health Agency Cost							70
71	Ambulance							71
72	Outpatient Rehabilitation (specify)							72
73	CMHC							73
74	Other Reimbursable Cost							74
	SPECIAL PURPOSE COST CENTERS							
83	Hospice							83
84	Other Special Purpose Cost							84
89	Subtotals							89
	NON REIMBURSABLE COST CENTERS							
90	Gift, Flower, Coffee Shops and Canteen							90
91	Barber and Beauty Shop							91
92	Physicians' Private Offices							92
93	Nonpaid Workers							93
94	Patients' Laundry							94
95	Other Nonreimbursable Cost							95
98	Cross Foot Adjustments							98
99	Negative Cost Center							99
100	Total							100

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

COST ALLOCATION - GENERAL SERVICE COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
	0	1	2	3	4 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							1
2 Capital-Related Costs - Moveable Equipment							2
3 Employee Benefits							3
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							5
6 Laundry and Linen Service							6
7 Housekeeping							7
8 Dietary							8
9 Nursing Administration							9
10 Central Services and Supply							10
11 Pharmacy							11
12 Medical Records and Library							12
13 Social Service							13
14 Nursing and Allied Health Education							14
15 Other General Service Cost							15
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF - Mentally Retarded							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							46
47 Electrocardiology							47
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							49
50 Dental Care - Title XIX only							50
51 Support Surfaces							51
52 Other Ancillary Service Cost							52

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description		CAP. REL. BUILDINGS & FIXTURES (Square Feet)	CAP. REL. MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
	0	1	2	3	4 A	4	
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustment							98
99 Negative Cost Center							99
102 Cost to be allocated (Per Wkst. B, Pt I.)							102
103 Unit Cost Multiplier (Wkst. B, Pt I.)							103
104 Cost to be allocated (Per Wkst. B, Pt. II)							104
105 Unit Cost Multiplier (Wkst B, Pt. II)							105

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

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

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

	Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nrsing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustment								98
99	Negative Cost Center								99
102	Cost to be allocated (Per Wkst. B, Pt I.)								102
103	Unit Cost Multiplier (Wkst. B, Pt I.)								103
104	Cost to be allocated (Per Wkst. B, Pt. II)								104
105	Unit Cost Multiplier (Wkst B, Pt. II)								105

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

	Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

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

	Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDU EDUCATION (Assigned Time)	GENERAL SERVICE COST COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustment								98
99	Negative Cost Center								99
102	Cost to be allocated (Per Wkst. B, Pt I.)								102
103	Unit Cost Multiplier (Wkst. B, Pt I.)								103
104	Cost to be allocated (Per Wkst. B, Pt. II)								104
105	Unit Cost Multiplier (Wkst B, Pt. II)								105

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD : FROM _____ TO _____		WORKSHEET B PART II			
	Cost Center Description	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART II

	Cost Center Description	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
		0	1	2	2 A	3	4	5	
	OUTPATIENT SERVICE COST CENTERS								
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
	OTHER REIMBURSABLE COST CENTERS								
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
	SPECIAL PURPOSE COST CENTERS								
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
	NON REIMBURSABLE COST CENTERS								
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

ALLOCATION OF CAPITAL - RELATED COSTS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B PART II

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Capital-Related Costs - Buildings & Fixtures							1
2	Capital-Related Costs - Moveable Equipment							2
3	Employee Benefits							3
4	Administrative and General							4
5	Plant Operation, Maintenance and Repairs							5
6	Laundry and Linen Service							6
7	Housekeeping							7
8	Dietary							8
9	Nursing Administration							9
10	Central Services and Supply							10
11	Pharmacy							11
12	Medical Records and Library							12
13	Social Service							13
14	Nursing and Allied Health Education							14
15	Other General Service Cost							15
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Skilled Nursing Facility							30
31	Nursing Facility							31
32	ICF - Mentally Retarded							32
33	Other Long Term Care							33
	ANCILLARY SERVICE COST CENTERS							
40	Radiology							40
41	Laboratory							41
42	Intravenous Therapy							42
43	Oxygen (Inhalation) Therapy							43
44	Physical Therapy							44
45	Occupational Therapy							45
46	Speech Pathology							46
47	Electrocardiology							47
48	Medical Supplies Charged to Patients							48
49	Drugs Charged to Patients							49
50	Dental Care - Title XIX only							50
51	Support Surfaces							51
52	Other Ancillary Service Cost							52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B PART II	
	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
Cost Center Description	6	7	8	9	10	11	
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
100 Total							100

