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. 0938-0050
EXPIRES 05-31-2019

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

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 OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)}for the cost reporting period beginning _____ and ending _____ and 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 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.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief FinancialOfficer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

| | | TITLE V | TITLE XVIII PART A | TITLE XVIII PART B | HIT | TITLE XIX | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | HOSPITAL | | | | | | 1 |
| 2 | SUBPROVIDER - IPF | | | | | | 2 |
| 3 | SUBPROVIDER - IRF | | | | | | 3 |
| 4 | SUBPROVIDER (OTHER) | | | | | | 4 |
| 5 | SWING BED - SNF | | | | | | 5 |
| 6 | SWING BED - NF | | | | | | 6 |
| 7 | SNF | | | | | | 7 |
| 8 | NF, ICF/IID | | | | | | 8 |
| 9 | HOME HEALTH AGENCY | | | | | | 9 |
| 10 | HOSPITAL-BASED - RHC | | | | | | 10 |
| 11 | HOSPITAL-BASED - FQHC | | | | | | 11 |
| 12 | OUTPATIENT REHABILITATION PROVIDER (Specify) | | | | | | 12 |
| 200 | TOTAL | | | | | | 200 |

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 0938-0050. The time required to complete this information collection is estimated 673 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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-2 PART I |
|---|---|---|---|

Hospital and Hospital Health Care Complex Address:

| | | | | | |
|---|---|---|---|---|---|
| 1 | Street: | P.O. Box: | | | 1 |
| 2 | City: | State: | ZIP Code: | County: | 2 |

Hospital and Hospital-Based Component Identification:

| | Component | Component Name | CCN Number | CBSA Number | Provider Type | Date Certified | Payment System (P, T, O, or N) V | XVIII | XIX | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 3 | Hospital | | | | | | | | | 3 |
| 4 | Subprovider- IPF | | | | | | | | | 4 |
| 5 | Subprovider- IRF | | | | | | | | | 5 |
| 6 | Subprovider- (Other) | | | | | | | | | 6 |
| 7 | Swing Beds-SNF | | | | | | | | | 7 |
| 8 | Swing Beds-NF | | | | | | | | | 8 |
| 9 | Hospital-Based SNF | | | | | | | | | 9 |
| 10 | Hospital-Based NF | | | | | | | | | 10 |
| 11 | Hospital-Based OLTC | | | | | | | | | 11 |
| 12 | Hospital-Based HHA | | | | | | | | | 12 |
| 13 | Separately Certified ASC | | | | | | | | | 13 |
| 14 | Hospital-Based Hospice | | | | | | | | | 14 |
| 15 | Hospital-Based Health Clinic-RHC | | | | | | | | | 15 |
| 16 | Hospital-Based Health Clinic-FQHC | | | | | | | | | 16 |
| 17 | Hospital-Based (CMHC, CORF and OPT) | | | | | | | | | 17 |
| 18 | Renal Dialysis | | | | | | | | | 18 |
| 19 | Other | | | | | | | | | 19 |
| 20 | Cost Reporting Period (mm/dd/yyyy) | From:_____ | To: _____ | | | | | | | 20 |
| 21 | Type of control (see instructions) | | | | | | | | | 21 |

| Inpatient PPS Information | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 22 | Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR 412.106 (c )(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no. | | | | 22 |
| 22.01 | Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) | | | | 22.01 |
| 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. | | | | 22.02 |
| 22.03 | Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. | | | | 22.03 |
| 23 | Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. | | | | 23 |

| | | In-State Medicaid paid days | In-State Medicaid eligible unpaid days | Out-of State Medicaid paid days | Out-of State Medicaid eligible unpaid days | Medicaid HMO days | Other Medicaid days | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| 24 | If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. | | | | | | | 24 |
| 25 | If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid HMO paid and eligible but unpaid days in column 5. | | | | | | | 25 |

| | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 26 | Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. | | | | 26 |
| 27 | Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. | | | | 27 |
| 35 | If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. | | | | 35 |
| 36 | Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. | Beginning:_____ | Ending: _____ | | 36 |
| 37 | If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. | | | | 37 |
| 37.01 | Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) | | | | 37.01 |
| 38 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. | Beginning:_____ | Ending: _____ | | 38 |
| 39 | Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii). Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) | | | | 39 |
| 40 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) | | | | 40 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: | PERIOD FROM TO | WORKSHEET S-2 PART I (CONT.) |
|---|---|---|---|

| | | V | XVIII | XIX | |
|---|---|---|---|---|---|
| | Prospective Payment System (PPS)-Capital | 1 | 2 | 3 | |
| 45 | Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions) | | | | 45 |
| 46 | Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III, and Wkst. L-1, Pt. I, through Pt. III. | | | | 46 |
| 47 | Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y for yes or "N" for no. | | | | 47 |
| 48 | Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. | | | | 48 |

| | | | | | |
|---|---|---|---|---|---|
| | Teaching Hospitals | 1 | 2 | 3 | |
| 56 | Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. | | | | 56 |
| 57 | If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1.<br>If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst. E-4.<br>If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. | | | | 57 |
| 58 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. | | | | 58 |
| 59 | Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. | | | | 59 |

| | | NAHE 413.85 Y/N | Worksheet A Line # | Pass-Through Qualification Criterion Code | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 60 | Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) | | | | 60 |
| 60.01 | If line 60 is yes, complete columns 2 and 3 for each program. (see instructions) | | | | 60.01 |

| | | Y/N | | | IME | Direct GME | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 61 | Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) | | | | | | 61 |

| | | | IME | Direct GME | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 61.01 | Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | | | | 61.01 |
| 61.02 | Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) | | | | 61.02 |
| 61.03 | Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) | | | | 61.03 |
| 61.04 | Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions) | | | | 61.04 |
| 61.05 | Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | 61.05 |
| 61.06 | Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) | | | | 61.06 |

| | | Program Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 61.10 | Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions)<br>Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. | | | | | 61.10 |
| 61.20 | Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions)<br>Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. | | | | | 61.20 |

| | | | |
|---|---|---|---|
| | ACA Provisions Affecting the Health Resources and Services Administration (HRSA) | 1 | |
| 62 | Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions) | | 62 |
| 62.01 | Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) | | 62.01 |

| | | | | | |
|---|---|---|---|---|---|
| | Teaching Hospitals that Claim Residents in Nonprovider Settings | 1 | 2 | 3 | |
| 63 | Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64 through 67. (see instructions) | | | | 63 |

| | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1 ÷ (col. 1 + col. 2)) | |
|---|---|---|---|---|---|
| | Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. | 1 | 2 | 3 | |
| 64 | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings.<br>Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.<br>Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) | | | | 64 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-2 PART I (CONT.)

| | | Program Name | Program Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 65 | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | | | | | | 65 |

| | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
|---|---|---|---|---|---|
| Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 | | 1 | 2 | 3 | |
| 66 | Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) | | | | 66 |

| | | Program Name | Program Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 67 | Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | | | | | | 67 |

| Inpatient Psychiatric Facility PPS | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 70 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. | | | | 70 |
| 71 | If line 70 is yes:<br>Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(C))<br>Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.<br>Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) | | | | 71 |

| Inpatient Rehabilitation Facility PPS | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 75 | Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no. | | | | 75 |
| 76 | If line 75 is yes:<br>Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no.<br>Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.<br>Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) | | | | 76 |

| Long Term Care Hospital PPS | | 1 | 2 | |
|---|---|---|---|---|
| 80 | Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. | | | 80 |
| 81 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter “Y” for yes and “N” for no. | | | 81 |

| TEFRA Providers | | 1 | 2 | |
|---|---|---|---|---|
| 85 | Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. | | | 85 |
| 86 | Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no. | | | 86 |
| 87 | Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | | | 87 |

| Title V and XIX Services | | V 1 | XIX 2 | |
|---|---|---|---|---|
| 90 | Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column. | | | 90 |
| 91 | Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. | | | 91 |
| 92 | Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. | | | 92 |
| 93 | Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. | | | 93 |
| 94 | Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. | | | 94 |
| 95 | If line 94 is "Y", enter the reduction percentage in the applicable column. | | | 95 |
| 96 | Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. | | | 96 |
| 97 | If line 96 is "Y", enter the reduction percentage in the applicable column. | | | 97 |
| 98 | Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98 |
| 98.01 | Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.01 |
| 98.02 | Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.02 |
| 98.03 | Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.03 |
| 98.04 | Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.04 |
| 98.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.05 |
| 98.06 | Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. | | | 98.06 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: | PERIOD FROM TO | WORKSHEET S-2 PART I (CONT.) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Rural Providers | | 1 | |
| 105 | Does this hospital qualify as a CAH? | | 105 |
| 106 | If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) | | 106 |
| 107 | If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25, and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II. | | 107 |
| 108 | Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no. | | 108 |

| | | Physical | Occupational | Speech | Respiratory | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 109 | If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | | | | | 109 |

| | | | |
|---|---|---|---|
| | | 1 | |
| 110 | Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable. | | 110 |

| | | | | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 111 | If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. | | | 111 |

| | | | | | |
|---|---|---|---|---|---|
| Miscellaneous Cost Reporting Information | | 1 | 2 | 3 | |
| 115 | Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1. | | | | 115 |

| | | | |
|---|---|---|---|
| | | 1 | |
| 116 | Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. | | 116 |
| 117 | Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. | | 117 |
| 118 | Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence. | | 118 |

| | | Premiums | Paid losses | Self insurance | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 118.01 | List amounts of malpractice premiums and paid losses: | | | | 118.01 |

| | | | | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 118.02 | Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. | | | 118.02 |
| 119 | What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year. | | | 119 |
| 120 | Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with ≤100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. | | | 120 |
| 121 | Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. | | | 121 |
| 122 | Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. | | | 122 |

| | | | | |
|---|---|---|---|---|
| Transplant Center Information | | 1 | 2 | |
| 125 | Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. | | | 125 |
| 126 | If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 126 |
| 127 | If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 127 |
| 128 | If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 128 |
| 129 | If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 129 |
| 130 | If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 130 |
| 131 | If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 131 |
| 132 | If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 132 |
| 133 | If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. | | | 133 |
| 134 | If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. | | | 134 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-2 PART I (CONT.) |
|---|---|---|---|

| All Providers | | 1 | 2 | |
|---|---|---|---|---|
| 140 | Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) | | | 140 |

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

| | | | | | |
|---|---|---|---|---|---|
| 141 | Name: | | Contractor's Name: _____ | Contractor's Number: _____ | 141 |
| 142 | Street: | P. O. Box: | | | 142 |
| 143 | City: | State: | Zip Code: | | 143 |

| | | 1 | 2 | |
|---|---|---|---|---|
| 144 | Are provider based physicians' costs included in Worksheet A? | | | 144 |
| 145 | If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. | | | 145 |
| 146 | Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. | | | 146 |
| 147 | Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. | | | 147 |
| 148 | Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. | | | 148 |
| 149 | Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. | | | 149 |

| Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (see 42 CFR 413.13) | | Title XVIII Part A | Title XVIII Part B | Title V | Title XIX | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 155 | Hospital | | | | | 155 |
| 156 | Subprovider - IPF | | | | | 156 |
| 157 | Subprovider - IRF | | | | | 157 |
| 158 | Subprovider - Other | | | | | 158 |
| 159 | SNF | | | | | 159 |
| 160 | HHA | | | | | 160 |
| 161 | CMHC | | | | | 161 |

| Multicampus | | | | | | | |
|---|---|---|---|---|---|---|---|
| 165 | Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. | | | | | | 165 |
| 166 | If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/Campus in column 5. (see instructions) | | | | | | 166 |
| | Name | County | State | Zip Code | CBSA | FTE/Campus | |
| | 0 | 1 | 2 | 3 | 4 | 5 | |
| | | | | | | | |

| Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act | | 1 | 2 | |
|---|---|---|---|---|
| 167 | Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no. | | | 167 |
| 168 | If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see instructions) | | | 168 |
| 168.01 | If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) | | | 168.01 |
| 169 | If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) | | | 169 |
| 170 | Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yyyy) | | | 170 |
| 171 | If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions) | | | 171 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-2 PART II |
|---|---|---|---|

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

COMPLETED BY ALL HOSPITALS

| | | 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 yes, 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 yes, 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? 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 yes, submit reconciliation. | | | | 5 |

| | | Y/N | Y/N | |
|---|---|---|---|---|
| | Approved Educational Activities | 1 | 2 | |
| 6 | Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? | | | 6 |
| 7 | Are costs claimed for allied health programs? If yes, see instructions. | | | 7 |
| 8 | Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. | | | 8 |
| 9 | Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions. | | | 9 |
| 10 | Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. | | | 10 |
| 11 | Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. | | | 11 |

| | Bad Debts | Y/N | |
|---|---|---|---|
| 12 | Is the provider seeking reimbursement for bad debts? If yes, see instructions. | | 12 |
| 13 | If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. | | 13 |
| 14 | If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. | | 14 |

| | Bed Complement | |
|---|---|---|
| 15 | Did total beds available change from the prior cost reporting period? If yes, see instructions. | 15 |

| | | Part A | | Part B | | |
|---|---|---|---|---|---|---|
| | | Y/N | Date | Y/N | Date | |
| | PS&R Report Data | 1 | 2 | 3 | 4 | |
| 16 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) | | | | | 16 |
| 17 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | | | | | 17 |
| 18 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions. | | | | | 18 |
| 19 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | | | | | 19 |
| 20 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: _____ | | | | | 20 |
| 21 | Was the cost report prepared only using the provider's records? If yes, see instructions. | | | | | 21 |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-2 Part II (CONT.) |
|---|---|---|---|

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

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

Capital Related Cost

| | | | |
|---|---|---|---|
| 22 | Have assets been relifed for Medicare purposes? If yes, see instructions. | | 22 |
| 23 | Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. | | 23 |
| 24 | Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. | | 24 |
| 25 | Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. | | 25 |
| 26 | Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. | | 26 |
| 27 | Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. | | 27 |

Interest Expense

| | | | |
|---|---|---|---|
| 28 | Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. | | 28 |
| 29 | Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. | | 29 |
| 30 | Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. | | 30 |
| 31 | Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. | | 31 |

Purchased Services

| | | | |
|---|---|---|---|
| 32 | Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. | | 32 |
| 33 | If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. | | 33 |

Provider-Based Physicians

| | | | |
|---|---|---|---|
| 34 | Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. | | 34 |
| 35 | If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. | | 35 |

| | | Y/N | Date | |
|---|---|---|---|---|
| | Home Office Costs | 1 | 2 | |
| 36 | Are home office costs claimed on the cost report? | | | 36 |
| 37 | If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. | | | 37 |
| 38 | If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. | | | 38 |
| 39 | If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. | | | 39 |
| 40 | If line 36 is yes, did the provider render services to the home office? If yes, see instructions. | | | 40 |

Cost Report Preparer Contact Information

| | | | | |
|---|---|---|---|---|
| 41 | First name: | Last name: | Title: | 41 |
| 42 | Employer: | | | 42 |
| 43 | Phone number: | E-mail Address: | | 43 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
STATISTICAL DATA

PROVIDER CCN: _____

PERIOD
FROM _____
TO _____

WORKSHEET S-3
PART I

| | Component | Worksheet A Line No. | No. of Beds | Bed Days Available | CAH Hours | Inpatient Days / Outpatient Visits / Trips | | | | Full Time Equivalents | | | Discharges | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Title V | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | Nonpaid Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Hospital Adults & Peds. (columns 5, 6, 7, and 8, exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | | | | | | | | | | | | | | | | 1 |
| 2 | HMO and other (see instructions) | | | | | | | | | | | | | | | | 2 |
| 3 | HMO IPF Subprovider | | | | | | | | | | | | | | | | 3 |
| 4 | HMO IRF Subprovider | | | | | | | | | | | | | | | | 4 |
| 5 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | | | | | | | | | | 5 |
| 6 | Hospital Adults & Peds. Swing Bed NF | | | | | | | | | | | | | | | | 6 |
| 7 | Total Adults and Peds. (exclude observation beds) (see instructions) | | | | | | | | | | | | | | | | 7 |
| 8 | Intensive Care Unit | | | | | | | | | | | | | | | | 8 |
| 9 | Coronary Care Unit | | | | | | | | | | | | | | | | 9 |
| 10 | Burn Intensive Care Unit | | | | | | | | | | | | | | | | 10 |
| 11 | Surgical Intensive Care Unit | | | | | | | | | | | | | | | | 11 |
| 12 | Other Special Care | | | | | | | | | | | | | | | | 12 |
| 13 | Nursery | | | | | | | | | | | | | | | | 13 |
| 14 | Total (see instructions) | | | | | | | | | | | | | | | | 14 |
| 15 | CAH visits | | | | | | | | | | | | | | | | 15 |
| 16 | Subprovider - IPF | | | | | | | | | | | | | | | | 16 |
| 17 | Subprovider - IRF | | | | | | | | | | | | | | | | 17 |
| 18 | Subprovider - Other | | | | | | | | | | | | | | | | 18 |
| 19 | Skilled Nursing Facility | | | | | | | | | | | | | | | | 19 |
| 20 | Nursing Facility | | | | | | | | | | | | | | | | 20 |
| 21 | Other Long Term Care | | | | | | | | | | | | | | | | 21 |
| 22 | Home Health Agency | | | | | | | | | | | | | | | | 22 |
| 23 | ASC (Distinct Part) | | | | | | | | | | | | | | | | 23 |
| 24 | Hospice (Distinct Part) | | | | | | | | | | | | | | | | 24 |
| 24.10 | Hospice (non-distinct part) | | | | | | | | | | | | | | | | 24.10 |
| 25 | CMHC | | | | | | | | | | | | | | | | 25 |
| 26 | RHC/FQHC (specify) | | | | | | | | | | | | | | | | 26 |
| 27 | Total (sum of lines 14-26) | | | | | | | | | | | | | | | | 27 |
| 28 | Observation Bed Days | | | | | | | | | | | | | | | | 28 |
| 29 | Ambulance Trips | | | | | | | | | | | | | | | | 29 |
| 30 | Employee discount days (see instructions) | | | | | | | | | | | | | | | | 30 |
| 31 | Employee discount days -IRF | | | | | | | | | | | | | | | | 31 |
| 32 | Labor & delivery (see instructions) | | | | | | | | | | | | | | | | 32 |
| 32.01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | | | | | | | | | 32.01 |
| 33 | LTCH non-covered days | | | | | | | | | | | | | | | | 33 |
| 33.01 | LTCH site neutral days and discharges | | | | | | | | | | | | | | | | 33.01 |

| HOSPITAL WAGE INDEX INFORMATION | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-3 PART II |
|---|---|---|---|