ALLOCATION OF CAPITAL - RELATED COSTS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET B PART II

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS								
1	Capital-Related Costs - Buildings & Fixtures								1
2	Capital-Related Costs - Moveable Equipment								2
3	Employee Benefits								3
4	Administrative and General								4
5	Plant Operation, Maintenance and Repairs								5
6	Laundry and Linen Service								6
7	Housekeeping								7
8	Dietary								8
9	Nursing Administration								9
10	Central Services and Supply								10
11	Pharmacy								11
12	Medical Records and Library								12
13	Social Service								13
14	Nursing and Allied Health Education								14
15	Other General Service Cost								15
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Skilled Nursing Facility								30
31	Nursing Facility								31
32	ICF - Mentally Retarded								32
33	Other Long Term Care								33
	ANCILLARY SERVICE COST CENTERS								
40	Radiology								40
41	Laboratory								41
42	Intravenous Therapy								42
43	Oxygen (Inhalation) Therapy								43
44	Physical Therapy								44
45	Occupational Therapy								45
46	Speech Pathology								46
47	Electrocardiology								47
48	Medical Supplies Charged to Patients								48
49	Drugs Charged to Patients								49
50	Dental Care - Title XIX only								50
51	Support Surfaces								51
52	Other Ancillary Service Cost								52

ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B PART II	

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
		12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS									
60	Clinic								60
61	Rural Health Clinic (RHC)								61
62	FQHC								62
63	Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS									
70	Home Health Agency Cost								70
71	Ambulance								71
72	Outpatient Rehabilitation (specify)								72
73	CMHC								73
74	Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS									
83	Hospice								83
84	Other Special Purpose Cost								84
89	Subtotals								89
NON REIMBURSABLE COST CENTERS									
90	Gift, Flower, Coffee Shops and Canteen								90
91	Barber and Beauty Shop								91
92	Physicians' Private Offices								92
93	Nonpaid Workers								93
94	Patients' Laundry								94
95	Other Nonreimbursable Cost								95
98	Cross Foot Adjustments								98
99	Negative Cost Center								99
100	Total								100

POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET B-2

	Description	Worksheet B		Amount	
		Part No.	Line No.		
	1	2	3	4	
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET C

	Cost Center Description	Total (from Wkst. B, Pt. I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2)	
		1	2	3	
ANCILLARY SERVICE COST CENTERS					
40	Radiology				40
41	Laboratory				41
42	Intravenous Therapy				42
43	Oxygen (Inhalation) Therapy				43
44	Physical Therapy				44
45	Occupational Therapy				45
46	Speech Pathology				46
47	Electrocardiology				47
48	Medical Supplies Charged to Patients				48
49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
51	Support Surfaces				51
52	Other Ancillary Service Cost				52
OUTPATIENT SERVICE COST CENTERS					
60	Clinic				60
61	Rural Health Clinic (RHC)				61
62	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PART I

Check applicable box:	[ ] Title V (1) [ ] Title XVIII [ ] Title XIX (1)
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR [ ] Other _____ [ ] PPS - Must also complete Part II

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

	Cost Center Description	Ratio of Cost to Charges (from Wkst. C, col. 3)	Health Care Program Charges		Healthcare Program Cost		
			Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
40	Radiology						40
41	Laboratory						41
42	Intravenous Therapy						42
43	Oxygen (Inhalation) Therapy						43
44	Physical Therapy						44
45	Occupational Therapy						45
46	Speech Pathology						46
47	Electrocardiology						47
48	Medical Supplies Charged to Patients						48
49	Drugs Charged to Patients						49
50	Dental Care - Title XIX only						50
51	Support Surfaces						51
52	Other Ancillary Service Cost						52
	OUTPATIENT COST CENTERS						
60	Clinic						60
61	Rural Health Clinic (RHC)						61
62	FQHC						62
63	Other Outpatient Service Cost						63
71	Ambulance (2)						71
100	Total (sum of lines 40 - 71)						100

(1) For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PARTS II & III

TITLE XVIII ONLY

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)		1
2	Program vaccine charges (From your records or the PS&R report)		2
3	Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E, Pt. I, line 1)		3

PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH

	Cost Center Description	Total Cost (from Wkst. B, Pt. I, col. 18)	Nursing & Allied Health (from Wkst. B, Pt. I, col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (col. 2 / col. 1)	Program Part A Cost (from Wkst. D., Pt. I, col. 4)	Part A Nursing & Allied Health Costs for Pass Through (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
40	Radiology						40
41	Laboratory						41
42	Intravenous Therapy						42
43	Oxygen (Inhalation) Therapy						43
44	Physical Therapy						44
45	Occupational Therapy						45
46	Speech Pathology						46
47	Electrocardiology						47
48	Medical Supplies Charged to Patients						48
49	Drugs Charged to Patients						49
50	Dental Care - Title XIX only						50
51	Support Surfaces						51
52	Other Ancillary Service Cost						52
100	Total (sum of lines 40 - 52)						100

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D-1 PARTS I & II

Check applicable box:	[ ] Title V [ ] Title XVIII [ ] Title XIX
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR

PART I - CALCULATION OF INPATIENT ROUTINE COSTS			
INPATIENT DAYS			
1	Inpatient days including private room days		1
2	Private room days		2
3	Inpatient days including private room days applicable to the Program		3
4	Medically necessary private room days applicable to the Program		4
5	Total general inpatient routine service cost		5
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
6	General inpatient routine service charges		6
7	General inpatient routine service cost/charge ratio (line 5 divided by line 6)		7
8	Enter private room charges from your records		8
9	Average private room per diem charge (private room charges on line 8 divided by private room days on line 2)		9
10	Enter semi-private room charges from your records		10
11	Average semi-private room per diem charge (semi-private room charges on line 10 divided by semi-private room days)		11
12	Average per diem private room charge differential (line 9 minus line 11)		12
13	Average per diem private room cost differential (line 7 times line 12)		13
14	Private room cost differential adjustment (line 2 times line 13)		14
15	General inpatient routine service cost net of private room cost differential (line 5 minus line 14)		15
PROGRAM INPATIENT ROUTINE SERVICE COSTS			
16	Adjusted general inpatient service cost per diem (line 15 divided by line 11)		16
17	Program routine service cost (line 3 times line 16)		17
18	Medically necessary private room cost applicable to program (line 4 times line 13)		18
19	Total program general inpatient routine service cost (line 17 plus line 18)		19
20	Capital related cost allocated to inpatient routine service costs (from Wkst. B, Pt. II, col. 18, line 30 for SNF; line 31 for NF; or line 32 for ICF/MR)		20
21	Per diem capital related costs (line 20 divided by line 1)		21
22	Program capital related cost (line 3 times line 21)		22
23	Inpatient routine service cost (line 19 minus line 22)		23
24	Aggregate charges to beneficiaries for excess costs (from provider records)		24
25	Total program routine service costs for comparison to the cost limitation (line 23 minus line 24)		25
26	Enter the per diem limitation (1)		26
27	Inpatient routine service cost limitation (line 3 times the per diem limitation line 26) (1)		27
28	Reimbursable inpatient routine service costs (line 22 plus the lesser of line 25 or line 27) (Transfer to Wkst. E, Pt. II, line 4) (see instructions)		28

PART II - CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH			
1	Total inpatient days		1
2	Program inpatient days (from Wkst. S-3, Pt. I, cols. 3, 4 or 5, line 1 or 2 as applicable)		2
3	Total nursing & allied health costs (see instructions)		3
4	Nursing & allied health ratio (line 2 divided by line 1)		4
5	Program nursing & allied health costs for pass-through (line 3 times line 4)		5

(1) Lines 26, 27 and 28 are not applicable for title XVIII, but may be used for title V and or title XIX

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART I

	PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
1	Inpatient PPS amount (see instructions)		1
2	Nursing and Allied Health Education Activities (pass through payments)		2
3	Subtotal (sum of lines 1 and 2)		3
4	Primary payor amounts		4
5	Coinsurance		5
6	Reimbursable bad debts (from your records)		6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		7
8	Adjusted reimbursable bad debts (see instructions)		8
9	Recovery of bad debts - for statistical records only		9
10	Utilization review		10
11	Subtotal (see instructions)		11
12	Interim payments (see instructions)		12
13	Tentative adjustment		13
14	Other adjustment (see instructions)		14
14.99	*Sequestration amount (see instructions)*		*14.99*
15	Balance due provider/program *(see instructions)* (Indicate overpayment in parentheses)		15
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		16

	PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		
17	Ancillary services Part B		17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)		18
19	Total reasonable costs (sum of lines 17 and 18)		19
20	Medicare Part B ancillary charges (see instructions)		20
21	Cost of covered services (lesser of line 19 or line 20)		21
22	Primary payor amounts		22
23	Coinsurance and deductibles		23
24	Reimbursable bad debts (from your records)		24
24.01	*Reimbursable bad debts for dual eligible beneficiaries (see instructions)*		*24.01*
24.02	*Adjusted reimbursable bad debts (see instructions)*		*24.02*
25	Subtotal (sum of lines 21 and 24.*02*, minus lines 22 and 23)		25
26	Interim payments (see instructions)		26
27	Tentative adjustment		27
28	Other Adjustments (Specify _____) (see instructions)		28
28.99	*Sequestration amount (see instructions)*		*28.99*
29	Balance due provider/program *(see instructions)* (indicate overpayments in parentheses)		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		30

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART II

Check applicable box:	[ ] Title V [ ] Title XIX
Check applicable box:	[ ] SNF [ ] NF [ ] ICF/MR

COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient ancillary services (see instructions)		1
2	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)		2
3	Outpatient services		3
4	Inpatient routine services (see instructions)		4
5	Utilization review - physicians' compensation (from provider records)		5
6	Cost of covered services (sum of lines 1 - 5)		6
7	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		7
8	Subtotal (line 6 minus line 7)		8
9	Primary payor amounts		9
10	Total reasonable cost (line 8 minus line 9)		10
REASONABLE CHARGES			
11	Inpatient ancillary service charges		11
12	Outpatient service charges		12
13	Inpatient routine service charges		13
14	Differential in charges between semiprivate accommodations and less than semiprivate accommodations		14
15	Total reasonable charges		15
CUSTOMARY CHARGES			
16	Aggregate amount actually collected from patients liable for payment for services on a charge basis		16
17	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		17
18	Ratio of line 16 to line 17 (not to exceed 1.000000)		18
19	Total customary charges (see instructions)		19
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
20	Cost of covered services (see instructions)		20
21	Deductibles		21
22	Subtotal (line 20 minus line 21)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Reimbursable bad debts (from your records)		25
26	Subtotal (sum of lines 24 and 25)		26
27	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit		27
28	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		28
29	Other adjustments (Specify _____) (see instructions)		29
30	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets (if minus, enter amount in parentheses)		30
31	Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)		31
32	Interim payments		32
33	Balance due provider/program (line 31 minus line 32) (indicate overpayments in parentheses) (see instructions)		33

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E-1

				Inpatient Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description			1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
2	List separately each retroactive lump sum							3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		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 & 3.99) (Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)							4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6	Determine net settlement amount (balance	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	*.02*					6.*02*
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contractor Number					8

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G

	Assets	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 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	Less: allowances for uncollectible notes and accounts receivable	( )	( )	( )	( )	6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (sum of lines 1 - 10)					11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Less: Accumulated depreciation	( )	( )	( )	( )	14
15	Buildings					15
16	Less Accumulated depreciation	( )	( )	( )	( )	16
17	Leasehold improvements					17
18	Less: Accumulated Amortization	( )	( )	( )	( )	18
19	Fixed equipment					19
20	Less: Accumulated depreciation	( )	( )	( )	( )	20
21	Automobiles and trucks					21
22	Less: Accumulated depreciation	( )	( )	( )	( )	22
23	Major movable equipment					23
24	Less: Accumulated depreciation	( )	( )	( )	( )	24
25	Minor equipment - Depreciable					25
26	Minor equipment nondepreciable					26
27	Other fixed assets					27
28	TOTAL FIXED ASSETS (sum of lines 12 - 27)					28
	OTHER ASSETS					
29	Investments					29
30	Deposits on leases					30
31	Due from owners/officers					31
32	Other assets					32
33	TOTAL OTHER ASSETS (sum of lines 29 - 32)					33
34	TOTAL ASSETS (sum of lines 11, 28 and 33)					34

( ) = contra amount

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G

	Liabilities and Fund Balances	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
	CURRENT LIABILITIES					
35	Accounts payable					35
36	Salaries, wages & fees payable					36
37	Payroll taxes payable					37
38	Notes & loans payable (short term)					38
39	Deferred income					39
40	Accelerated payments					40
41	Due to other funds					41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES (sum of lines 35 - 42)					43
	LONG TERM LIABILITIES					
44	Mortgage payable					44
45	Notes payable					45
46	Unsecured loans					46
47	Loans from owners:					47
48	Other long term liabilities					48
49	Other (specify)					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)					50
51	TOTAL LIABILITIES (sum of lines 43 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement and expansion					58
59	TOTAL FUND BALANCES (sum of lines 52 thru 58)					59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)					60

( ) = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G - 1

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net income (loss) (from Wkst. G-3, line 31)									2
3	Total (sum of line 1 and line 2)									3
4	Additions (credit adjustments)									4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 5 - 9)									10
11	Subtotal (line 3 plus line 10)									11
12	Deductions (debit adjustments)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 13 - 17)									18
19	Fund balance at end of period per balance sheet (line 11 - line 18)									19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G - 2 PARTS I & II

PART I - PATIENT REVENUES

	Revenue Center	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
General Inpatient Routine Care Services					
1	Skilled nursing facility				1
2	Nursing facility				2
3	ICF-Mentally Retarded				3
4	Other long term care				4
5	Total general inpatient care services (sum of lines 1 - 4)				5
All Other Care Service					
6	Ancillary services				6
7	Clinic				7
8	Home health agency				8
9	Ambulance				9
10	RHC/FQHC				10
11	CMHC				11
12	SNF based hospice				12
13	Other (specify)				13
14	Total patient revenues (sum of lines 5 - 13) (transfer to Wkst. G-3, col. 3, line 1)				14

PART II - OPERATING EXPENSES

1	Operating Expenses (per Wkst. A, col. 3, line 100)			1
2	Add (Specify)			2
3				3
4				4
5				5
6				6
7				7
8	Total Additions (sum of lines 2 - 7)			8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (sum of lines 9 - 13)			14
15	Total Operating Expenses (sum of lines 1 and 8, minus line 14)			15

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G-3

1	Total patient revenues (from Wkst. G-2, Pt. I, col. 3, line 14)		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 (fom Wkst. G-2, Pt. II, line 15)		4
5	Net income from service to patients (line 3 minus 4)		5
	Other income:		
6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from communications (telephone and internet service)		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
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	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, flower, coffee shops, canteen		20
21	Rental of vending machines		21
22	Rental of skilled nursing space		22
23	Governmental appropriations		23
24	Other miscellaneous revenue (specify _____)		24
25	Total other income (sum of lines 6 - 24)		25
26	Total (line 5 plus line 25)		26
27	Other expenses (specify _____)		27
28			28
29			29
30	Total other expenses (sum of lines 27 - 29)		30
31	Net income (or loss) for the period (line 26 minus line 30)		31

ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS	PROVIDER CCN: HHA *CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET H

	COST CENTER DESCRIPTIONS	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	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
15	Telemedicine											15
	HHA NONREIMBURSABLE SERVICES											
16	Home Dialysis Aide Services											16
17	Respiratory Therapy											17
18	Private Duty Nursing											18
19	Clinic											19
20	Health Promotion Activities											20
21	Day Care Program											21
22	Home Delivered Meals Program											22
23	Homemaker Service											23
24	All Others											24
25	Total (sum of lines 1-24)											25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | PROVIDER CCN: HHA *CCN*: | PERIOD : FROM _____ TO _____ | WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0 through 4)	ADMINIS-TRATIVE & GENERAL	TOTAL (cols. 4A + 5)	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4A	5	6	
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									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25

COST ALLOCATION - HHA STATISTICAL BASIS	PROVIDER CCN: HHA *CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET H-1, PART II

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL	TOTAL	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
			(Square Feet)	(Dollar Value or Square Feet)	(Square Feet)	(Mileage)		(Accumulated Cost)		
		0	1	2	3	4	5A	5	6	
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									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25
26	Cost to be allocated									26
27	Unit Cost Multiplier									27

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS | PROVIDER CCN: HHA *CCN*: | PERIOD: FROM _____ TO _____ | WORKSHEET H-2, PART I

	HHA COST CENTER	From Wkst. H-1, Pt. I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
			0	1	2	3	3A	4	5	6	
1	Administrative and General	5									1
2	Skilled Nursing Care	6									2
3	Physical Therapy	7									3
4	Occupational Therapy	8									4
5	Speech Pathology	9									5
6	Medical Social Services	10									6
7	Home Health Aide	11									7
8	Supplies	12									8
9	Drugs	13									9
10	DME	14									10
11	Telemedicine	15									11
12	Home Dialysis Aide Services	16									12
13	Respiratory Therapy	17									13
14	Private Duty Nursing	18									14
15	Clinic	19									15
16	Health Promotion Activities	20									16
17	Day Care Program	21									17
18	Home Delivered Meals Program	22									18
19	Homemaker Service	23									19
20	All Others	24									20
21	Totals (sum of lines 1-20) (2)										21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.										22

(1) Column 0, line 21 must agree with Wkst. A, col. 7, line 70.

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: HHA *CCN*:	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER	HOUSE KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		7	8	9	10	11	12	13	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: HHA *CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	CAPITAL RELATED COSTS BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED COSTS MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	OPERATION OF PLANT (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	
		1	2	3	4A	4	5	6	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA *CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	HOUSE-KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	
		7	8	9	10	11	12	13	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: HHA *CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (SPECIFY)	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-3, Parts I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	Cost Per Visit Computation	From, Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2. Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Costs (col. 1 + col 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			Cost of Services				
									Part B			Part B		Total Program Cost (sum of cols. 9-10)	
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	Patient Services	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 1-6)														7

	Patient Services by CBSA	CBSA No. (1)	Program Visits			
				Part B		
			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 8-13)					14

	Supplies and Drugs Cost Computations	From Wkst. H-2, Pt. I, col. 20,	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Cost (cols. 1 + 2)	Total Charges (from HHA records)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services			
									Part B			Part B		
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Other Patient Services	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 SKILLED NURSING FACILITY DEPARTMENTS

		From Wkst. C, col. 3, line -	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Pt. 1 -	
			1	2	3	4	
1	Physical Therapy	44				col. 2, line 2	1
2	Occupational Therapy	45				col. 2, line 3	2
3	Speech Pathology	46				col. 2, line 4	3
4	Cost of Medical Supplies	48				col. 2, line 15	4
5	Cost of Drugs	49				col. 2, line 16	5

(1) The CBSA numbers flow from Wkst. S-4, line 22, and subscripts as indicated should be replicated on lines 8-13.

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: HHA *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET H-4, Parts I & II

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

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

	Description	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		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 charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
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

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	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
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 through 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	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
30.99	*Sequestration amount (see instructions)*			*30.99*
31	Subtotal (line 29 plus/minus line 30)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (*see instructions*)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER - BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: HHA *CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET H-5

	Description			Part A mm/dd/yyyy 1	Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
3	List separately each retroactive lump sum							3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		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) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)							4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99					5.99
6	Determine net settlement amount (balance	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contractor Number					8

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

ANALYSIS OF SNF - BASED RURAL HEALTH CLINIC / FEDERALLY QUALIFIED HEALTH CENTER COSTS	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET I-1