Part II - Wage Data

| | | Wkst. A Line Number | Amount Reported | Reclassification of Salaries (from Wkst. A-6) | Adjusted Salaries (column 2 ± column 3) | Paid Hours Related to Salaries in column 4 | Average Hourly Wage (column 4 ÷ column 5) | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| | SALARIES | | | | | | | |
| 1 | Total salaries (see instructions) | | | | | | | 1 |
| 2 | Non-physician anesthetist Part A | | | | | | | 2 |
| 3 | Non-physician anesthetist Part B | | | | | | | 3 |
| 4 | Physician-Part A - Administrative | | | | | | | 4 |
| 4.01 | Physician-Part A - Teaching | | | | | | | 4.01 |
| 5 | Physician and Non Physician-Part B | | | | | | | 5 |
| 6 | Non-physician-Part B for hospital-based RHC and FQHC services | | | | | | | 6 |
| 7 | Interns & residents (in an approved program) | | | | | | | 7 |
| 7.01 | Contracted interns & residents (in an approved program) | | | | | | | 7.01 |
| 8 | Home office and/or related organization personnel | | | | | | | 8 |
| 9 | SNF | | | | | | | 9 |
| 10 | Excluded area salaries (see instructions) | | | | | | | 10 |
| | OTHER WAGES AND RELATED COSTS | | | | | | | |
| 11 | Contract labor : Direct Patient Care | | | | | | | 11 |
| 12 | Contract labor: Top level management and other management and administrative services | | | | | | | 12 |
| 13 | Contract labor: Physician-Part A - Administrative | | | | | | | 13 |
| 14 | Home office and/or related organization salaries and wage-related costs | | | | | | | 14 |
| 14.01 | Home office salaries | | | | | | | 14.01 |
| 14.02 | Related organization salaries | | | | | | | 14.02 |
| 15 | Home office: Physician Part A - Administrative | | | | | | | 15 |
| 16 | Home office & Contract Physicians Part A - Teaching | | | | | | | 16 |
| | WAGE-RELATED COSTS | | | | | | | |
| 17 | Wage-related costs (core) (see instructions) | | | | | | | 17 |
| 18 | Wage-related costs (other) (see instructions) | | | | | | | 18 |
| 19 | Excluded areas | | | | | | | 19 |
| 20 | Non-physician anesthetist Part A | | | | | | | 20 |
| 21 | Non-physician anesthetist Part B | | | | | | | 21 |
| 22 | Physician Part A - Administrative | | | | | | | 22 |
| 22.01 | Physician Part A - Teaching | | | | | | | 22.01 |
| 23 | Physician Part B | | | | | | | 23 |
| 24 | Wage-related costs (RHC/FQHC) | | | | | | | 24 |
| 25 | Interns & residents (in an approved program) | | | | | | | 25 |
| 25.50 | Home office wage-related (core) | | | | | | | 25.50 |
| 25.51 | Related organization wage-related (core) | | | | | | | 25.51 |
| 25.52 | Home office: Physician Part A - Administrative - wage-related (core) | | | | | | | 25.52 |
| 25.53 | Home office & Contract Physicians Part A - Teaching - wage-related (core) | | | | | | | 25.53 |

| HOSPITAL WAGE INDEX INFORMATION | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET S-3 PART II & III |
|---|---|---|---|

Part II - Wage Data

| | | Worksheet A Line Number | Amount Reported | Reclassification of Salaries (from Worksheet A-6) | Adjusted Salaries (column 2 ± column 3) | Paid Hours Related to Salaries in column 4 | Average Hourly Wage (column 4 ÷ column 5) | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| | OVERHEAD COSTS - DIRECT SALARIES | | | | | | | |
| 26 | Employee Benefits Department | 4 | | | | | | 26 |
| 27 | Administrative & General | 5 | | | | | | 27 |
| 28 | Administrative & General under contract (see instructions) | | | | | | | 28 |
| 29 | Maintenance & Repairs | 6 | | | | | | 29 |
| 30 | Operation of Plant | 7 | | | | | | 30 |
| 31 | Laundry & Linen Service | 8 | | | | | | 31 |
| 32 | Housekeeping | 9 | | | | | | 32 |
| 33 | Housekeeping under contract (see instructions) | | | | | | | 33 |
| 34 | Dietary | 10 | | | | | | 34 |
| 35 | Dietary under contract (see instructions) | | | | | | | 35 |
| 36 | Cafeteria | 11 | | | | | | 36 |
| 37 | Maintenance of Personnel | 12 | | | | | | 37 |
| 38 | Nursing Administration | 13 | | | | | | 38 |
| 39 | Central Services and Supply | 14 | | | | | | 39 |
| 40 | Pharmacy | 15 | | | | | | 40 |
| 41 | Medical Records & Medical Records Library | 16 | | | | | | 41 |
| 42 | Social Service | 17 | | | | | | 42 |
| 43 | Other General Service | 18 | | | | | | 43 |

Part III - Hospital Wage Index Summary

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | Net salaries (see instructions) | | | | | | | 1 |
| 2 | Excluded area salaries (see instructions) | | | | | | | 2 |
| 3 | Subtotal salaries (line 1 minus line 2) | | | | | | | 3 |
| 4 | Subtotal other wages and related costs (see instructions) | | | | | | | 4 |
| 5 | Subtotal wage-related costs (see instructions) | | | | | | | 5 |
| 6 | Total (sum of lines 3 through 5) | | | | | | | 6 |
| 7 | Total overhead cost (see instructions) | | | | | | | 7 |

| HOSPITAL 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 | Nonqualified Defined Benefit Plan Cost (see instructions) | | 3 |
| 4 | Qualified Defined Benefit Plan Cost (see instructions) | | 4 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization): | | |
| 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 |
| 8.01 | Health Insurance (Self Funded without a Third Party Administrator) | | 8.01 |
| 8.02 | Health Insurance (Self Funded with a Third Party Administrator) | | 8.02 |
| 8.03 | Health Insurance (Purchased) | | 8.03 |
| 9 | Prescription Drug Plan | | 9 |
| 10 | Dental, Hearing and Vision Plan | | 10 |
| 11 | Life Insurance (If employee is owner or beneficiary) | | 11 |
| 12 | Accident 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 (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions) | | 21 |
| 22 | Day Care Cost and Allowances | | 22 |
| 23 | Tuition Reimbursement | | 23 |
| 24 | Total Wage Related cost (Sum of lines 1 through 23) | | 24 |

Part B - Other than Core Related Cost

| | | | |
|---|---|---|---|
| 25 | Other Wage Related Costs (specify) _____ | | 25 |

| HOSPITAL CONTRACT LABOR AND BENEFIT COST | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-3 PART V |
|---|---|---|---|

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

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

HOME HEALTH AGENCY STATISTICAL DATA County: _____

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

| | Enter the number of hours in your normal work week _____ | Number of Employees (Full Time Equivalent) | | | |
|---|---|---|---|---|---|
| | | Staff | Contract | Total | |
| | | 1 | 2 | 3 | |
| 3 | Administrator and Assistant Administrator(s) | | | | 3 |
| 4 | Director(s) and Assistant Director(s) | | | | 4 |
| 5 | Other Administrative Personnel | | | | 5 |
| 6 | Direct Nursing Service | | | | 6 |
| 7 | Nursing Supervisor | | | | 7 |
| 8 | Physical Therapy Service | | | | 8 |
| 9 | Physical Therapy Supervisor | | | | 9 |
| 10 | Occupational Therapy Service | | | | 10 |
| 11 | Occupational Therapy Supervisor | | | | 11 |
| 12 | Speech Pathology Service | | | | 12 |
| 13 | Speech Pathology Supervisor | | | | 13 |
| 14 | Medical Social Service | | | | 14 |
| 15 | Medical Social Service Supervisor | | | | 15 |
| 16 | Home Health Aide | | | | 16 |
| 17 | Home Health Aide Supervisor | | | | 17 |
| 18 | Other (specify) | | | | 18 |

HOME HEALTH AGENCY CBSA CODES

| | | | |
|---|---|---|---|
| 19 | Enter the number of CBSAs where you provided services during the cost reporting period. | | 19 |
| 20 | List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code). | | 20 |

PPS ACTIVITY

| | | Full Episodes | | | | Total | |
|---|---|---|---|---|---|---|---|
| | | Without Outliers | With Outliers | LUPA Episodes | PEP only Episodes | (columns 1 through 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 21 | Skilled Nursing Visits | | | | | | 21 |
| 22 | Skilled Nursing Visit Charges | | | | | | 22 |
| 23 | Physical Therapy Visits | | | | | | 23 |
| 24 | Physical Therapy Visit Charges | | | | | | 24 |
| 25 | Occupational Therapy Visits | | | | | | 25 |
| 26 | Occupational Therapy Visit Charges | | | | | | 26 |
| 27 | Speech Pathology Visits | | | | | | 27 |
| 28 | Speech Pathology Visit Charges | | | | | | 28 |
| 29 | Medical Social Service Visits | | | | | | 29 |
| 30 | Medical Social Service Visit Charges | | | | | | 30 |
| 31 | Home Health Aide Visits | | | | | | 31 |
| 32 | Home Health Aide Visit Charges | | | | | | 32 |
| 33 | Total visits (sum of lines 21, 23, 25, 27, 29, and 31) | | | | | | 33 |
| 34 | Other Charges | | | | | | 34 |
| 35 | Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) | | | | | | 35 |
| 36 | Total Number of Episodes (standard/non-outlier) | | | | | | 36 |
| 37 | Total Number of Outlier Episodes | | | | | | 37 |
| 38 | Total Non-Routine Medical Supply Charges | | | | | | 38 |

| HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-5 |
|---|---|---|---|

RENAL DIALYSIS STATISTICS

| | DESCRIPTION | Outpatient Regular (1) | Outpatient High Flux (2) | Training Hemo-dialysis (3) | Training CAPD CCPD (4) | Home Hemo-dialysis (5) | Home CAPD CCPD (6) | |
|---|---|---|---|---|---|---|---|---|
| 1 | Number of patients in program at end of cost reporting period | | | | | | | 1 |
| 2 | Number of times per week patient receives dialysis | | | | | | | 2 |
| 3 | Average patient dialysis time including setup | | | | | | | 3 |
| 4 | CAPD exchanges per day | | | | | | | 4 |
| 5 | Number of days in year dialysis furnished | | | | | | | 5 |
| 6 | Number of stations | | | | | | | 6 |
| 7 | Treatment capacity per day per station | | | | | | | 7 |
| 8 | Utilization (see instructions) | | | | | | | 8 |
| 9 | Average times dialyzers re-used | | | | | | | 9 |
| 10 | Percentage of patients re-using dialyzers | | | | | | | 10 |

| | ESRD PPS | 1 | 2 | |
|---|---|---|---|---|
| 10.01 | Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions) | | | 10.01 |
| 10.02 | Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.) | | | 10.02 |
| 10.03 | If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions) | | | 10.03 |

TRANSPLANT INFORMATION

| | | | |
|---|---|---|---|
| 11 | Number of patients on transplant list | | 11 |
| 12 | Number of patients transplanted during the cost reporting period | | 12 |

EPOETIN

| | | | |
|---|---|---|---|
| 13 | Net costs of Epoetin furnished to all maintenance dialysis patients by the provider | | 13 |
| 14 | Epoetin amount from Worksheet A for home dialysis program | | 14 |
| 15 | Number of EPO units furnished relating to the renal dialysis department | | 15 |
| 16 | Number of EPO units furnished relating to the home dialysis department | | 16 |

ARANESP

| | | | |
|---|---|---|---|
| 17 | Net costs of ARANESP furnished to all maintenance dialysis patients by the provider | | 17 |
| 18 | ARANESP amount from Worksheet A for home dialysis program | | 18 |
| 19 | Number of ARANESP units furnished relating to the renal dialysis department | | 19 |
| 20 | Number of ARANESP units furnished relating to the home dialysis department | | 20 |

PHYSICIAN PAYMENT METHOD (Enter "X" for applicable method(s))

| | | |
|---|---|---|
| 21 | MCP_____ INITIAL METHOD_____ | 21 |

| | Erythropoiesis-Stimulating Agents (ESA) Statistics: | ESA Description (1) | Net Cost of ESAs for Renal Patients (2) | Net Cost of ESAs for Home Patients (3) | Number of ESA Units - Renal Dialysis Dept. (4) | Number of ESA Units - Home Dialysis Dept. (5) | |
|---|---|---|---|---|---|---|---|
| 22 | Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions) | | | | | | 22 |

| | LOW VOLUME | CCN (1) | Treatments (2) | |
|---|---|---|---|---|
| 23 | If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions) | | | 23 |

| HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-6 |
|---|---|---|---|

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

| Check applicable box: | [ ] CMHC [ ] OOT<br>[ ] CORF [ ] OSP<br>[ ] OPT |
|---|---|

Enter the number of hours in your normal workweek _____

| | | Staff | Contract | Total (column 1 + column 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 |

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

| | | Y/N | Date | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 1 | If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes and do not complete the rest of this worksheet. | | | 1 |
| 2 | Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2. | | | 2 |

| | Group | SNF Days | Swing Bed SNF Days | TOTAL (sum of col. 2 + 3) | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | |
| 3 | RUX | | | | 3 |
| 4 | RUL | | | | 4 |
| 5 | RVX | | | | 5 |
| 6 | RVL | | | | 6 |
| 7 | RHX | | | | 7 |
| 8 | RHL | | | | 8 |
| 9 | RMX | | | | 9 |
| 10 | RML | | | | 10 |
| 11 | RLX | | | | 11 |
| 12 | RUC | | | | 12 |
| 13 | RUB | | | | 13 |
| 14 | RUA | | | | 14 |
| 15 | RVC | | | | 15 |
| 16 | RVB | | | | 16 |
| 17 | RVA | | | | 17 |
| 18 | RHC | | | | 18 |
| 19 | RHB | | | | 19 |
| 20 | RHA | | | | 20 |
| 21 | RMC | | | | 21 |
| 22 | RMB | | | | 22 |
| 23 | RMA | | | | 23 |
| 24 | RLB | | | | 24 |
| 25 | RLA | | | | 25 |
| 26 | ES3 | | | | 26 |
| 27 | ES2 | | | | 27 |
| 28 | ES1 | | | | 28 |
| 29 | HE2 | | | | 29 |
| 30 | HE1 | | | | 30 |
| 31 | HD2 | | | | 31 |
| 32 | HD1 | | | | 32 |
| 33 | HC2 | | | | 33 |
| 34 | HC1 | | | | 34 |
| 35 | HB2 | | | | 35 |
| 36 | HB1 | | | | 36 |
| 37 | LE2 | | | | 37 |
| 38 | LE1 | | | | 38 |
| 39 | LD2 | | | | 39 |
| 40 | LD1 | | | | 40 |
| 41 | LC2 | | | | 41 |
| 42 | LC1 | | | | 42 |
| 43 | LB2 | | | | 43 |
| 44 | LB1 | | | | 44 |
| 45 | CE2 | | | | 45 |
| 46 | CE1 | | | | 46 |
| 47 | CD2 | | | | 47 |
| 48 | CD1 | | | | 48 |
| 49 | CC2 | | | | 49 |
| 50 | CC1 | | | | 50 |
| 51 | CB2 | | | | 51 |
| 52 | CB1 | | | | 52 |
| 53 | CA2 | | | | 53 |
| 54 | CA1 | | | | 54 |

| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-7 (CONT.) |
|---|---|---|---|

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

SNF SERVICES

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

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

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

| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-8 |
|---|---|---|---|

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

Clinic Address and Identification:

| | | |
|---|---|---|
| 1 | Street: | 1 |
| 2 | City: State: Zip Code: County: | 2 |
| 3 | HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban | 3 |

Source of Federal Funds:

| | | Grant Award | Date | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 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 this facility operate as other than a hospital-based 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]

| | | Sunday | | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Type Operation | 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 |

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 as defined in CMS Pub. 100-04, chapter 9, section 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 | RHC/FQHC name: _____ CCN number: _____ | | | 14 |

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

| HOSPITAL-BASED HOSPICE IDENTIFICATION DATA | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-9 PARTS I THROUGH IV |
|---|---|---|---|

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

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

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

| | | Title XVIII | Title XIX | Title XVIII Skilled Nursing Facility | Title XIX Nursing Facility | All Other | Total (sum of cols. 1, 2 and 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 |