Check applicable box: [ ] RHC [ ] FQHC

		COMPEN-SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 +/- col.6)	
			2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility health care staff costs								9
10	Subtotal (sum of lines 1 - 9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other costs under agreement								13
14	Subtotal (sum of lines 11 - 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation - Medical Equipment								17
18	Professional Liability Insurance								18
19	Other health care costs								19
21	Subtotal (sum of lines 15 - 19)								21
22	Total cost of health care services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC / FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other non reimbursable costs								26
28	Total nonreimbursable costs (sum of lines 23 - *26*)								28
	FACILITY OVERHEAD								
29	Facility costs								29
30	Administrative costs								30
31	Total facility overhead (sum of lines 29-30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

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

ALLOCATION OF OVERHEAD TO RHC / FQHC SERVICES	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I-2

Check applicable box: [ ] RHC [ ] FQHC

PART I - VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of Column 2 or Column 4	
		1	2	3	4	5	
1	Physicians			4200			1
2	Physician Assistants			2100			2
3	Nurse Practitioners			2100			3
4	Subtotal (sum of lines 1 - 3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Medical Nutrition Therapist (FQHC only)						8
9	Diabetes Self Management Training (FQHC only)						9
10	Total FTEs and visits (sum of lines 4 - 9)						10
11	Physician Services Under Agreements						11

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC / FQHC SERVICES

12	Total costs of health care services (from Wkst. I-1, col. 7, line 22)		12
13	Total nonreimbursable costs (from Wkst I-1, col 7, line 28)		13
14	Cost of all services - excluding overhead (sum of lines 12 and 13)		14
15	Ratio of RHC / FQHC services (line 12 divided by line 14)		15
16	Total facility overhead (from Wkst. I-1, col. 7, line 31)		16
17	Parent provider overhead allocated to facility (see instructions)		17
18	Total overhead (sum of lines 16 and 17)		18
19	Overhead applicable to RHC / FQHC services (lines 15 X line 18)		19
20	Total allowable cost of RHC / FQHC services (sum of lines 12 and 19)		20

(1) Productivity standards established by CMS are: 4200 visits for each physician, and 2100 visits for each nonphysician practitioner.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC / FQHC SERVICES	PROVIDER CCN: *COMPONENT CCN:*	PERIOD : FROM _____ TO _____	WORKSHEET I-3

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

PART I - DETERMINATION OF RATE FOR RHC / FQHC SERVICES			
1	Total allowable cost of RHC/FQHC services (from Wkst. I-2, Pt. II, line 20)		1
2	Cost of vaccines and their administration (from Wkst. I-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total FTEs and visits (from Wkkst. I-2, col. 5, line 10)		4
5	Physicians' visits under agreement (from Wkst. I-2, col. 5, line 11)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

CALCULATION OF LIMIT Lines 8 through 14: Fiscal year providers use columns 1 and 2. Lines 8 through 14: Calendar year providers use column 2 only.		Prior to January 1 1	On or after January 1 2	
8	Rate per visit limit (from your contractor)			8
9	Rate for Program covered visits (see instructions)			9

PART II - CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)			10
11	Program cost excluding costs for mental health services (line 9 x line 10)			11
12	Program covered visits for mental health services (from contractor records)			12
13	Program covered cost for mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (see instructions)			14
15	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 and 2)			15
15.01	Total Program charges (see instructions) (from contractor records)			15.01
15.02	Total Program preventive charges (see instructions) (from provider records)			15.02
15.03	Total Program preventive costs ((line 15.02/line 15.01) times line 15)			15.03
15.04	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17) times .80)			15.04
15.05	Total Program cost (see instructions)			15.05
16	Primary payer amounts			16
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17
18	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			18
19	Net Program cost excluding vaccines (see instructions)			19
20	Program cost of vaccines and their administration (from Wkst. I -4, line 16)			20
21	Total reimbursable Program cost (line 19 plus 20)			21
22	Reimbursable bad debts			22
22.01	*Adjusted reimbursable bad debts (see instructions)*			*22.01*
23	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			23
24	Other adjustments			24
25	Net reimbursable amount *(see instructions)*			25
25.01	*Sequestration amount (see instructions)*			25.01
26	Interim payments (from Wkst. I-5, line 4)			26
27	Tentative settlement (for contractor use only)			27
28	Balance due component/Program *(see instructions)*			28
29	Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2			29

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN: *COMPONENT CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET I-4

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

	CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the facility (from Wkst. I-1, col. 7, line 22)			6
7	Total overhead (from Wkst. I-2, line 18)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and its (their) adminstration (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			15
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			16

ANALYSIS OF PAYMENTS TO SNF - BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET I - 5

Check applicable box: [ ] RHC [ ] FQHC

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. I-3, line 26)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contractor Number			8

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

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	
			BUILDS. & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	3A	4	
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	Appr. 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 Other*							21
22	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS-TRATION	
		5	6	7	8	9	
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	Appr. 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 Other*						21
22	Totals (sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICES	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	
		10	11	12	13	14	15	
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	Appr. 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 Other*							21
22	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I