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

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

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

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

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

| HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-10 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Uncompensated and indigent care cost computation | | | |
| 1 | Cost to charge ratio (Worksheet C, Part I, line 202, column 3, divided by line 202, column 8) | | 1 |
| Medicaid (see instructions for each line) | | | |
| 2 | Net revenue from Medicaid | | 2 |
| 3 | Did you receive DSH or supplemental payments from Medicaid? | | 3 |
| 4 | If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? | | 4 |
| 5 | If line 4 is no, enter DSH and/or supplemental payments from Medicaid | | 5 |
| 6 | Medicaid charges | | 6 |
| 7 | Medicaid cost (line 1 times line 6) | | 7 |
| 8 | Difference between net revenue and costs for Medicaid program (line 7 minus lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero. | | 8 |
| Children's Health Insurance Program (CHIP) (see instructions for each line) | | | |
| 9 | Net revenue from stand-alone CHIP | | 9 |
| 10 | Stand-alone CHIP charges | | 10 |
| 11 | Stand-alone CHIP cost (line 1 times line 10) | | 11 |
| 12 | Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero. | | 12 |
| Other state or local government indigent care program (see instructions for each line) | | | |
| 13 | Net revenue from state or local indigent care program (not included on lines 2, 5, or 9) | | 13 |
| 14 | Charges for patients covered under state or local indigent care program (not included in lines 6 or 10) | | 14 |
| 15 | State or local indigent care program cost (line 1 times line 14) | | 15 |
| 16 | Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13) If line 15 is less than line 13, then enter zero. | | 16 |
| Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) | | | |
| 17 | Private grants, donations, or endowment income restricted to funding charity care | | 17 |
| 18 | Government grants, appropriations or transfers for support of hospital operations | | 18 |
| 19 | Total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs (sum of lines 8, 12, and 16) | | 19 |

Uncompensated Care (see instructions for each line)

| | | Uninsured patients | Insured patients | Total (col. 1 + col. 2) | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 20 | Charity care charges and uninsured discounts for the entire facility (see instructions) | | | | 20 |
| 21 | Cost of patients approved for charity care and uninsured discounts (see instructions) | | | | 21 |
| 22 | Payments received from patients for amounts previously written off as charity care | | | | 22 |
| 23 | Cost of charity care (line 21 minus line 22) | | | | 23 |

| | | | |
|---|---|---|---|
| 24 | Does the amount on line 20, column 2, include charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program? | | 24 |
| 25 | If line 24 is yes, enter the charges for patient days beyond the indigent care program's length-of-stay limit (see instructions) | | 25 |
| 26 | Total bad debt expense for the entire hospital complex (see instructions) | | 26 |
| 27 | Medicare reimbursable bad debts for the entire hospital complex (see instructions) | | 27 |
| 27.01 | Medicare allowable bad debts for the entire hospital complex (see instructions) | | 27.01 |
| 28 | Non-Medicare bad debt expense (see instructions) | | 28 |
| 29 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) | | 29 |
| 30 | Cost of uncompensated care (line 23 column 3 plus line 29) | | 30 |
| 31 | Total unreimbursed and uncompensated care cost (line 19 plus line 30) | | 31 |

| HOSPITAL-BASED FQHC IDENTIFICATION DATA | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET S-11 PART I |
|---|---|---|---|

PART I - HOSPITAL-BASED FQHC IDENTIFICATION DATA

| | 1 | Type of control (see instructions) 2 | Date Decertified 3 | V/I Decertification 4 | Date of CHOW 5 | |
|---|---|---|---|---|---|---|
| 1 | Site Name: | | | | | 1 |
| 2 | Street: P.O. Box: | | | | | 2 |
| 3 | City: State: ZIP Code: County: | Designation - Enter "R" for rural or "U" for urban: | | | | 3 |
| 4 | Is this hospital-based FQHC part of an entity that owns, leases or controls multiple FQHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below. | | | | | 4 |
| 5 | Name of Entity: | | | | | 5 |
| 6 | Street: P.O. Box: HRSA Award Number: | | | | | 6 |
| 7 | City: State: ZIP Code: | | | | | 7 |

| Consolidated Cost Report | | 1 Y/N | 2 Date Requested | 3 Date Approved | 4 Number of FQHCs | |
|---|---|---|---|---|---|---|
| 8 | Is this hospital-based FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 9 beginning with line 9.01. If column 1 is no, leave line 9 blank. (see instructions) | | | | | 8 |

| | 1 | CCN 2 | CBSA 3 | Date Requested 4 | Date Approved 5 | |
|---|---|---|---|---|---|---|
| 9 | List of Consolidated Providers: | | | | | 9 |
| 9.01 | Site Name: | | | | | 9.01 |

| Hospital-Based FQHC Operations | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 10 | What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions) | | | | 10 |
| 11 | Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the hospital-based FQHC reported on line 1, column 1, receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 12) | | | | 11 |
| 12 | If the response to line 11 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2, and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly. | | | | 12 |
| Medical Malpractice | | | | | |
| 13 | Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2. | | | | 13 |
| Interns and Residents | | | | | |
| 14 | Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, the number of FTE residents that your hospital-based FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) | | | | 14 |

| HOSPITAL-BASED FQHC IDENTIFICATION DATA | PROVIDER CCN: _____ COMPONENT CCN: _____ SUBCOMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-11 PART II |
|---|---|---|---|

PART II - HOSPITAL-BASED FQHC CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA

| | 1 | | | | Date Certified 2 | Type of control (see instructions) 3 | Date Decertified 4 | V/I Decertification 5 | Date of CHOW 6 | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Site Name: | | | | | | | | | 1 |
| 2 | Street: | P.O. Box: | | | | | | | | 2 |
| 3 | City: | State: | ZIP Code: | County: | | Designation - Enter "R" for rural or "U" for urban: | | | | 3 |

| Hospital-Based FQHC Operations | | 1 | 2 | 3 | |
|---|---|---|---|---|---|
| 4 | What type of organization is this hospital-based FQHC? If you operate as more than one sub-type of an organization, enter only the applicable alpha characters in column 2. (see instructions) | | | | 4 |
| 5 | Did this hospital-based FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 6) | | | | 5 |
| 6 | If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly. | | | | 6 |
| Medical Malpractice | | | | | |
| 7 | Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2. | | | | 7 |
| Interns and Residents | | | | | |
| 8 | Did this hospital-based FQHC receive a THC development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) | | | | 8 |

| HOSPITAL-BASED FQHC IDENTIFICATION DATA | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-11 PART III |
|---|---|---|---|

PART III - HOSPITAL-BASED FQHC STATISTICAL DATA

| | | COMPONENT CCN | Title V | Title XVIII | Title XIX | Other | Total All Patients | |
|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 | 5 | |
| 1 | Medical Visits | | | | | | | 1 |
| 2 | Total Medical Visits | | | | | | | 2 |
| 3 | Mental Health Visits | | | | | | | 3 |
| 4 | Total Mental Health Visits | | | | | | | 4 |

This page is reserved for future use.

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

| | | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | 00100 | Capital Related Costs-Buildings and Fixtures | | | | | | | | 1 |
| 2 | 00200 | Capital Related Costs-Movable Equipment | | | | | | | | 2 |
| 3 | 00300 | Other Capital Related Costs | | | | | | | -0- | 3 |
| 4 | 00400 | Employee Benefits Department | | | | | | | | 4 |
| 5 | 00500 | Administrative and General | | | | | | | | 5 |
| 6 | 00600 | Maintenance and Repairs | | | | | | | | 6 |
| 7 | 00700 | Operation of Plant | | | | | | | | 7 |
| 8 | 00800 | Laundry and Linen Service | | | | | | | | 8 |
| 9 | 00900 | Housekeeping | | | | | | | | 9 |
| 10 | 01000 | Dietary | | | | | | | | 10 |
| 11 | 01100 | Cafeteria | | | | | | | | 11 |
| 12 | 01200 | Maintenance of Personnel | | | | | | | | 12 |
| 13 | 01300 | Nursing Administration | | | | | | | | 13 |
| 14 | 01400 | Central Services and Supply | | | | | | | | 14 |
| 15 | 01500 | Pharmacy | | | | | | | | 15 |
| 16 | 01600 | Medical Records & Medical Records Library | | | | | | | | 16 |
| 17 | 01700 | Social Service | | | | | | | | 17 |
| 18 | | Other General Service (specify) | | | | | | | | 18 |
| 19 | 01900 | Nonphysician Anesthetists | | | | | | | | 19 |
| 20 | 02000 | Nursing School | | | | | | | | 20 |
| 21 | 02100 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | 21 |
| 22 | 02200 | Intern & Res. Other Program Costs (Approved) | | | | | | | | 22 |
| 23 | | Paramedical Ed. Program (specify) | | | | | | | | 23 |
| | | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | 03000 | Adults and Pediatrics (General Routine Care) | | | | | | | | 30 |
| 31 | 03100 | Intensive Care Unit | | | | | | | | 31 |
| 32 | 03200 | Coronary Care Unit | | | | | | | | 32 |
| 33 | 03300 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | 03400 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | | Other Special Care (specify) | | | | | | | | 35 |
| 40 | 04000 | Subprovider - IPF | | | | | | | | 40 |
| 41 | 04100 | Subprovider - IRF | | | | | | | | 41 |
| 42 | | Subprovider (specify) | | | | | | | | 42 |
| 43 | 04300 | Nursery | | | | | | | | 43 |
| 44 | 04400 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | 04500 | Nursing Facility | | | | | | | | 45 |
| 46 | 04600 | Other Long Term Care | | | | | | | | 46 |

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

| | | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | 05000 | Operating Room | | | | | | | | 50 |
| 51 | 05100 | Recovery Room | | | | | | | | 51 |
| 52 | 05200 | Labor Room and Delivery Room | | | | | | | | 52 |
| 53 | 05300 | Anesthesiology | | | | | | | | 53 |
| 54 | 05400 | Radiology-Diagnostic | | | | | | | | 54 |
| 55 | 05500 | Radiology-Therapeutic | | | | | | | | 55 |
| 56 | 05600 | Radioisotope | | | | | | | | 56 |
| 57 | 05700 | Computed Tomography (CT) Scan | | | | | | | | 57 |
| 58 | 05800 | Magnetic Resonance Imaging (MRI) | | | | | | | | 58 |
| 59 | 05900 | Cardiac Catheterization | | | | | | | | 59 |
| 60 | 06000 | Laboratory | | | | | | | | 60 |
| 61 | 06100 | PBP Clinical Laboratory Services-Program Only | | | | | | | | 61 |
| 62 | 06200 | Whole Blood & Packed Red Blood Cells | | | | | | | | 62 |
| 63 | 06300 | Blood Storing, Processing, & Trans. | | | | | | | | 63 |
| 64 | 06400 | Intravenous Therapy | | | | | | | | 64 |
| 65 | 06500 | Respiratory Therapy | | | | | | | | 65 |
| 66 | 06600 | Physical Therapy | | | | | | | | 66 |
| 67 | 06700 | Occupational Therapy | | | | | | | | 67 |
| 68 | 06800 | Speech Pathology | | | | | | | | 68 |
| 69 | 06900 | Electrocardiology | | | | | | | | 69 |
| 70 | 07000 | Electroencephalography | | | | | | | | 70 |
| 71 | 07100 | Medical Supplies Charged to Patients | | | | | | | | 71 |
| 72 | 07200 | Implantable Devices Charged to Patients | | | | | | | | 72 |
| 73 | 07300 | Drugs Charged to Patients | | | | | | | | 73 |
| 74 | 07400 | Renal Dialysis | | | | | | | | 74 |
| 75 | 07500 | ASC (Non-Distinct Part) | | | | | | | | 75 |
| 76 | | Other Ancillary (specify) | | | | | | | | 76 |
| 77 | 07700 | Allogeneic Stem Cell Acquisition | | | | | | | | 77 |
| | | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 88 | 08800 | Rural Health Clinic (RHC) | | | | | | | | 88 |
| 89 | 08900 | Federally Qualified Health Center (FQHC) | | | | | | | | 89 |
| 90 | 09000 | Clinic | | | | | | | | 90 |
| 91 | 09100 | Emergency | | | | | | | | 91 |
| 92 | 09200 | Observation Beds | | | | | | | | 92 |
| 93 | | Other Outpatient Service (specify) | | | | | | | | 93 |
| 93.99 | 09399 | Partial Hospitalization Program | | | | | | | | 93.99 |

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

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

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

| | EXPLANATION OF RECLASSIFICATION(S) | CODE (1) | INCREASES | | | | DECREASES | | | | Wkst. A-7 Ref. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | COST CENTER | LINE # | SALARY | OTHER | COST CENTER | LINE # | SALARY | OTHER | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 1 | | | | | | | | | | | | 1 |
| 2 | | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | | 12 |
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| 14 | | | | | | | | | | | | 14 |
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| 31 | | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | | 35 |
| 500 | Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9) | | | | | | | | | | | 500 |

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

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

| | Description | Beginning Balances | Acquisitions: Purchases | Acquisitions: Donation | Acquisitions: Total | Disposals and Retirements | Ending Balance | Fully Depreciated Assets | |
|---|---|---|---|---|---|---|---|---|---|
| | | 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 | HIT-designated Assets | | | | | | | | 7 |
| 8 | Subtotal (sum of lines 1-7) | | | | | | | | 8 |
| 9 | Reconciling Items | | | | | | | | 9 |
| 10 | Total (line 7 minus line 9) | | | | | | | | 10 |

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

| | Description | SUMMARY OF CAPITAL: Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | Other Capital-Related Costs (see instructions) | Total (1) (sum of cols. 9 through 14) | |
|---|---|---|---|---|---|---|---|---|---|
| * | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | 2 |
| 3 | Total (sum of lines 1-2) | | | | | | | | 3 |

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

| | Description | COMPUTATION OF RATIOS: Gross Assets | Capitalized Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | ALLOCATION OF OTHER CAPITAL: Insurance | Taxes | Other Capital-Related Costs | Total (sum of cols. 5 through 7) | |
|---|---|---|---|---|---|---|---|---|---|---|
| * | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | 2 |
| 3 | Total (sum of lines 1-2) | | | | 1.000000 | | | | | 3 |

| | Description | SUMMARY OF CAPITAL: Depreciation | Lease | Interest | Insurance (see instructions) | Taxes (see instructions) | Other Capital-Related Costs (see instructions) | Total (2) (sum of cols. 9 through 14) | |
|---|---|---|---|---|---|---|---|---|---|
| * | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | 2 |
| 3 | Total (sum of lines 1-2) | | | | | | | | 3 |

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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

| | DESCRIPTION (1) | BASIS / CODE (2) | AMOUNT | EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER | LINE # | Wkst. A-7 Ref. | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | Investment income - buildings and fixtures (chapter 2) | | | Buildings and Fixtures | 1 | | 1 |
| 2 | Investment income - movable equipment (chapter 2) | | | Movable Equipment | 2 | | 2 |
| 3 | Investment income - other (chapter 2) | | | | | | 3 |
| 4 | Trade, quantity, and time discounts (chapter 8) | | | | | | 4 |
| 5 | Refunds and rebates of expenses (chapter 8) | | | | | | 5 |
| 6 | Rental of provider space by suppliers (chapter 8) | | | | | | 6 |
| 7 | Telephone services (pay stations excluded) (chapter 21) | | | | | | 7 |
| 8 | Television and radio service (chapter 21) | | | | | | 8 |
| 9 | Parking lot (chapter 21) | | | | | | 9 |
| 10 | Provider-based physician adjustment | Worksheet A-8-2 | | | | | 10 |
| 11 | Sale of scrap, waste, etc. (chapter 23) | | | | | | 11 |
| 12 | Related organization transactions (chapter 10) | Worksheet A-8-1 | | | | | 12 |
| 13 | Laundry and linen service | | | | | | 13 |
| 14 | Cafeteria-employees and guests | | | | | | 14 |
| 15 | Rental of quarters to employee and others | | | | | | 15 |
| 16 | Sale of medical and surgical supplies to other than patients | | | | | | 16 |
| 17 | Sale of drugs to other than patients | | | | | | 17 |
| 18 | Sale of medical records and abstracts | | | | | | 18 |
| 19 | Nursing and allied health education (tuition, fees, books, etc.) | | | | | | 19 |
| 20 | Vending machines | | | | | | 20 |
| 21 | Income from imposition of interest, finance or penalty charges (chapter 21) | | | | | | 21 |
| 22 | Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments | | | | | | 22 |
| 23 | Adjustment for respiratory therapy costs in excess of limitation (chapter 14) | Worksheet A-8-3 | | Respiratory Therapy | 65 | | 23 |
| 24 | Adjustment for physical therapy costs in excess of limitation (chapter 14) | Worksheet A-8-3 | | Physical Therapy | 66 | | 24 |
| 25 | Utilization review - physicians' compensation (chapter 21) | | | Utilization Review - SNF | 114 | | 25 |
| 26 | Depreciation - buildings and fixtures | | | Buildings and Fixtures | 1 | | 26 |
| 27 | Depreciation - movable equipment | | | Movable Equipment | 2 | | 27 |
| 28 | Non-physician Anesthetist | | | Nonphysician Anesthetist | 19 | | 28 |
| 29 | Physicians' assistant | | | | | | 29 |
| 30 | Adjustment for occupational therapy costs in excess of limitation (chapter 14) | Worksheet A-8-3 | | Occupational Therapy | 67 | | 30 |
| 30.99 | Hospice (non-distinct) (see instructions) | | | Adults and Pediatrics | 30 | | 30.99 |
| 31 | Adjustment for speech pathology costs in excess of limitation (chapter 14) | Worksheet A-8-3 | | Speech Pathology | 68 | | 31 |
| 32 | CAH HIT adjustment for depreciation | | | | | | 32 |
| 33 | Other adjustments (specify) [3] | | | | | | 33 |
| 50 | TOTAL (sum of lines 1 through 49) (Transfer to Worksheet A, column 6, line 200) | | | | | | 50 |

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

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 through 49 and subscripts thereof.

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

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

A. 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 of Allowable Cost | Amount included in Wkst. A column 5 | Net Adjustments (col. 4 minus col. 5) * | Wkst. A-7 Ref. | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1 | | | | | | | | 1 |
| 2 | | | | | | | | 2 |
| 3 | | | | | | | | 3 |
| 4 | | | | | | | | 4 |
| 5 | TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12. | | | | | | | 5 |

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

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

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

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

| | | | | Related Organization(s) and/or Home Office | | | |
|---|---|---|---|---|---|---|---|
| | Symbol (1) | Name | Percentage of Ownership | Name | Percentage of Ownership | Type of Business | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| 6 | | | | | | | 6 |
| 7 | | | | | | | 7 |
| 8 | | | | | | | 8 |
| 9 | | | | | | | 9 |
| 10 | | | | | | | 10 |

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

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

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

| | Wkst. A Line # | Cost Center/ Physician Identifier | Total Remuneration | Professional Component | Provider Component | RCE Amount | Physician/ Provider Component Hours | Unadjusted RCE Limit | 5 Percent of Unadjusted RCE Limit | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| 1 | | | | | | | | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 200 | TOTAL | | | | | | | | | 200 |

| | Wkst. A Line # | 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 RCE Limit | RCE Disallowance | Adjustment | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | |
| 1 | | | | | | | | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 200 | TOTAL | | | | | | | | | 200 |

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

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

PART I - GENERAL INFORMATION

| | | | |
|---|---|---|---|
| 1 | Total number of weeks worked (excluding aides) (see instructions) | | 1 |
| 2 | Line 1 multiplied by 15 hours per week | | 2 |
| 3 | Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) | | 3 |
| 4 | Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions) | | 4 |
| 5 | Number of unduplicated offsite visits - supervisors or therapists (see instructions) | | 5 |
| 6 | Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) | | 6 |
| 7 | Standard travel expense rate | | 7 |
| 8 | Optional travel expense rate per mile | | 8 |

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

| | | | |
|---|---|---|---|
| 21 | Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others) | | 21 |
| 22 | Weighted allowance excluding aides and trainees (line 2 times line 21) | | 22 |
| 23 | Total salary equivalency (see instructions) | | 23 |

| REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-3, PARTS III & IV |
|---|---|---|---|

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

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | | |
|---|---|---|---|
| | Standard Travel Allowance | | |
| 24 | Therapists (line 3 times column 2, line 11) | | 24 |
| 25 | Assistants (line 4 times column 3, line 11) | | 25 |
| 26 | Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) | | 26 |
| 27 | Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) | | 27 |
| 28 | Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) | | 28 |
| | Optional Travel Allowance and Optional Travel Expense | | |
| 29 | Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12 ) | | 29 |
| 30 | Assistants (column 3, line 10 times column 3, line 12) | | 30 |
| 31 | Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) | | 31 |
| 32 | Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) | | 32 |
| 33 | Standard travel allowance and standard travel expense (line 28) | | 33 |
| 34 | Optional travel allowance and standard travel expense (sum of lines 27 and 31) | | 34 |
| 35 | Optional travel allowance and optional travel expense (sum of lines 31 and 32) | | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | | |
|---|---|---|---|
| | Standard Travel Expense | | |
| 36 | Therapists (line 5 times column 2, line 11) | | 36 |
| 37 | Assistants (line 6 times column 3, line 11) | | 37 |
| 38 | Subtotal (sum of lines 36 and 37) | | 38 |
| 39 | Standard travel expense (line 7 times the sum of lines 5 and 6) | | 39 |
| | Optional Travel Allowance and Optional Travel Expense | | |
| 40 | Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) | | 40 |
| 41 | Assistants (column 3, line 12.01 times column 3, line 10) | | 41 |
| 42 | Subtotal (sum of lines 40 and 41) | | 42 |
| 43 | Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) | | 43 |
| | Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate. | | |
| 44 | Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions) | | 44 |
| 45 | Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions) | | 45 |
| 46 | Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions) | | 46 |

| REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-3, PARTS V-VI |
|---|---|---|---|

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

PART V - OVERTIME COMPUTATION

| | | Therapists | Assistants | Aides | Trainees | Total | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 47 | Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or great than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) | | | | | | 47 |
| 48 | Overtime rate (see instructions) | | | | | | 48 |
| 49 | Total overtime (including base and overtime allowance) (multiply line 47 times line 48) | | | | | | 49 |
| | CALCULATION OF LIMIT | | | | | | |
| 50 | Percentage of overtime hours by category (divide the hours in each column on liine 47 by the total overtime worked in column 5, line 47. | | | | | | 50 |
| 51 | Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) | | | | | | 51 |
| | DETERMINATION OF OVERTIME ALLOWANCE | | | | | | |
| 52 | Adjusted hourly salary equivalency amount (see instructions) | | | | | | 52 |
| 53 | Overtime cost limitation (line 51 times line 52) | | | | | | 53 |
| 54 | Maximum overtime cost (enter the lesser of line 49 or line 53) | | | | | | 54 |
| 55 | Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52) | | | | | | 55 |
| 56 | Overtime allowance (line 54 minus line 55 - if negative enter zero) ( Enter in column 5, the sum of columns 1, 3, and 4, for respiratory therapy, and columns 1 through 3 for all others.) | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | |
|---|---|---|---|
| 57 | Salary equivalency amount (from line 23) | | 57 |
| 58 | Travel allowance and expense - provider site (from lines 33, 34, or 35)) | | 58 |
| 59 | Travel allowance and expense - Offsite services (from lines 44, 45, or 46) | | 59 |
| 60 | Overtime allowance (from column 5, line 56) | | 60 |
| 61 | Equipment cost (see instructions) | | 61 |
| 62 | Supplies (see instructions) | | 62 |
| 63 | Total allowance (sum of lines 57-62) | | 63 |
| 64 | Total cost of outside supplier services (from provider records) | | 64 |
| 65 | Excess over limitation (line 64 minus line 63; if negative, enter zero) | | 65 |

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

| | COST CENTER DESCRIPTIONS | NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7) | CAPITAL RELATED COSTS | | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols. 0-4) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | 46 |

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

| | COST CENTER DESCRIPTIONS | NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7) | CAPITAL RELATED COSTS | | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols. 0-4) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Services-Program Only | | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Trans. | | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 70 | Electroencephalography | | | | | | | | | 70 |
| 71 | Medical Supplies Charged to Patients | | | | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | | | | 82 |
| 73 | Drugs Charged to Patients | | | | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | | | | 89 |
| 90 | Clinic | | | | | | | | | 90 |
| 91 | Emergency | | | | | | | | | 91 |
| 92 | Observation Beds | | | | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | | | | 93.99 |

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

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

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

| | COST CENTER DESCRIPTIONS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | MAIN-TENANCE OF PERSONNEL | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | | | 46 |

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

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

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

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

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

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE | NON-PHYSICIAN ANES-THETISTS | NURSING SCHOOL | INTERNS & RESIDENTS SALARY AND FRINGES | INTERNS & RESIDENTS PROGRAM COSTS | PARAMEDICAL EDUCATION (SPECIFY) | SUBTOTAL | INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | | 46 |

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

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE | NON-PHYSICIAN ANES-THETISTS | NURSING SCHOOL | INTERNS & RESIDENTS SALARY AND FRINGES | INTERNS & RESIDENTS PROGRAM COSTS | PARAMEDICAL EDUCATION (SPECIFY) | SUBTOTAL | INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Services-Program Only | | | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Trans. | | | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | | 69 |
| 70 | Electroencephalography | | | | | | | | | | 70 |
| 71 | Medical Supplies Charged to Patients | | | | | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | | | | | 82 |
| 73 | Drugs Charged to Patients | | | | | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | | | | | 89 |
| 90 | Clinic | | | | | | | | | | 90 |
| 91 | Emergency | | | | | | | | | | 91 |
| 92 | Observation Beds | | | | | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | | | | | 93.99 |

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

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

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

| | COST CENTER DESCRIPTIONS | DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS | CAPITAL RELATED COSTS | | SUBTOTAL (sum of (cols. 0-2) | EMPLOYEE BENEFITS DEPARTMENT | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 2A | 4 | 5 | 6 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | 36 |
| 40 | Subprovider IPF | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | 46 |

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

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

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

| | COST CENTER DESCRIPTIONS | DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS | CAPITAL RELATED COSTS | | SUBTOTAL (sum of (cols. 0-2) | EMPLOYEE BENEFITS DEPARTMENT | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 2A | 4 | 5 | 6 | 7 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | | 94 |
| 95 | Ambulance Services | | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | | | | 98 |
| 99 | Outpatient Rehabilitation Provider (specify) | | | | | | | | | 99 |
| 100 | Intern-Resident Service (not appvd. tchng. prgm.) | | | | | | | | | 100 |
| 101 | Home Health Agency | | | | | | | | | 101 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 105 | Kidney Acquisition | | | | | | | | | 105 |
| 106 | Heart Acquisition | | | | | | | | | 106 |
| 107 | Liver Acquisition | | | | | | | | | 107 |
| 108 | Lung Acquisition | | | | | | | | | 108 |
| 109 | Pancreas Acquisition | | | | | | | | | 109 |
| 110 | Intestinal Acquisition | | | | | | | | | 110 |
| 111 | Islet Acquisition | | | | | | | | | 111 |
| 112 | Other Organ Acquisition (specify) | | | | | | | | | 112 |
| 115 | Ambulatory Surgical Center (Distinct Part) | | | | | | | | | 115 |
| 116 | Hospice | | | | | | | | | 113 |
| 117 | Other Special Purpose (specify) | | | | | | | | | 117 |
| 118 | SUBTOTALS (sum of lines 1 through 117) | | | | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 190 | Gift, Flower, Coffee Shop, & Canteen | | | | | | | | | 190 |
| 191 | Research | | | | | | | | | 191 |
| 192 | Physicians' Private Offices | | | | | | | | | 192 |
| 193 | Nonpaid Workers | | | | | | | | | 193 |
| 194 | Other Nonreimbursable (specify) | | | | | | | | | 194 |
| 200 | Cross Foot Adjustments | | | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | | | 201 |
| 202 | TOTAL (sum lines 118 through 201) | | | | | | | | | 202 |

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

| | COST CENTER DESCRIPTIONS | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | MAIN-TENANCE OF PERSONNEL | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | | | 36 |
| 40 | Subprovider IPF | | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | | | 46 |

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

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

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

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

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

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE | NON-PHYSICIAN ANES-THETISTS | NURSING SCHOOL | INTERNS & RESIDENTS SALARY AND FRINGES | INTERNS & RESIDENTS PROGRAM COSTS | PARAMEDICAL EDUCATION (SPECIFY) | SUBTOTAL | INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | | 3 |
| 5 | Administrative and General | | | | | | | | | | 4 |
| 6 | Maintenance and Repairs | | | | | | | | | | 5 |
| 7 | Operation of Plant | | | | | | | | | | 6 |
| 8 | Laundry and Linen Service | | | | | | | | | | 7 |
| 9 | Housekeeping | | | | | | | | | | 8 |
| 10 | Dietary | | | | | | | | | | 9 |
| 11 | Cafeteria | | | | | | | | | | 10 |
| 12 | Maintenance of Personnel | | | | | | | | | | 11 |
| 13 | Nursing Administration | | | | | | | | | | 12 |
| 14 | Central Services and Supply | | | | | | | | | | 13 |
| 15 | Pharmacy | | | | | | | | | | 14 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | | 15 |
| 17 | Social Service | | | | | | | | | | 16 |
| 18 | Other General Service (specify) | | | | | | | | | | 17 |
| 19 | Nonphysician Anesthetists | | | | | | | | | | 18 |
| 20 | Nursing School | | | | | | | | | | 19 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | | 20 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | | 21 |
| 23 | Paramedical Education Program (specify) | | | | | | | | | | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | | 36 |
| 40 | Subprovider IPF | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | 41 |
| 42 | Subprovider (specify) | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | | 46 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | COST CENTER DESCRIPTIONS | OTHER GENERAL SERVICE (SPECIFY) | NON-PHYSICIAN ANES-THETISTS (ASGND TIME) | NURSING SCHOOL (ASSIGNED TIME) | INTERNS & RESIDENTS: SALARY AND FRINGES (ASSIGNED TIME) | INTERNS & RESIDENTS: PROGRAM COSTS (ASSIGNED TIME) | PARA-MEDICAL EDUCATION (ASSIGNED TIME) | SUBTOTAL | INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | | | 94 |
| 95 | Ambulance Services | | | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | | | | | 98 |
| 99 | Outpatient Rehabilitation Provider (specify) | | | | | | | | | | 99 |
| 100 | Intern-Resident Service (not appvd. tchng. prgm.) | | | | | | | | | | 100 |
| 101 | Home Health Agency | | | | | | | | | | 101 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | | |
| 105 | Kidney Acquisition | | | | | | | | | | 105 |
| 106 | Heart Acquisition | | | | | | | | | | 106 |
| 107 | Liver Acquisition | | | | | | | | | | 107 |
| 108 | Lung Acquisition | | | | | | | | | | 108 |
| 109 | Pancreas Acquisition | | | | | | | | | | 109 |
| 110 | Intestinal Acquisition | | | | | | | | | | 110 |
| 111 | Islet Acquisition | | | | | | | | | | 111 |
| 112 | Other Organ Acquisition (specify) | | | | | | | | | | 112 |
| 115 | Ambulatory Surgical Center (Distinct Part) | | | | | | | | | | 115 |
| 116 | Hospice | | | | | | | | | | 116 |
| 117 | Other Special Purpose (specify) | | | | | | | | | | 117 |
| 118 | SUBTOTALS (sum of lines 1 through 117) | | | | | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | | |
| 190 | Gift, Flower, Coffee Shop, & Canteen | | | | | | | | | | 190 |
| 191 | Research | | | | | | | | | | 191 |
| 192 | Physicians' Private Offices | | | | | | | | | | 192 |
| 193 | Nonpaid Workers | | | | | | | | | | 193 |
| 194 | Other Nonreimbursable (specify) | | | | | | | | | | 194 |
| 200 | Cross foot adjustments | | | | | | | | | | 200 |
| 201 | Negative cost centers | | | | | | | | | | 201 |
| 202 | Cost to be allocated (per Worksheet B, Part I) | | | | | | | | | | 202 |
| 203 | Unit cost multiplier (Worksheet B, Part I) | | | | | | | | | | 203 |
| 204 | Cost to be allocated (per Worksheet B, Part II) | | | | | | | | | | 204 |
| 205 | Unit cost multiplier (Worksheet B, Part II) | | | | | | | | | | 205 |
| 206 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | | | | | 206 |
| 207 | NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | | | | | 207 |

| POST STEPDOWN ADJUSTMENTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B-2 |
|---|---|---|---|

| | DESCRIPTION | WORKSHEET CODE | WORKSHEET LINE NO. | AMOUNT | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | |
| 1 | Adjustment for EPO costs in Renal Dialysis cost center | 1 | 74 | | 1 |
| 2 | Adjustment for EPO costs in Home Program Dialysis cost center | 1 | 94 | | 2 |
| 3 | Adjustment for ARANESP costs in Renal Dialysis cost center | 1 | 74 | | 3 |
| 4 | Adjustment for ARANESP costs in Home Program Dialysis cost center | 1 | 94 | | 4 |
| 5 | Adjustment for ESA costs in Renal Dialysis cost center (see instructions) | 1 | 74 | | 5 |
| 6 | Adjustment for ESA costs in Home Program Dialysis cost center (see instructions) | 1 | 94 | | 6 |
| 7 | | | | | 7 |
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COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

| | COST CENTER DESCRIPTIONS | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Costs | | | Charges | | | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total Costs | RCE Dis-allowance | Total Costs | Inpatient | Outpatient | Total (column 6 + column 7) | | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | | | 34 |
| 35 | Other Special Care (specify) | | | | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | | | 41 |
| 42 | Subprovider (Specify) | | | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | | | | 46 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Services-Prgm. Only | | | | | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Trans. | | | | | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | | | | 68 |

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

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

| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C, PART II |
|---|---|---|---|

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

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

| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C. PART II (CONT.) |
|---|---|---|---|

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

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

| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART I |
|---|---|---|---|

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] PPS [ ] TEFRA

| | | Capital Related Cost (from Wkst. B, Part II, col. 26) | Swing Bed Adjustment | Reduced Capital Related Cost (col. 1 minus col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | INPATIENT ROUTNE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics (General Routine Care) | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | 41 |
| 42 | Subprovider (Other) | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | 45 |
| 200 | Total (lines 30 through 199) | | | | | | | | 200 |