	COMPONENT COST CENTER	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	SUBTOTAL	ALLOCATED A & G (see Pt. II)	TOTAL (sum of cols. 18 and 19 ()	
		16	17	18	19	20	
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	Appr. 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 Other*						21
22	Totals (Sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

(1) Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

	COMPONENT COST CENTER	CAPITAL RELATED		EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)				
		1	2	3	4A	4	
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	App. 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 Other*						21
22	Totals (sum of lines 1-21)						22
23	Total cost to be allocated						23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

	COMPONENT COST CENTER	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE - KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours of Service)	
		5	6	7	8	9	
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	App. 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 Other*						21
22	Totals (sum of lines 1-21)						22
23	Total cost to be allocated						23
24	Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART II

	COMPONENT COST CENTER	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE ( )	
		10	11	12	13	14	15	
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	App. 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 Other*							21
22	Totals (sum of lines 1-21)							22
23	Total cost to be allocated							23
24	Unit Cost Multiplier							24

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART I

PART I - APPORTIONMENT OF CMHC COST CENTERS

		Total Costs (from Wkst. J-1, Pt. I, col. 20)	Total Charges	Ratio of Costs to Charges	Title V		Title XVIII		Title XIX		
					Charges	Costs (col. 3 x col. 4)	Charges	Costs (col. 3 x col. 6)	Charges	Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
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	App. 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 Other*										21
22	Totals (sum of lines 2-21)										22

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART II

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

		Ratio of Costs to Charges	Title V		Title XVIII		Title XIX		
			Charges	Costs (col. 3 x col. 4)	Charges	Costs (col. 3 x col. 6)	Charges	Costs (col. 3 x col. 8)	
		3	4	5	6	7	8	9	
23	Oxygen (Inhalation) Therapy								23
24	Physical Therapy								24
25	Occupational Therapy								25
26	Speech Pathology								26
27	Medical Supplies Charged to Patients								27
28	Drugs Charged to Patients								28
29	Other Costs Furnished by shared Departments								29
30	Total (sum of lines 23 through 29)								30
31	Total component cost (sum of Pt. I, line 22 and Pt. II, line 30) (Transfer to Wkst. J-3)								31

(1) Part II - From Wkst. C, col. 3, lines as applicable

CALCULATION OF REIMBURSEMENT SETTLEMENT OF COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES	PROVIDER CCN: *COMPONENT CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET J-3

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

		PROGRAM COST	
1	Cost of component services (from Wkst. J-2, Pt. II, line 31)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
CUSTOMARY CHARGES			
6	Total charges for program services		6
7	Excess of customary charges over reasonable cost (see instructions)		7
8	Excess of reasonable cost over customary charges (see instructions)		8
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
9	Total reasonable cost (see instructions)		9
10	Part B deductible billed to program patients		10
11	Part B coinsurance billed to program patients (from provider records)		11
12	Net cost (line 9 minus lines 10 and 11)		12
13	Reimbursable bad debts (from provider records) (see instructions)		13
13.01	*Adjusted reimbursable bad debts (see instructions)*		*13.01*
14	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		14
15	Net reimbursable amount (see instructions)		15
16	Other adjustments (see instructions) (specify)		16
17	Total cost (line 15 plus or minus line 16)		17
17.01	*Sequestration amount (see instructions)*		*17.01*
18	Interim payments (see instructions)		18
19	Tentative settlement (for contractor use only)		19
20	Balance due component/program (line 17 minus lines 18 and 19)		20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		21

ANALYSIS OF PAYMENTS TO PROVIDER - BASED CMHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: *COMPONENT CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET J - 4

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. J-3: Pt. I, line 18)					4
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	Name of Contractor		Contractor Number			8

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

ANALYSIS OF PROVIDER - BASED HOSPICE COSTS | PROVIDER CCN: *HOSPICE CCN* : | PERIOD : FROM _____ TO _____ | WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR-TATION (see instruc.)	CON-TRACTED SERVICES (from Wkst. K-3)	OTHER	TOTAL (cols. 1 through 5)	RECLASSI-FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	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											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 through 38)											39

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4157)

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN:

HOSPICE CCN :

PERIOD :
FROM _____
TO _____

WORKSHEET K-1

	COST CENTER DESCRIPTIONS	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL 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										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 through 38)										39

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

HOSPICE COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER CCN:

HOSPICE CCN :

PERIOD :
FROM _____
TO _____

WORKSHEET K-2

	COST CENTER DESCRIPTIONS	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL 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										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 through 38)										39

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

HOSPICE COMPENSATION ANALYSIS
CONTRATED SERVICES / PURCHASED SERVICES

PROVIDER CCN:

HOSPICE CCN :

PERIOD :
FROM _____
TO _____

WORKSHEET K-3

	COST CENTER DESCRIPTIONS	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL 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										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 through 38)										39