(A) Worksheet A line numbers

| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D PART II |
|---|---|---|---|

| Check applicable boxes: | [ ] Title V | [ ] Hospital | [ ] Subprovider (Other) | [ ] PPS |
|---|---|---|---|---|
| | [ ] Title XVIII, Part A | [ ] IPF | | [ ] TEFRA |
| | [ ] Title XIX | [ ] IRF | | |

| (A) | Cost Center Description | Capital Related Cost (from Wkst. B, Part II, col. 26) | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col .1 ÷ col. 2) | Inpatient Program Charges | Capital Costs (column 3 x column 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | | | | | | 50 |
| 51 | Recovery Room | | | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | | | 52 |
| 53 | Anesthesiology | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | 55 |
| 56 | Radioisotope | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | 60 |
| 60 | Laboratory | | | | | | 60 |
| 61 | PBP Clinical Laboratory Services-Prgm. Only | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | 62 |
| 63 | Blood Storing, Processing, & Transfusing | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | 65 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 69 | Electrocardiology | | | | | | 69 |
| 70 | Electroencephalography | | | | | | 70 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | 89 |
| 90 | Clinic | | | | | | 90 |
| 91 | Emergency | | | | | | 91 |
| 92 | Observation Beds | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | 93.99 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94 | Home Program Dialysis | | | | | | 94 |
| 95 | Ambulance Services | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | 98 |
| 200 | Total (sum of lines 50 through 199) | | | | | | 200 |

(A) Worksheet A line numbers

| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS-THROUGH COSTS | PROVIDER CCN: _____ | PERIOD FROM _____ TO _____ | WORKSHEET D, PART III |
|---|---|---|---|

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] PPS [ ] TEFRA [ ] Other

| | | Nursing School Post-Stepdown Adjustments | Nursing School | Allied Health Post-Stepdown Adjustments | Allied Health Cost | All Other Medical Education Cost | Swing-Bed Adjustment Amount (see instructions) | Total Costs (sum of cols. 1, 2, and 3, minus col. 4) | Total Patient Days | Per Diem (col. 5 ÷ col. 6) | Inpatient Program Days | Inpatient Program Pass-Through Cost (col. 7 x col. 8) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1A | 1 | 2A | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | | |
| 30 | Adults & Pediatrics (General Routine Care) | | | | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | | | | 41 |
| 42 | Subprovider (Other) | | | | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | | | | 45 |
| 200 | Total (sum of lines 30 through 199) | | | | | | | | | | | | 200 |

(A) Worksheet A line numbers

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS-THROUGH COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART IV |
|---|---|---|---|

| Check applicable boxes: | | | | | |
|---|---|---|---|---|---|
| | [ ] Title V | [ ] Hospital | [ ] Subprovider (Other) | [ ] ICF/IID | [ ] PPS |
| | [ ] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA |
| | [ ] Title XIX | [ ] IRF | [ ] NF | | [ ] Other |

| | | Non Physician Anesthetist Cost | Nursing School Post-Stepdown Adjustments | Nursing School | Allied Health Post-Stepdown Adjustments | Allied Health | All Other Medical Education Cost | Total cost (sum of cols. 1, 2 3, and 4) | Total Outpatient Cost (sum of cols. 2, 3, and 4) | |
|---|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 50 | Operating Room | | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | | 51 |
| 52 | Labor room and Delivery Room | | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Serv.-Prgm. Only | | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Transfusing | | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | | 69 |
| 70 | Electroencephalography | | | | | | | | | 70 |
| 71 | Medical Supplies Charged To Patients | | | | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | | | | 89 |
| 90 | Clinic | | | | | | | | | 90 |
| 91 | Emergency | | | | | | | | | 91 |
| 92 | Observation Beds | | | | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | | | | 93.99 |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART IV (Cont.) |
|---|---|---|---|

| Check applicable boxes: | [ ] Title V | [ ] Hospital | [ ] Subprovider (Other) | [ ] ICF/IID | [ ] PPS |
|---|---|---|---|---|---|
| | [ ] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA |
| | [ ] Title XIX | [ ] IRF | [ ] NF | | [ ] Other |

| | | Non Physician Anesthetist Cost | Nursing School Post-Stepdown Adjustments | Nursing School | Allied Health Post-Stepdown Adjustments | Allied Health | All Other Medical Education Cost | Total cost (sum of cols. 1, 2 3, and 4) | Total Outpatient Cost (sum of cols. 2, 3, and 4) | |
|---|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 1 | 2A | 2 | 3A | 3 | 4 | 5 | 6 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | | 94 |
| 95 | Ambulance Services | | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | | | | 98 |
| 200 | Total (sum of lines 50 through 199) | | | | | | | | | 200 |

(A) Worksheet A line numbers

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART IV (Cont.) |
|---|---|---|---|

| Check applicable boxes: | | | | | |
|---|---|---|---|---|---|
| | [ ] Title V | [ ] Hospital | [ ] Subprovider (Other) | [ ] ICF/IID | [ ] PPS |
| | [ ] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA |
| | [ ] Title XIX | [ ] IRF | [ ] NF | | [ ] Other |

| | | Total Charges (from Wkst. C, Part I, col. 8) | Ratio of Cost to Charges (col. 5 ÷ col. 7) | Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) | Inpatient Program Charges | Inpatient Program Pass-Through Costs (col. 8 x col. 10) | Outpatient Program Charges | Outpatient Program Pass-Through Costs (col. 9 x col. 12) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | Cost Center Description | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | 51 |
| 52 | Delivery Room and Labor Room | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Serv.-Prgm. Only | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Transfusing | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | 69 |
| 70 | Electroencephalography | | | | | | | | 70 |
| 71 | Medical Supplies Charged To Patients | | | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | | | 89 |
| 90 | Clinic | | | | | | | | 90 |
| 91 | Emergency | | | | | | | | 91 |
| 92 | Observation Beds | | | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | | | 93.99 |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART IV (Cont.) |
|---|---|---|---|

| Check applicable boxes: | | | | | |
|---|---|---|---|---|---|
| | [ ] Title V | [ ] Hospital | [ ] Subprovider (Other) | [ ] ICF/IID | [ ] PPS |
| | [ ] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA |
| | [ ] Title XIX | [ ] IRF | [ ] NF | | [ ] Other |

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

(A) Worksheet A line numbers

| APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D, PART V |
|---|---|---|---|

| Check applicable boxes: | | | | |
|---|---|---|---|---|
| | [ ] Title V - O/P | [ ] Hospital | [ ] Subprovider (Other) | [ ] Swing Bed SNF |
| | [ ] Title XVIII, Part B | [ ] IPF | [ ] SNF | [ ] Swing Bed NF |
| | [ ] Title XIX - O/P | [ ] IRF | [ ] NF | [ ] ICF/IID |

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

| | | | Program Charges | | | Program Cost | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Cost to Charge Ratio from Worksheet C, Part I, col. 9 | PPS Reimbursed Services (see inst.) | Cost Reimbursed Services Subject to Ded. & Coins. (see inst.) | Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.) | PPS Services (see (see inst.) | Cost Reimbursed Services Subject to Ded. & Coins. (see inst.) | Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.) | |
| (A) | Cost Center Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 50 | Operating Room | | | | | | | | 50 |
| 51 | Recovery Room | | | | | | | | 51 |
| 52 | Labor & Delivery Room | | | | | | | | 52 |
| 53 | Anesthesiology | | | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | | | 55 |
| 56 | Radioisotope | | | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | | | 58 |
| 59 | Cardiac Catheterization | | | | | | | | 59 |
| 60 | Laboratory | | | | | | | | 60 |
| 61 | PBP Clinical Laboratory Serv.-Prgm. Only | | | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | | | 62 |
| 63 | Blood Storing, Processing, & Transfusing | | | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | | | 65 |
| 66 | Physical Therapy | | | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | | | 67 |
| 68 | Speech Pathology | | | | | | | | 68 |
| 69 | Electrocardiology | | | | | | | | 69 |
| 70 | Electroencephalography | | | | | | | | 70 |
| 71 | Medical Supplies Charged To Patients | | | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 88 | Rural Health Clinic (RHC) | | | | | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | | | | | 89 |
| 90 | Clinic | | | | | | | | 90 |
| 91 | Emergency | | | | | | | | 91 |
| 92 | Observation Bed | | | | | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | | | | | 93.99 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | 94 |
| 95 | Ambulance | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | 97 |
| 98 | Other Reimbursable Cost Center | | | | | | | | 98 |
| 200 | Subtotal (see instructions) | | | | | | | | 200 |
| 201 | Less PBP Clinic Lab. Services-Program Only Charges | | | | | | | | 201 |
| 202 | Net Charges (line 200 - line 201 ) | | | | | | | | 202 |

| COMPUTATION OF INPATIENT OPERATING COST | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-1, PART I |
|---|---|---|---|

| Check applicable boxes: | [ ] Title V - I/P | [ ] Hospital | [ ] Subprovider (other) | [ ] ICF/IID | [ ] PPS |
|---|---|---|---|---|---|
| | [ ] Title XVIII, Part A | [ ] IPF | [ ] SNF | | [ ] TEFRA |
| | [ ] Title XIX - I/P | [ ] IRF | [ ] NF | | [ ] Other |

PART I - ALL PROVIDER COMPONENTS

| | | | |
|---|---|---|---|
| | INPATIENT DAYS | | |
| 1 | Inpatient days (including private room days and swing-bed days, excluding newborn) | | 1 |
| 2 | Inpatient days (including private room days, excluding swing-bed and newborn days) | | 2 |
| 3 | Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. | | 3 |
| 4 | Semi-private room days (excluding swing-bed and observation bed days) | | 4 |
| 5 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period | | 5 |
| 6 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 6 |
| 7 | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period | | 7 |
| 8 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 8 |
| 9 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) | | 9 |
| 10 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions). | | 10 |
| 11 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 11 |
| 12 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period. | | 12 |
| 13 | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 13 |
| 14 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | | 14 |
| 15 | Total nursery days (title V or XIX only) | | 15 |
| 16 | Nursery days (title V or XIX only) | | 16 |
| | SWING BED ADJUSTMENT | | |
| 17 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period | | 17 |
| 18 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18 |
| 19 | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period | | 19 |
| 20 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | | 20 |
| 21 | Total general inpatient routine service cost (see instructions) | | 21 |
| 22 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) | | 22 |
| 23 | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) | | 23 |
| 24 | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) | | 24 |
| 25 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) | | 25 |
| 26 | Total swing-bed cost (see instructions) | | 26 |
| 27 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | | 28 |
| 29 | Private room charges (excluding swing-bed charges) | | 29 |
| 30 | Semi-private room charges (excluding swing-bed charges) | | 30 |
| 31 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | | 31 |
| 32 | Average private room per diem charge (line 29 ÷ line 3) | | 32 |
| 33 | Average semi-private room per diem charge (line 30 ÷ line 4) | | 33 |
| 34 | Average per diem private room charge differential (line 32 minus line 33) (see instructions) | | 34 |
| 35 | Average per diem private room cost differential (line 34 x line 31) | | 35 |
| 36 | Private room cost differential adjustment (line 3 x line 35) | | 36 |
| 37 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) | | 37 |

| COMPUTATION OF INPATIENT OPERATING COST | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-1, PART II |
|---|---|---|---|

| Check applicable boxes: | | | | |
|---|---|---|---|---|
| | [ ] Title V - I/P | [ ] Hospital | [ ]Subprovider (other) | [ ] PPS |
| | [ ] Title XVIII, Part A | [ ] IPF | | [ ] TEFRA |
| | [ ] Title XIX - I/P | [ ] IRF | | [ ] Other |

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS | | | | | 1 | |
| 38 | Adjusted general inpatient routine service cost per diem (see instructions) | | | | | | 38 |
| 39 | Program general inpatient routine service cost (line 9 x line 38) | | | | | | 39 |
| 40 | Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | | | | 40 |
| 41 | Total Program general inpatient routine service cost (line 39 + line 40) | | | | | | 41 |
| | | Total Inpatient Cost | Total Inpatient Days | Average Per Diem (col. 1 ÷ col. 2) | Program Days | Program Cost (col. 3 x col. 4) | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 42 | Nursery (titles V & XIX only) | | | | | | 42 |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| 43 | Intensive Care Unit | | | | | | 43 |
| 44 | Coronary Care Unit | | | | | | 44 |
| 45 | Burn Intensive Care Unit | | | | | | 45 |
| 46 | Surgical Intensive Care Unit | | | | | | 46 |
| 47 | Other Special Care Unit (specify) | | | | | | 47 |
| | | | | | | 1 | |
| 48 | Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) | | | | | | 48 |
| 49 | Total Program inpatient costs (sum of lines 41 through 48) (see instructions) | | | | | | 49 |
| | PASS-THROUGH COST ADJUSTMENTS | | | | | | |
| 50 | Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III) | | | | | | 50 |
| 51 | Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV) | | | | | | 51 |
| 52 | Total Program excludable cost (sum of lines 50 and 51) | | | | | | 52 |
| 53 | Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52) | | | | | | 53 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| 54 | Program discharges | | | | | | 54 |
| 55 | Target amount per discharge | | | | | | 55 |
| 56 | Target amount (line 54 x line 55) | | | | | | 56 |
| 57 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | | | | | | 57 |
| 58 | Bonus payment (see instructions) | | | | | | 58 |
| 59 | Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket | | | | | | 59 |
| 60 | Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket | | | | | | 60 |
| 61 | If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) | | | | | | 61 |
| 62 | Relief payment (see instructions) | | | | | | 62 |
| 63 | Allowable Inpatient cost plus incentive payment (see instructions) | | | | | | 63 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 64 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only) | | | | | | 64 |
| 65 | Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only) | | | | | | 65 |
| 66 | Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.) | | | | | | 66 |
| 67 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | | | | | | 67 |
| 68 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | | | | | 68 |
| 69 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | | | | | | 69 |

| COMPUTATION OF INPATIENT OPERATING COST | | | | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-1, PARTS III & IV |
|---|---|---|---|---|---|---|
| Check applicable boxes: | [ ] Title V - I/P<br>[ ] Title XVIII, Part A<br>[ ] Title XIX - I/P | [ ] Hospital<br>[ ] IPF<br>[ ] IRF | [ ] Subprovider (other)<br>[ ] SNF<br>[ ] NF | [ ] ICF/IID | [ ] PPS<br>[ ] TEFRA<br>[ ] Other | |

PART III - SNF, NF, AND ICF/IID ONLY

| | | | |
|---|---|---|---|
| 70 | SNF / NF / ICF/IID routine service cost (line 37) | | 70 |
| 71 | Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) | | 71 |
| 72 | Program routine service cost (line 9 x line 71) | | 72 |
| 73 | Medically necessary private room cost applicable to Program (line 14 x line 35) | | 73 |
| 74 | Total Program general inpatient routine service costs (line 72 + line 73) | | 74 |
| 75 | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) | | 75 |
| 76 | Per diem capital-related costs (line 75 ÷ line 2) | | 76 |
| 77 | Program capital-related costs (line 9 x line 76) | | 77 |
| 78 | Inpatient routine service cost (line 74 minus line 77) | | 78 |
| 79 | Aggregate charges to beneficiaries for excess costs (from provider records) | | 79 |
| 80 | Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 80 |
| 81 | Inpatient routine service cost per diem limitation | | 81 |
| 82 | Inpatient routine service cost limitation (line 9 x line 81) | | 82 |
| 83 | Reasonable inpatient routine service costs (see instructions) | | 83 |
| 84 | Program inpatient ancillary services (see instructions) | | 84 |
| 85 | Utilization review - physician compensation (see instructions) | | 85 |
| 86 | Total Program inpatient operating costs (sum of lines 83 through 85) | | 86 |

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

| | | | |
|---|---|---|---|
| 87 | Total observation bed days (see instructions) | | 87 |
| 88 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | | 88 |
| 89 | Observation bed cost (line 87 x line 88) (see instructions) | | 89 |

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

| | | Cost | Routine Cost (from line 21) | column 1 ÷ column 2 | Total Observation Bed Cost (from line 89) | Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 90 | Capital-related cost | | | | | | 90 |
| 91 | Nursing School cost | | | | | | 91 |
| 92 | Allied Health cost | | | | | | 92 |
| 93 | All other Medical Education | | | | | | 93 |

| APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-2, PARTS I-III |
|---|---|---|---|

PART I - NOT IN APPROVED TEACHING PROGRAM

| | Cost Centers | Percent of Assigned Time | Expense Allocation | Total Inpatient Days All Patients | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 1 | Total cost of services rendered | 100.00 | | | 1 |
| | Hospital Inpatient Routine Services: | | | | |
| 2 | Adults & pediatrics (general routine care) | | | | 2 |
| 3 | Intensive care unit | | | | 3 |
| 4 | Coronary care unit | | | | 4 |
| 5 | Burn Intensive Care Unit | | | | 5 |
| 6 | Surgical Intensive Care Unit | | | | 6 |
| 7 | Other Special Care (specify) | | | | 7 |
| 8 | Nursery | | | | 8 |
| 9 | Subtotal (sum of lines 2 through 8) | | | | 9 |
| 10 | IPF - Inpatient routine service | | | | 10 |
| 11 | IRF - Inpatient routine service | | | | 11 |
| 12 | Subprovider (Other) - Inpatient routine service | | | | 12 |
| 13 | Skilled Nursing Facility | | | | 13 |
| 14 | Nursing Facility | | | | 14 |
| 15 | Other Long Term Care | | | | 15 |
| 16 | Home Health Agency | | | | 16 |
| 17 | Outpatient Rehabilitation Providers | | | | 17 |
| 18 | Ambulatory Surgical Center | | | | 18 |
| 19 | Hospice | | | | 19 |
| 20 | Subtotal (sum of lines 9 through 19) | | | | 20 |
| | Hospital Outpatient Services: | | | Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93) | |
| 21 | Rural Health Clinic (RHC) | | | | 21 |
| 22 | Federally Qualified Health Center (FQHC) | | | | 22 |
| 23 | Clinic | | | | 23 |
| 24 | Emergency | | | | 24 |
| 25 | Observation beds | | | | 25 |
| 26 | Other Outpatient Service (specify) | | | | 26 |
| 27 | Subtotal (sum of lines 21 through 26) | | | | 27 |
| 28 | Total (sum of lines 20 and 27) | 100.00 | | | 28 |

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

| | Hospital Inpatient Routine Services: | Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22 | Swing Bed Amount | Net Cost (column 1 plus column 2) | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 29 | Adults & Pediatrics (general routine care) | | | | 29 |
| 30 | Swing Bed - SNF | | | | 30 |
| 31 | Swing Bed - NF | | | | 31 |
| 32 | Intensive care unit | | | | 32 |
| 33 | Coronary care unit | | | | 33 |
| 34 | Burn Intensive Care Unit | | | | 34 |
| 35 | Surgical Intensive Care Unit | | | | 35 |
| 36 | Other Special Care (specify) | | | | 36 |
| 37 | Subtotal (sum of lines 29, and 32 through 36) | | | | 37 |
| 38 | IPF - Inpatient routine service | | | | 38 |
| 39 | IRF - Inpatient routine service | | | | 39 |
| 40 | Subprovider (Other)- Inpatient routine service | | | | 40 |
| 41 | Skilled Nursing Facility | | | | 41 |
| 42 | Total (sum of lines 37 through 41) | | | | 42 |

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

| | Hospital | Not In Approved Teaching Program (from Part I) | Amount | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 43 | Inpatient | column 9, line 9 | | 43 |
| 44 | Outpatient | column 9, line 27 | | 44 |
| 45 | Total Hospital (sum of lines 43 and 44) | | | 45 |
| 46 | IPF - Inpatient routine service | column 9, line 10 | | 46 |
| 47 | IRF - Inpatient routine service | column 9, line 11 | | 47 |
| 48 | Subprovider (Other)- Inpatient routine service | column 9, line 12 | | 48 |
| 49 | Skilled Nursing Facility | column 9, line 13 | | 49 |

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

PART I - NOT IN APPROVED TEACHING PROGRAM

| | Average Cost Per Day | Health Care Program Inpatient Days | | | Title V (col. 4 x col. 5) | Title XVIII (col. 4 x col. 6) | Title XIX (col. 4 x col. 7) | |
|---|---|---|---|---|---|---|---|---|
| | | Title V | Title XVIII, Part B | Title XIX | | | | |
| | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 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 |

| | Ratio of Cost to Charges (column 2 ÷ column 3) | Titles V and XIX Outpatient and Title XVIII Part B Charges | | | Titles V and XIX Outpatient and Title XVIII Part B Cost | | | |
|---|---|---|---|---|---|---|---|---|
| | | Title V | Title XVIII Part B | Title XIX | Title V | Title XVIII Part B | Title XIX | |
| 21 | | | | | | | | 21 |
| 22 | | | | | | | | 22 |
| 23 | | | | | | | | 23 |
| 24 | | | | | | | | 24 |
| 25 | | | | | | | | 25 |
| 26 | | | | | | | | 26 |
| 27 | | | | | | | | 27 |
| 28 | | | | | | | | 28 |

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

| | Total Inpatient Days - All Patients | Average Cost Per Day (column 3 ÷ column 4) | Title XVIII Part B Inpatient Days | Expenses Applicable to Title XVIII (col. 5 x col. 6) | | | | |
|---|---|---|---|---|---|---|---|---|
| | 4 | 5 | 6 | 7 | | | | |
| 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 |

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

| | In Approved Teaching Program | | Total Title XVIII Costs | | | | | |
|---|---|---|---|---|---|---|---|---|
| | (from Part II, col. 7) | Amount | (to Wkst. E, Part B) | (col. 2 + col. 4) | | | | |
| | 3 | 4 | 5 | 6 | | | | |
| 43 | line 37 | | | | | | | 43 |
| 44 | | | | | | | | 44 |
| 45 | | | line 22 | | | | | 45 |
| 46 | line 38 | | line 22 | | | | | 46 |
| 47 | line 39 | | line 22 | | | | | 47 |
| 48 | line 40 | | line 22 | | | | | 48 |
| 49 | line 41 | | line 22 | | | | | 49 |

| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-3 |
|---|---|---|---|

Check applicable boxes: [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX [ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other) [ ] SNF [ ] NF [ ] Swing-Bed SNF [ ] Swing-Bed NF [ ] ICF/IID [ ] PPS [ ] TEFRA [ ] Other

| | COST CENTER DESCRIPTION | Ratio of Cost to Charges | Inpatient Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
|---|---|---|---|---|---|
| (A) | | 1 | 2 | 3 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | 30 |
| 31 | Intensive Care Unit | | | | 31 |
| 32 | Coronary Care Unit | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | 34 |
| 35 | Other Special Care (specify) | | | | 35 |
| 40 | Subprovider IPF | | | | 40 |
| 41 | Subprovider IRF | | | | 41 |
| 42 | Subprovider (Specify) | | | | 42 |
| 43 | Nursery | | | | 43 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50 | Operating Room | | | | 50 |
| 51 | Recovery Room | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | 52 |
| 53 | Anesthesiology | | | | 53 |
| 54 | Radiology-Diagnostic | | | | 54 |
| 55 | Radiology-Therapeutic | | | | 55 |
| 56 | Radioisotope | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | 58 |
| 59 | Cardiac Catheterization | | | | 59 |
| 60 | Laboratory | | | | 60 |
| 61 | PBP Clinical Laboratory Services-Prgm. Only | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | 62 |
| 63 | Blood Storing, Processing, & Trans. | | | | 63 |
| 64 | Intravenous Therapy | | | | 64 |
| 65 | Respiratory Therapy | | | | 65 |
| 66 | Physical Therapy | | | | 66 |
| 67 | Occupational Therapy | | | | 67 |
| 68 | Speech Pathology | | | | 68 |
| 69 | Electrocardiology | | | | 69 |
| 70 | Electroencephalography | | | | 70 |
| 71 | Medical Supplies Charged to Patients | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | 72 |
| 73 | Drugs Charged to Patients | | | | 73 |
| 74 | Renal Dialysis | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | 75 |
| 76 | Other Ancillary (specify) | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | 77 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 88 | Rural Health Clinic (RHC) | | | | 88 |
| 89 | Federally Qualified Health Center (FQHC) | | | | 89 |
| 90 | Clinic | | | | 90 |
| 91 | Emergency | | | | 91 |
| 92 | Observation Beds (see instructions) | | | | 92 |
| 93 | Other Outpatient Service (specify) | | | | 93 |
| 93.99 | Partial Hospitalization Program | | | | 93.99 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 94 | Home Program Dialysis | | | | 94 |
| 95 | Ambulance Services | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | 98 |
| 200 | Total (sum of lines 50 through 94 and 96 through 98) | | | | 200 |
| 201 | Less PBP Clinic Laboratory Services-Program only charges (line 61) | | | | 201 |
| 202 | Net charges (line 200 minus line 201) | | | | 202 |

(A) Worksheet A line numbers

| COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS | PROVIDER CCN: _____ OPO CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-4, PART I |
|---|---|---|---|

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)

| | Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition | Inpatient Routine Organ Charges | | Per Diem Costs (from Wkst. D-1, Part II) | Organ Acquisition Days | Cost (col. 2 x col. 3) | |
|---|---|---|---|---|---|---|---|
| | | 1 | D | 2 | 3 | 4 | |
| 1 | Adults and Pediatrics | | 38 | | | | 1 |
| 2 | Intensive Care | | 43 | | | | 2 |
| 3 | Coronary Care | | 44 | | | | 3 |
| 4 | Burn Intensive Care Unit | | 45 | | | | 4 |
| 5 | Surgical Intensive Care Unit | | 46 | | | | 5 |
| 6 | Other Special Care (specify) | | 47 | | | | 6 |
| 7 | TOTAL (sum of lines 1 through 6) | | | | | | 7 |

| | Computation of Ancillary Service Costs Applicable to Organ Acquisition | | Ratio of Cost to Charges (from Wkst. C) | Organ Acquisition Ancillary Charges | Organ Acquisition Ancillary Costs | |
|---|---|---|---|---|---|---|
| | | C | 1 | 2 | 3 | |
| 8 | Operating Room | 50 | | | | 8 |
| 9 | Recovery Room | 51 | | | | 9 |
| 10 | Labor Room & Delivery Room | 52 | | | | 10 |
| 11 | Anesthesiology | 53 | | | | 11 |
| 12 | Radiology-Diagnostic | 54 | | | | 12 |
| 13 | Radiology-Therapeutic | 55 | | | | 13 |
| 14 | Radioisotope | 56 | | | | 14 |
| 15 | Computed Tomography (CT) Scan | 57 | | | | 15 |
| 16 | Magnetic Resonance Imaging (MRI) | 58 | | | | 16 |
| 17 | Cardiac Catheterization | 59 | | | | 17 |
| 18 | Laboratory | 60 | | | | 18 |
| 19 | PBP Clinical Laboratory Services-Program Only | 61 | | | | 19 |
| 20 | Whole Blood & Packed Red Blood Cells | 62 | | | | 20 |
| 21 | Blood Storage, Processing, & Transfusing | 63 | | | | 21 |
| 22 | IV Therapy | 64 | | | | 22 |
| 23 | Respiratory Therapy | 65 | | | | 23 |
| 24 | Physical Therapy | 66 | | | | 24 |
| 25 | Occupational Therapy | 67 | | | | 25 |
| 26 | Speech Pathology | 68 | | | | 26 |
| 27 | Electrocardiology | 69 | | | | 27 |
| 28 | Electroencephalography | 70 | | | | 28 |
| 29 | Medical Supplies Charged to Patients | 71 | | | | 29 |
| 30 | Implantable Devices Charged to Patients | 72 | | | | 30 |
| 31 | Drugs Charged to Patients | 73 | | | | 31 |
| 32 | Renal Dialysis | 74 | | | | 32 |
| 33 | ASC (non-distinct part) | 75 | | | | 33 |
| 34 | Other Ancillary (specify) | 76 | | | | 34 |
| 35 | Rural Health Clinic (RHC) | 88 | | | | 35 |
| 36 | Federally Qualified Health Center (FQHC) | 89 | | | | 36 |
| 37 | Clinic | 90 | | | | 37 |
| 38 | Emergency Room | 91 | | | | 38 |
| 39 | Observation Beds | 92 | | | | 39 |
| 40 | Other Outpatient Service (specify) | 93 | | | | 40 |
| 41 | TOTAL (sum of lines 8 through 40) | | | | | 41 |

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

| COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS | PROVIDER CCN: _____ OPO CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-4, PART II |
|---|---|---|---|

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

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

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

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

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

| COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS | PROVIDER CCN: _____ OPO CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-4, PARTS III & IV |
|---|---|---|---|

Check applicable box: [ ] HEART [ ] LIVER [ ] PANCREAS [ ] ISLET [ ] KIDNEY [ ] LUNG [ ] INTESTINE

PART III - SUMMARY OF COSTS AND CHARGES

| | | Cost | | Charges | | |
|---|---|---|---|---|---|---|
| | | Part A | Part B | Part A | Part B | |
| | | 1 | 2 | 3 | 4 | |
| 56 | Routine and Ancillary from Part I | | | | | 56 |
| 57 | Interns and Residents (inpatient) | | | | | 57 |
| 58 | Interns and Residents (outpatient) | | | | | 58 |
| 59 | Direct Organ Acquisition (see instructions) | | | | | 59 |
| 60 | Cost of physicians' services in a teaching hospital (see instructions) | | | | | 60 |
| 61 | Total (sum of lines 56 through 60) | | | | | 61 |
| 62 | Total Usable Organs (see instructions) | | | | | 62 |
| 63 | Medicare Usable Organs (see instructions) | | | | | 63 |
| 64 | Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62) | | | | | 64 |
| 65 | Medicare Cost/Charges (see instructions) | | | | | 65 |
| 66 | Revenue for Organs Sold | | | | | 66 |
| 67 | Subtotal (line 65 minus line 66) | | | | | 67 |
| 68 | Organs Furnished Part B | | | | | 68 |
| 69 | Net Organ Acquisition Cost and Charges (see instructions) | | | | | 69 |

PART IV - STATISTICS

| | | Living Related | Cadaveric | Revenue | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 70 | Organs Excised in Provider (1) | | | | 70 |
| 71 | Organs Purchased from Other Transplant Hospitals (2) | | | | 71 |
| 72 | Organs Purchased from Non-Transplant Hospitals | | | | 72 |
| 73 | Organs Purchased from OPOs | | | | 73 |
| 74 | Total (sum of lines 70 through 73) | | | | 74 |
| 75 | Organs Transplanted | | | | 75 |
| 76 | Organs Sold to Other Hospitals | | | | 76 |
| 77 | Organs Sold to OPOs | | | | 77 |
| 78 | Organs Sold to Transplant Hospitals | | | | 78 |
| 79 | Organs Sold to Military or VA Hospitals | | | | 79 |
| 80 | Organs Sold Outside the U.S. | | | | 80 |
| 81 | Organs Sent Outside the U.S. (no revenue received) | | | | 81 |
| 82 | Organs Used for Research | | | | 82 |
| 83 | Unusable/Discarded Organs | | | | 83 |
| 84 | Total (sum of lines 75 through 83 should equal line 74) | | | | 84 |

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

| APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET D-5, PART I |
|---|---|---|---|

Check applicable box: [ ] Hospital Staff [ ] Medical Staff

PART I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ENDING BEFORE JUNE 30, 2014

| Line No. | Specialty Description/Physician Identifier | Total Remuneration | Professional Component | RCE Amount | Physician/ Professional Component Hours | Unadjusted RCE Limit | 5 Percent of Unadjusted RCE Limit | |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | General Practitioner Family Practice | | | | | | | 1 |
| 2 | Internal Medicine | | | | | | | 2 |
| 3 | Surgery | | | | | | | 3 |
| 4 | Pediatrics | | | | | | | 4 |
| 5 | Obstetrics-Gynecology | | | | | | | 5 |
| 6 | Radiology | | | | | | | 6 |
| 7 | Psychiatry | | | | | | | 7 |
| 8 | Anesthesiology | | | | | | | 8 |
| 9 | Pathology | | | | | | | 9 |
| 10 | All Other | | | | | | | 10 |
| 11 | Total | | | | | | | 11 |

| Line No. | Specialty Description/Physician Identifier | Cost of Membership & Continuing Education | Professional Component Share of col. 11 | Cost of Physician Malpractice Insurance | Professional Component Share of col. 13 | Adjusted RCE Limit | Adjust Cost of Physician's Direct Medical & Surgical Services | |
|---|---|---|---|---|---|---|---|---|
| 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| 1 | General Practitioner Family Practice | | | | | | | 1 |
| 2 | Internal Medicine | | | | | | | 2 |
| 3 | Surgery | | | | | | | 3 |
| 4 | Pediatrics | | | | | | | 4 |
| 5 | Obstetrics-Gynecology | | | | | | | 5 |
| 6 | Radiology | | | | | | | 6 |
| 7 | Psychiatry | | | | | | | 7 |
| 8 | Anesthesiology | | | | | | | 8 |
| 9 | Pathology | | | | | | | 9 |
| 10 | All Other | | | | | | | 10 |
| 11 | Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate) | | | | | | | 11 |

| APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-5, PART II |
|---|---|---|---|

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

PART II - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL FOR COST REPORTING PERIODS ENDING BEFORE JUNE 30, 2014

| | | Hospital Staff | Medical School Faculty | Total (col 1 + col 2) | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 1 | Adjusted Cost of Physician's Direct Medical and Surgical Services | | | | 1 |
| 2 | Total Inpatient Days and Outpatient Visit Days | | | | 2 |
| 3 | Average Per Diem (line 1 ÷ line 2) | | | | 3 |
| | HEALTH CARE PROGRAM REIMBURSABLE DAYS | | | | |
| 4 | Title V - Inpatient | | | | 4 |
| 5 | Title V - Outpatient | | | | 5 |
| 6 | Title XVIII - Part A | | | | 6 |
| 7 | Title XVIII - Part B | | | | 7 |
| 8 | Title XIX - Inpatient | | | | 8 |
| 9 | Title XIX - Outpatient | | | | 9 |
| 10 | Inpatient and Outpatient Kidney Acquisition | | | | 10 |
| 11 | Inpatient and Outpatient Liver Acquisition | | | | 11 |
| 12 | Inpatient and Outpatient Heart Acquisition | | | | 12 |
| 13 | Inpatient and Outpatient Lung Acquisition | | | | 13 |
| 14 | Inpatient and Outpatient Pancreas Acquisition | | | | 14 |
| 15 | Inpatient and Outpatient Intestine Acquisition | | | | 15 |
| 16 | Inpatient and Outpatient Islet Acquisition | | | | 16 |
| 17 | Other Organ Acquisition | | | | 17 |
| | HEALTH CARE PROGRAM REIMBURSABLE COST | | | | |
| 18 | Title V - Inpatient (line 3 x line 4) | | | | 18 |
| 19 | Title V - Outpatient (line 3 x line 5) | | | | 19 |
| 20 | Title XVIII - Part A (line 3 x line 6) | | | | 20 |
| 21 | Title XVIII - Part B (line 3 x line 7) | | | | 21 |
| 22 | Title XIX - Inpatient (line 3 x line 8) | | | | 22 |
| 23 | Title XIX - Outpatient (line 3 x line 9) | | | | 23 |
| 24 | Inpatient and Outpatient Kidney Acquisition (line 3 x line 10) | | | | 24 |
| 25 | Inpatient and Outpatient Liver Acquisition (line 3 x line 11) | | | | 25 |
| 26 | Inpatient and Outpatient Heart Acquisition (line 3 x line 12) | | | | 26 |
| 27 | Inpatient and Outpatient Lung Acquisition (line 3 x line 13) | | | | 27 |
| 28 | Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14) | | | | 28 |
| 29 | Inpatient and Outpatient Intestine Acquisition (line 3 x line 15) | | | | 29 |
| 30 | Inpatient and Outpatient Islet Acquisition (line 3 x line 16) | | | | 30 |
| 31 | Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17) | | | | 31 |