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | PROVIDER CCN: *HOSPICE CCN* : | PERIOD : FROM _____ TO _____ | WORKSHEET K-4 PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC. (1) (from Wkst. K, col. 10)	CAPITAL RELATED COST BUILDS. & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (cols. 0 through 5)	ADMINIS-TRATIVE & GENERAL	TOTAL	
		0	1	2	3	4	5	5A	6	7	
	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										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 through 38)										39

COST ALLOCATION - HOSPICE
STATISTICAL BASIS

PROVIDER CCN:

HOSPICE CCN :

PERIOD :
FROM _____
TO _____

WORKSHEET K-4
PART II

		CAPITAL RELATED COST								
		BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)	PLANT OPERATION & MAINT. (Square Feet)	TRANS-PORTATION (Mileage)	VOLUNTEER SERVICE COORDINATOR (Hours)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6A	6	7	
	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									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	Cost to be allocated (per Wkst. K-4, Pt. I)									39
40	Unit Cost Multiplier									40

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER CCN: *HOSPICE CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET K-5, PART I

	HOSPICE COST CENTER (1)	From Wkst. K-4, Pt. I, col. 7, line -	HOSPICE TRIAL BALANCE	CAPITAL RELATED		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT				
			0	1	2	3	3A	4	
1	Administrative and General	6							1
2	Inpatient - General Care	7							2
3	Inpatient - Respite Care	8							3
4	Physician Services	9							4
5	Nursing Care	10							5
6	Nursing Care- Continuous Home Care	11							6
7	Physical Therapy	12							7
8	Occupational Therapy	13							8
9	Speech/ Language Pathology	14							9
10	Medical Social Services - Direct	15							10
11	Spiritual Counseling	16							11
12	Dietary Counseling	17							12
13	Counseling - Other	18							13
14	Home Health Aide and Homemakers	19							14
15	HH Aide & Homemaker - Cont. Home Care	20							15
16	Other	21							16
17	Drugs, Biologicals and Infusion	22							17
18	Analgesics	23							18
19	Sedative/Hypnotics	24							19
20	Other - Specify	25							20
21	Durable Medical Equipment/Oxygen	26							21
22	Patient Transportation	27							22
23	Imaging Services	28							23
24	Labs and Diagnostics	29							24
25	Medical Supplies	30							25
26	Outpatient Services (incl. E/R Dept.)	31							26
27	Radiation Therapy	32							27
28	Chemotherapy	33							28
29	Other	34							29
30	Bereavement Program Costs	35							30
31	Volunteer Program Costs	36							31
32	Fundraising	37							32
33	Other Program Costs	38							33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER CCN: *HOSPICE CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part I

	HOSPICE COST CENTER (1)	PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
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 - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	PROVIDER CCN: *HOSPICE CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part I

	HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	ALLOCATED HOSPICE A & G (see Pt. II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
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 - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

(1) Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS	PROVIDER CCN: *HOSPICE CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET K-5, PART II

	HOSPICE COST CENTER (1)	CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accumulated Cost)	
		1	2	3	4A	4	
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 - Direct						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemakers						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biologicals and Infusion						17
18	Analgesics						18
19	Sedative/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 (incl. E/R Dept.)						26
27	Radiation Therapy						27
28	Chemotherapy						28
29	Other						29
30	Bereavement Program Costs						30
31	Volunteer Program Costs						31
32	Fundraising						32
33	Other Program Costs						33
34	Totals (sum of lines 1 through 33)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier						36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS	PROVIDER CCN: *HOSPICE CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET K-5 PART II

	HOSPICE COST CENTER (1)	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
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 - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

ALLOCATION OF GENERAL SERVICE COSTS
TO HOSPICE COST CENTERS - STATISTICAL BASIS

PROVIDER CCN:
HOSPICE CCN:

PERIOD :
FROM _____
TO _____

WORKSHEET K-5
PART II

	HOSPICE COST CENTER (1)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (Specify)	SUBTOTAL	ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
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 - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/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 (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: *HOSPICE CCN* :	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst. C, col. 3, line:	Cost to Charge Ratio	Total Hospice Charges (from provider records)	Hospice Shared Ancillary Costs (col. 1 x col. 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	44				1
2	Occupational Therapy	45				2
3	Speech/ Language Pathology	46				3
4	Drugs, Biologicals and Infusion	49				4
5	Labs and Diagnostics	41				5
6	Medical Supplies	48				6
7	Radiation Therapy	40				7
8	Other	52				8
9	Total (sum of lines 1-8)					9

CALCULATION OF PER DIEM COST	PROVIDER CCN: *HOSPICE CCN*:	PERIOD : FROM _____ TO _____	WORKSHEET K-6

		Tittle XVIII	Title XIX	Other	Total	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Wkst. S-8, line 5, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Wkst. S-8, line 5, col. 1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Wkst. S-8, line 5, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Wkst. S-8, line 5, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Wkst. S-8, line 5, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other unduplicated days (Wkst. S-8, line 5, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13