Transfer the amounts in column 3 as follows:
- Add lines 18 and 19, and transfer to Worksheet E-3, Part VII
- Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate
- Line 21 to Worksheet E, Part B
- Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate
- Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

| APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D-5, PART III |
|---|---|---|---|

PART III - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR COST REPORTING PERIODS ENDING ON OR AFTER JUNE 30, 2014

| | Wkst. A Line # | Cost Center / Physician Identifier | Total Remuneration | Professional Component | RCE Amount | Physician/ Professional Component Hours | Unadjusted RCE Limit | 5 Percent of Unadjusted RCE Limit | |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | | | | | | | | | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 200 | | Total | | | | | | | 200 |

| | Wkst. A Line # | Cost Center / Physician Identifier | Cost of Membership & Continuing Education | Professional Component Share of Column 11 | Cost of Physician Malpractice Insurance | Professional Component Share of Column 13 | Adjusted RCE Limit | Adjust Cost of Physician's Direct Medical & Surgical Services | |
|---|---|---|---|---|---|---|---|---|---|
| | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| 1 | | | | | | | | | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 200 | | Total (transfer the amount in column 16, line 200, to Part IV, line 1) | | | | | | | 200 |

| APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET D-5, PART IV |
|---|---|---|---|

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

PART IV - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL FOR COST REPORTING PERIODS ENDING ON OR AFTER JUNE 30, 2014

| | | | |
|---|---|---|---|
| 1 | Adjusted cost of physicians' direct medical and surgical services | | 1 |
| 2 | Total inpatient days and outpatient visit days | | 2 |
| 3 | Average per diem (line 1 ÷ line 2) | | 3 |

HEALTH CARE PROGRAM REIMBURSABLE DAYS

| | | | |
|---|---|---|---|
| 4 | Title V - Inpatient | | 4 |
| 5 | Title V - Outpatient | | 5 |
| 6 | Title XVIII - Part A | | 6 |
| 7 | Title XVIII - Part B | | 7 |
| 8 | Title XIX - Inpatient | | 8 |
| 9 | Title XIX - Outpatient | | 9 |
| 10 | Inpatient and outpatient kidney acquisition | | 10 |
| 11 | Inpatient and outpatient liver acquisition | | 11 |
| 12 | Inpatient and outpatient heart acquisition | | 12 |
| 13 | Inpatient and outpatient lung acquisition | | 13 |
| 14 | Inpatient and outpatient pancreas acquisition | | 14 |
| 15 | Inpatient and outpatient intestine acquisition | | 15 |
| 16 | Inpatient and autpatient islet acquisition | | 16 |
| 17 | | | 17 |

HEALTH CARE PROGRAM REIMBURSABLE COST

| | | | |
|---|---|---|---|
| 18 | Title V - Inpatient (line 3 x line 4) | | 18 |
| 19 | Title V - Outpatient (line 3 x line 5) | | 19 |
| 20 | Title XVIII - Part A (line 3 x line 6) | | 20 |
| 21 | Title XVIII - Part B (line 3 x line 7) | | 21 |
| 22 | Title XIX - Inpatient (line 3 x line 8) | | 22 |
| 23 | Title XIX - Outpatient (line 3 x line 9) | | 23 |
| 24 | Inpatient and outpatient kidney acquisition (line 3 x line 10) | | 24 |
| 25 | Inpatient and outpatient liver acquisition (line 3 x line 11) | | 25 |
| 26 | Inpatient and outpatient heart acquisition (line 3 x line 12) | | 26 |
| 27 | Inpatient and outpatient lung acquisition (line 3 x line 13) | | 27 |
| 28 | Inpatient and outpatient pancreas acquisition (line 3 x line 14) | | 28 |
| 29 | Inpatient and outpatient intestine acquisition (line 3 x line 15) | | 29 |
| 30 | Inpatient and outpatient islet acquisition (line 3 x line 16) | | 30 |
| 31 | | | 31 |

Transfer amounts as follows:
Add lines 18 and 19, and transfer to Worksheet E-3, Part VII, line 20 (title V hospital or component)
Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF); Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (Cost reimbursement)
Line 21 to Worksheet E, Part B , line 23 (Medicare Part B Medical and Other Health Services)
Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, line 20 (title XIX hospital or component)
Sum of lines 24 through 30 to Worksheet D-4, Part III, line 60

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E, PART A |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | | |
| 1 | DRG amounts other than outlier payments | | | 1 |
| 1.01 | DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) | | | 1.01 |
| 1.02 | DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) | | | 1.02 |
| 1.03 | DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) | | | 1.03 |
| 1.04 | DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) | | | 1.04 |
| 2 | Outlier payments for discharges (see instructions) | | | 2 |
| 2.01 | Outlier reconciliation amount | | | 2.01 |
| 2.02 | Outlier payment for discharges for Model 4 BPCI (see instructions) | | | 2.02 |
| *2.03* | *Outlier payments for discharges occurring prior to October 1 (see instructions)* | | | *2.03* |
| *2.04* | *Outlier payments for discharges occurring on or after October 1 (see instructions)* | | | *2.04* |
| 3 | Managed care simulated payments | | | 3 |
| 4 | Bed days available divided by number of days in the cost reporting period (see instructions) | | | 4 |
| | Indirect Medical Education Adjustment Calculation for Hospitals | | | |
| 5 | FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) | | | 5 |
| 6 | FTE count for allopathic and osteopathic programs *that* meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) | | | 6 |
| 7 | MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1) | | | 7 |
| 7.01 | ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions. | | | 7.01 |
| 8 | Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). | | | 8 |
| 8.01 | The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. | | | 8.01 |
| 8.02 | The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions) | | | 8.02 |
| 9 | Sum of lines 5 plus 6, minus lines 7 and 7.01, plus/minus line 8, plus lines 8.01 and 8.02 (see instructions) | | | 9 |
| 10 | FTE count for allopathic and osteopathic programs in the current year from your records | | | 10 |
| 11 | FTE count for residents in dental and podiatric programs | | | 11 |
| 12 | Current year allowable FTE (see instructions) | | | 12 |
| 13 | Total allowable FTE count for the prior year | | | 13 |
| 14 | Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero. | | | 14 |
| 15 | Sum of lines 12 through 14 divided by 3 | | | 15 |
| 16 | Adjustment for residents in initial years of the program | | | 16 |
| 17 | Adjustment for residents displaced by program or hospital closure | | | 17 |
| 18 | Adjusted rolling average FTE count | | | 18 |
| 19 | Current year resident to bed ratio (line 18 divided by line 4) | | | 19 |
| 20 | Prior year resident to bed ratio (see instructions) | | | 20 |
| 21 | Enter the lesser of lines 19 or 20 (see instructions) | | | 21 |
| 22 | IME payment adjustment (see instructions) | | | 22 |
| 22.01 | IME payment adjustment - Managed Care (see instructions) | | | 22.01 |
| | Indirect Medical Education Adjustment for the Add-on for §422 of the MMA | | | |
| 23 | Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C ). | | | 23 |
| 24 | IME FTE resident count over cap (see instructions) | | | 24 |
| 25 | If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) | | | 25 |
| 26 | Resident to bed ratio (divide line 25 by line 4) | | | 26 |
| 27 | IME payments adjustment factor (see instructions) | | | 27 |
| 28 | IME add-on adjustment amount (see instructions) | | | 28 |
| 28.01 | IME add-on adjustment amount - Managed Care (see instructions) | | | 28.01 |
| 29 | Total IME payment (sum of lines 22 and 28) | | | 29 |
| 29.01 | Total IME payment - Managed Care (sum of lines 22.01 and 28.01) | | | 29.01 |
| | Disproportionate Share Adjustment | | | |
| 30 | Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) | | | 30 |
| 31 | Percentage of Medicaid patient days to total patient days (see instructions) | | | 31 |
| 32 | Sum of lines 30 and 31 | | | 32 |
| 33 | Allowable disproportionate share percentage (see instructions) | | | 33 |
| 34 | Disproportionate share adjustment (see instructions) | | | 34 |
| | Uncompensated Care Adjustment | Prior to October 1 | On or after October 1 | |
| 35 | Total uncompensated care amount (see instructions) | | | 35 |
| 35.01 | Factor 3 (see instructions) | | | 35.01 |
| 35.02 | Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) | | | 35.02 |
| 35.03 | Pro rata share of the hospital uncompensated care payment amount (see instructions) | | | 35.03 |
| 35.04 | Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions) | | | 35.04 |
| 35.05 | Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions) | | | 35.05 |
| 36 | Total uncompensated care (sum of columns 1 and 2 on line 35.03) | | | 36 |
| | Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) | | | |
| 40 | Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) | | | 40 |
| 41 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions) | | | 41 |
| 41.01 | Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see instructions) | | | 41.01 |
| 42 | Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) | | | 42 |
| 43 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions) | | | 43 |
| 44 | Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) | | | 44 |
| 45 | Average weekly cost for dialysis treatments (see instructions) | | | 45 |
| 46 | Total additional payment (line 45 times line 44 times line 41.01) | | | 46 |
| 47 | Subtotal (see instructions) | | | 47 |
| 48 | Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions) | | | 48 |
| 49 | Total payment for inpatient operating costs (see instructions) | | | 49 |
| 50 | Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable) | | | 50 |
| 51 | Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions) | | | 51 |
| 52 | Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions). | | | 52 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E, PART A (Cont.) |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS *(Cont.)* | | | |
| 53 | Nursing and allied health managed care payment | | | 53 |
| 54 | Special add-on payments for new technologies | | | 54 |
| 54.01 | Islet isolation add-on payment | | | 54.01 |
| 55 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) | | | 55 |
| 56 | Cost of physicians' services in a teaching hospital (see instructions) | | | 56 |
| 57 | Routine service other pass through costs (from Wkst .D, Pt. III, col. 9, lines 30 through 35) | | | 57 |
| 58 | Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200) | | | 58 |
| 59 | Total (sum of amounts on lines 49 through 58) | | | 59 |
| 60 | Primary payer payments | | | 60 |
| 61 | Total amount payable for program beneficiaries (line 59 minus line 60) | | | 61 |
| 62 | Deductibles billed to program beneficiaries | | | 62 |
| 63 | Coinsurance billed to program beneficiaries | | | 63 |
| 64 | Allowable bad debts (see instructions) | | | 64 |
| 65 | Adjusted reimbursable bad debts (see instructions) | | | 65 |
| 66 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 66 |
| 67 | Subtotal (line 61 plus line 65 minus lines 62 and 63) | | | 67 |
| 68 | Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions) | | | 68 |
| 69 | Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions) | | | 69 |
| 70 | Other adjustments (specify) (see instructions) | | | 70 |
| 70.50 | Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) | | | 70.50 |
| 70.87 | Demonstration payment adjustment amount before sequestration | | | 70.87 |
| 70.88 | SCH or MDH volume decrease adjustment (contractor use only) | | | 70.88 |
| 70.89 | Pioneer ACO demonstration payment adjustment amount (see instructions) | | | 70.89 |
| 70.90 | HSP bonus payment HVBP adjustment amount (see instructions) | | | 70.90 |
| 70.91 | HSP bonus payment HRR adjustment amount (see instructions) | | | 70.91 |
| 70.92 | Bundled Model 1 discount amount (see instructions) | | | 70.92 |
| 70.93 | HVBP payment adjustment amount (see instructions) | | | 70.93 |
| 70.94 | HRR adjustment amount (see instructions) | | | 70.94 |
| 70.95 | Recovery of accelerated depreciation | | | 70.95 |
| 70.96 | Low volume adjustment for federal fiscal year (yyyy) | | | 70.96 |
| 70.97 | Low volume adjustment for federal fiscal year (yyyy) | | | 70.97 |
| 70.99 | HAC adjustment amount (see instructions) | | | 70.99 |
| 71 | Amount due provider (see instructions) | | | 71 |
| 71.01 | Sequestration adjustment (see instructions) | | | 71.01 |
| 71.02 | Demonstration payment adjustment amount after sequestration | | | 71.02 |
| 72 | Interim payments | | | 72 |
| 73 | Tentative settlement (for contractor use only) | | | 73 |
| 74 | Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73) | | | 74 |
| 75 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 75 |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | |
| 90 | Operating outlier amount from Wkst. E, Pt. A, line 2, *or sum of 2.03 plus 2.04* (see instructions) | | | 90 |
| 91 | Capital outlier from Wkst. L, Pt. I, line 2 | | | 91 |
| 92 | Operating outlier reconciliation adjustment amount (see instructions) | | | 92 |
| 93 | Capital outlier reconciliation adjustment amount (see instructions) | | | 93 |
| 94 | The rate used to calculate the time value of money (see instructions) | | | 94 |
| 95 | Time value of money for operating expenses (see instructions) | | | 95 |
| 96 | Time value of money for capital related expenses (see instructions) | | | 96 |
| | HSP Bonus Payment Amount | Prior to 10/1 | On or After 10/1 | |
| 100 | HSP bonus amount (see instructions) | | | 100 |
| | HVBP Adjustment for HSP Bonus Payment | Prior to 10/1 | On or After 10/1 | |
| 101 | HVBP adjustment factor (see instructions) | | | 101 |
| 102 | HVBP adjustment amount for HSP bonus payment (see instructions) | | | 102 |
| | HRR Adjustment for HSP Bonus Payment | Prior to 10/1 | On or After 10/1 | |
| 103 | HRR adjustment factor (see instructions) | | | 103 |
| 104 | HRR adjustment amount for HSP bonus payment (see instructions) | | | 104 |
| | Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment | | | |
| 200 | Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. | | | 200 |
| | Cost Reimbursement | | | |
| 201 | Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) | | | 201 |
| 202 | Medicare discharges (see instructions) | | | 202 |
| 203 | Case-mix adjustment factor (see instructions) | | | 203 |
| | Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) | | | |
| 204 | Medicare target amount | | | 204 |
| 205 | Case-mix adjusted target amount (line 203 times line 204) | | | 205 |
| 206 | Medicare inpatient routine cost cap (line 202 times line 205) | | | 206 |
| | Adjustment to Medicare Part A Inpatient Reimbursement | | | |
| 207 | Program reimbursement under the §410A Demonstration (see instructions) | | | 207 |
| 208 | Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) | | | 208 |
| 209 | Adjustment to Medicare IPPS payments (see instructions) | | | 209 |
| 210 | Reserved for future use | | | 210 |
| 211 | Total adjustment to Medicare IPPS payments (see instructions) | | | 211 |
| | Comparison of PPS versus Cost Reimbursement | | | |
| 212 | Total adjustment to Medicare Part A IPPS payments (from line 211) | | | 212 |
| 213 | Low-volume adjustment (see instructions) | | | 213 |
| 218 | Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions) | | | 218 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E, PART B |
|---|---|---|---|

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | | |
|---|---|---|---|
| 1 | Medical and other services (see instructions) | | 1 |
| 2 | Medical and other services reimbursed under OPPS (see instructions) | | 2 |
| 3 | OPPS payments | | 3 |
| 4 | Outlier payment (see instructions) | | 4 |
| 4.01 | Outlier reconciliation amount (see instructions) | | 4.01 |
| 5 | Enter the hospital specific payment to cost ratio (see instructions) | | 5 |
| 6 | Line 2 times line 5 | | 6 |
| 7 | Sum of lines 3, 4, and 4.01, divided by line 6 | | 7 |
| 8 | Transitional corridor payment (see instructions) | | 8 |
| 9 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | | 9 |
| 10 | Organ acquisition | | 10 |
| 11 | Total cost (sum of lines 1 and 10) (see instructions) | | 11 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | |
| | Reasonable charges | | |
| 12 | Ancillary service charges | | 12 |
| 13 | Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69) | | 13 |
| 14 | Total reasonable charges (sum of lines 12 and 13) | | 14 |
| | Customary charges | | |
| 15 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 15 |
| 16 | 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) | | 16 |
| 17 | Ratio of line 15 to line 16 (not to exceed 1.000000) | | 17 |
| 18 | Total customary charges (see instructions) | | 18 |
| 19 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) | | 19 |
| 20 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) | | 20 |
| 21 | Lesser of cost or charges (see instructions) | | 21 |
| 22 | Interns and residents (see instructions) | | 22 |
| 23 | Cost of physicians' services in a teaching hospital (see instructions) | | 23 |
| 24 | Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9) | | 24 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 25 | Deductibles and coinsurance *amounts* (see instructions) | | 25 |
| 26 | Deductibles and Coinsurance *amounts* relating to amount on line 24 (see instructions) | | 26 |
| 27 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 50) | | 28 |
| 29 | ESRD direct medical education costs (from Wkst. E-4, line 36) | | 29 |
| 30 | Subtotal (sum of lines 27 through 29) | | 30 |
| 31 | Primary payer payments | | 31 |
| 32 | Subtotal (line 30 minus line 31) | | 32 |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | |
| 33 | Composite rate ESRD (from Wkst. I-5, line 11) | | 33 |
| 34 | Allowable bad debts (see instructions) | | 34 |
| 35 | Adjusted reimbursable bad debts (see instructions) | | 35 |
| 36 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | 36 |
| 37 | Subtotal (see instructions) | | 37 |
| 38 | MSP-LCC reconciliation amount from PS&R | | 38 |
| 39 | Other adjustments (specify) (see instructions) | | 39 |
| 39.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 39.50 |
| 39.97 | Demonstration payment adjustment amount before sequestration | | 39.97 |
| 39.98 | Partial or full credits received from manufacturers for replaced devices (see instructions) | | 39.98 |
| 39.99 | Recovery of Accelerated depreciation | | 39.99 |
| 40 | Subtotal (see instructions) | | 40 |
| 40.01 | Sequestration adjustment (see instructions) | | 40.01 |
| 40.02 | Demonstration payment adjustment amount after sequestration | | 40.02 |
| 41 | Interim payments | | 41 |
| 42 | Tentative settlement (for contractors use only) | | 42 |
| 43 | Balance due provider/program (see instructions) | | 43 |
| 44 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 44 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E, PART B (Cont.) |
|---|---|---|---|

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] Subprovider (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

TO BE COMPLETED BY CONTRACTOR

| | | | |
|---|---|---|---|
| 90 | Original outlier amount (see instructions) | | 90 |
| 91 | Outlier reconciliation adjustment amount (see instructions) | | 91 |
| 92 | The rate used to calculate the Time Value of Money | | 92 |
| 93 | Time Value of Money (see instructions) | | 93 |
| 94 | Total (sum of lines 91 and 93) | | 94 |

| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-1, PART I |
|---|---|---|---|

| Check applicable box: | [ ] Hospital | [ ] Subprovider (Other) |
|---|---|---|
| | [ ] IPF | [ ] SNF |
| | [ ] IRF | [ ] Swing-Bed SNF |

| | Description | | | Inpatient Part A mm/dd/yyyy 1 | Inpatient 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 for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | | | | | 2 |
| 3 | List separately each retroactive | Program to Provider | .01 | | | | | 3.01 |
| | lump sum adjustment amount based | | .02 | | | | | 3.02 |
| | on subsequent revision of the | | .03 | | | | | 3.03 |
| | interim rate for the cost reporting period. | | .04 | | | | | 3.04 |
| | Also show date of each payment. | | .05 | | | | | 3.05 |
| | If none, write "NONE" or enter a zero. (1) | 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. E or Wkst. E-3, line and column as appropriate) | | | | | | | 4 |
| 5 | List separately each tentative settlement | Program to Provider | .01 | | | | | 5.01 |
| | payment after desk review. Also show | | .02 | | | | | 5.02 |
| | date of each payment. | | .03 | | | | | 5.03 |
| | If none, write "NONE" or enter a zero. (1) | 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 | Determined 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 | | NPR Date (Month/Day/Year) | | 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.

| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-1, PART II |
|---|---|---|---|

| Check applicable box: | [ ] Hospital [ ] CAH |
|---|---|

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

| | | | |
|---|---|---|---|
| 1 | Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14) | | 1 |
| 2 | Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1 and 8 through 12) | | 2 |
| 3 | Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2) | | 3 |
| 4 | Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1 and 8 through 12) | | 4 |
| 5 | Total hospital charges (Wkst. C, Pt. I, col. 8, line 200) | | 5 |
| 6 | Total hospital charity care charges (Wkst. S-10, col. 3, line 20) | | 6 |
| 7 | CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168) | | 7 |
| 8 | Calculation of the HIT incentive payment (see instructions) | | 8 |
| 9 | Sequestration adjustment amount (see instructions) | | 9 |
| 10 | Calculation of the HIT incentive payment after sequestration (see instructions) | | 10 |

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-2 |
|---|---|---|---|

| Check applicable boxes: | [ ] Title V<br>[ ] Title XVIII<br>[ ] Title XIX | [ ] Swing Bed - SNF<br>[ ] Swing Bed - NF |
|---|---|---|

| | COMPUTATION OF NET COST OF COVERED SERVICES | PART A<br>1 | PART B<br>2 | |
|---|---|---|---|---|
| 1 | Inpatient routine services - swing bed-SNF (see instructions) | | | 1 |
| 2 | Inpatient routine services - swing bed-NF (see instructions) | | | 2 |
| 3 | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A; and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions) | | | 3 |
| 4 | Per diem cost for interns and residents not in approved teaching program (see instructions) | | | 4 |
| 5 | Program days | | | 5 |
| 6 | Interns and residents not in approved teaching program (see instructions) | | | 6 |
| 7 | Utilization review - physician compensation - SNF optional method only | | | 7 |
| 8 | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | | | 8 |
| 9 | Primary payer payments (see instructions) | | | 9 |
| 10 | Subtotal (line 8 minus line 9) | | | 10 |
| 11 | Deductibles billed to program patients (exclude amounts applicable to physician professional services) | | | 11 |
| 12 | Subtotal (line 10 minus line 11) | | | 12 |
| 13 | Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) | | | 13 |
| 14 | 80% of Part B costs (line 12 x 80%) | | | 14 |
| 15 | Subtotal (enter the lesser of line 12 minus line 13, or line 14) | | | 15 |
| 16 | Other adjustments (specify) (see instructions) | | | 16 |
| 16.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 16.50 |
| 16.55 | Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions) | | | 16.55 |
| 16.99 | Demonstration payment adjustment amount before sequestration | | | 16.99 |
| 17 | Allowable bad debts (see instructions) | | | 17 |
| 17.01 | Adjusted reimbursable bad debts (see instructions) | | | 17.01 |
| 18 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 18 |
| 19 | Total (see instructions) | | | 19 |
| 19.01 | Sequestration adjustment (see instructions) | | | 19.01 |
| 19.02 | Demonstration payment adjustment amount after sequestration | | | 19.02 |
| 20 | Interim payments | | | 20 |
| 21 | Tentative settlement (for contractor use only) | | | 21 |
| 22 | Balance due provider/program (line 19 minus lines 19.01, 19.02, 20, and 21) | | | 22 |
| 23 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 23 |
| | Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment | | | |
| 200 | Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. | | | 200 |
| | Cost Reimbursement | | | |
| 201 | Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) | | | 201 |
| 202 | Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) | | | 202 |
| 203 | Total (sum of lines 201 and 202) | | | 203 |
| 204 | Medicare swing-bed SNF discharges (see instructions) | | | 204 |
| | Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) | | | |
| 205 | Medicare swing-bed SNF target amount | | | 205 |
| 206 | Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) | | | 206 |
| | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement | | | |
| 207 | Program reimbursement under the §410A Demonstration (see instructions) | | | 207 |
| 208 | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) | | | 208 |
| 209 | Adjustment to Medicare swing-bed SNF PPS payments (see instructions) | | | 209 |
| 210 | Reserved for future use | | | 210 |
| | Comparison of PPS versus Cost Reimbursement | | | |
| 215 | Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions) | | | 215 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART I |
|---|---|---|---|

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART II |
|---|---|---|---|

| Check applicable box: | [ ] Hospital<br>[ ] Subprovider IPF |
|---|---|

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

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

TO BE COMPLETED BY CONTRACTOR

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART III |
|---|---|---|---|

| Check applicable box: | [ ] Hospital<br>[ ] Subprovider IRF |
|---|---|

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

| | | | |
|---|---|---|---|
| 1 | Net Federal PPS payment (see instructions) | | 1 |
| 2 | Medicare SSI ratio (IRF PPS only) (see instructions) | | 2 |
| 3 | Inpatient Rehabilitation LIP payments (see instructions) | | 3 |
| 4 | Outlier payments | | 4 |
| 5 | Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) | | 5 |
| 5.01 | Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) | | 5.01 |
| 6 | New teaching program adjustment (see instructions) | | 6 |
| 7 | Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see isntructions) | | 7 |
| 8 | Current year unweighted I&R FTE count for residents within the new program growth period of a “new teaching program” (see isntructions) | | 8 |
| 9 | Intern and resident count for IRF PPS medical education adjustment (see instructions) | | 9 |
| 10 | Average daily census (see instructions) | | 10 |
| 11 | Teaching Adjustment Factor (see instructions) | | 11 |
| 12 | Teaching Adjustment (see instructions) | | 12 |
| 13 | Total PPS Payment (see instructions) | | 13 |
| 14 | Nursing and allied health managed care payments (see instructions) | | 14 |
| 15 | Organ acquisition DO NOT USE THIS LINE | | 15 |
| 16 | Cost of physicians' services in a teaching hospital (see instructions) | | 16 |
| 17 | Subtotal (see instructions) | | 17 |
| 18 | Primary payer payments | | 18 |
| 19 | Subtotal (line 17 less line 18) | | 19 |
| 20 | Deductibles | | 20 |
| 21 | Subtotal (line 19 minus line 20) | | 21 |
| 22 | Coinsurance | | 22 |
| 23 | Subtotal (line 21 minus line 22) | | 23 |
| 24 | Allowable bad debts (exclude bad debts for professional services) (see instructions) | | 24 |
| 25 | Adjusted reimbursable bad debts (see instructions) | | 25 |
| 26 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | 26 |
| 27 | Subtotal (sum of lines 23 and 25) | | 27 |
| 28 | Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only) | | 28 |
| 29 | Other pass through costs (see instructions) | | 29 |
| 30 | Outlier payments reconciliation | | 30 |
| 31 | Other adjustments (specify) (see instructions) | | 31 |
| 31.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 31.50 |
| 31.99 | Demonstration payment adjustment amount before sequestration | | 31.99 |
| 32 | Total amount payable to the provider (see instructions) | | 32 |
| 32.01 | Sequestration adjustment (see instructions) | | 32.01 |
| 32.02 | Demonstration payment adjustment amount after sequestration | | 32.02 |
| 33 | Interim payments | | 33 |
| 34 | Tentative settlement (for contractor use only) | | 34 |
| 35 | Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) | | 35 |
| 36 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | 36 |

TO BE COMPLETED BY CONTRACTOR

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART IV |
|---|---|---|---|

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

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

TO BE COMPLETED BY CONTRACTOR

| | | | |
|---|---|---|---|
| 50 | Original outlier amount from Wkst. E-3, Pt. IV, line 2 (see instructions) | | 50 |
| 51 | Outlier reconciliation adjustment amount (see instructions) | | 51 |
| 52 | The rate used to calculate the Time Value of Money (see instructions) | | 52 |
| 53 | Time Value of Money (see instructions) | | 53 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART V |
|---|---|---|---|

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

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART VI |
|---|---|---|---|

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

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-3, PART VII |
|---|---|---|---|

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

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

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

| DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-4 |
|---|---|---|---|

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT

| | | | |
|---|---|---|---|
| 1 | Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996 | | 1 |
| 2 | Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions) | | 2 |
| 3 | Amount of reduction to Direct GME cap under §422 of MMA | | 3 |
| 3.01 | Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011) | | 3.01 |
| 4 | Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) | | 4 |
| 4.01 | ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011) | | 4.01 |
| 4.02 | ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011) | | 4.02 |
| 5 | FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts | | 5 |
| 6 | Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions) | | 6 |
| 7 | Enter the lesser of line 5 or line 6 | | 7 |

| | | Primary Care | Other | Total | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| 8 | Weighted FTE count for physicians in an allopathic and osteopathic program for the current year | | | | 8 |
| 9 | If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6 | | | | 9 |
| 10 | Weighted dental and podiatric resident FTE count for the current year | | | | 10 |
| 10.01 | Unweighted dental and podiatric resident FTE count for the current year | | | | 10.01 |
| 11 | Total weighted FTE count | | | | 11 |
| 12 | Total weighted resident FTE count for the prior cost reporting year (see instructions) | | | | 12 |
| 13 | Total weighted resident FTE count for the penultimate cost reporting year (see instr.) | | | | 13 |
| 14 | Rolling average FTE count (sum of lines 11 through 13 divided by 3) | | | | 14 |
| 15 | Adjustment for residents in initial years of new programs | | | | 15 |
| 15.01 | Unweighted adjustment for residents in initial years of new programs | | | | 15.01 |
| 16 | Adjustment for residents displaced by program or hospital closure | | | | 16 |
| 16.01 | Unweighted adjustment for residents displaced by program or hospital closure | | | | 16.01 |
| 17 | Adjusted rolling average FTE count | | | | 17 |
| 18 | Per resident amount | | | | 18 |
| 19 | Approved amount for resident costs | | | | 19 |
| 20 | Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c )(4) | | | | 20 |
| 21 | Direct GME FTE unweighted resident count over cap (see instructions) | | | | 21 |
| 22 | Allowable additional direct GME FTE resident count (see instructions) | | | | 22 |
| 23 | Enter the locality adjustment national average per resident amount (see instructions) | | | | 23 |
| 24 | Multiply line 22 time line 23 | | | | 24 |
| 25 | Total direct GME amount (sum of lines 19 and 24) | | | | 25 |

| | COMPUTATION OF PROGRAM PATIENT LOAD | Inpatient Part A | Managed Care | | |
|---|---|---|---|---|---|
| 26 | Inpatient days (see instructions) | | | | 26 |
| 27 | Total inpatient days (see instructions) | | | | 27 |
| 28 | Ratio of inpatient days to total inpatient days | | | | 28 |
| 29 | Program direct GME amount | | | | 29 |
| 30 | Reduction for direct GME payments for Medicare Advantage | | | | 30 |
| 31 | Net Program direct GME amount | | | | 31 |

DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)

| | | | |
|---|---|---|---|
| 32 | Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) | | 32 |
| 33 | Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) | | 33 |
| 34 | Ratio of direct medical education costs to total charges (line 32 ÷ line 33) | | 34 |
| 35 | Medicare outpatient ESRD charges (see instructions) | | 35 |
| 36 | Medicare outpatient ESRD direct medical education costs (line 34 x line 35) | | 36 |

| DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E-4 |
|---|---|---|---|

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

| | | | |
|---|---|---|---|
| | APPORTIONMENT OF MEDICARE REASONABLE COST OF GME | | |
| | Part A Reasonable Cost | | |
| 37 | Reasonable cost (see instructions) | | 37 |
| 38 | Organ acquisition costs Wkst. D-4, Pt. III, col. 1, line 69) | | 38 |
| 39 | Cost of physicians' services in a teaching hospital (see instructions) | | 39 |
| 40 | Primary payer payments (see instructions) | | 40 |
| 41 | Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) | | 41 |
| | Part B Reasonable Cost | | |
| 42 | Reasonable cost (see instructions) | | 42 |
| 43 | Primary payer payments (see instructions) | | 43 |
| 44 | Total Part B reasonable cost (line 42 minus line 43) | | 44 |
| 45 | Total reasonable cost (sum of lines 41 and 44) | | 45 |
| 46 | Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) | | 46 |
| 47 | Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) | | 47 |
| | ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B | | |
| 48 | Total program GME payment (line 31) | | 48 |
| 49 | Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) | | 49 |
| 50 | Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) | | 50 |

| 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 (Omit cents) | 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 | 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 | Accumulated depreciation | | | | | 14 |
| 15 | Buildings | | | | | 15 |
| 16 | Accumulated depreciation | | | | | 16 |
| 17 | Leasehold improvements | | | | | 17 |
| 18 | Accumulated depreciation | | | | | 18 |
| 19 | Fixed equipment | | | | | 19 |
| 20 | Accumulated depreciation | | | | | 20 |
| 21 | Automobiles and trucks | | | | | 21 |
| 22 | Accumulated depreciation | | | | | 22 |
| 23 | Major movable equipment | | | | | 23 |
| 24 | Accumulated depreciation | | | | | 24 |
| 25 | Minor equipment depreciable | | | | | 25 |
| 26 | Accumulated depreciation | | | | | 26 |
| 27 | HIT designated Assets | | | | | 27 |
| 28 | Accumulated depreciation | | | | | 28 |
| 29 | Minor equipment-nondepreciable | | | | | 29 |
| 30 | Total fixed assets (sum of lines 12-29) | | | | | 30 |
| | OTHER ASSETS | | | | | |
| 31 | Investments | | | | | 31 |
| 32 | Deposits on leases | | | | | 32 |
| 33 | Due from owners/officers | | | | | 33 |
| 34 | Other assets | | | | | 34 |
| 35 | Total other assets (sum of lines 31-34) | | | | | 35 |
| 36 | Total assets (sum of lines 11, 30, and 35) | | | | | 36 |

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 (CONT.)

| | Liabilities and Fund Balances (Omit cents) | General Fund 1 | Specific Purpose Fund 2 | Endowment Fund 3 | Plant Fund 4 | |
|---|---|---|---|---|---|---|
| | CURRENT LIABILITIES | | | | | |
| 37 | Accounts payable | | | | | 37 |
| 38 | Salaries, wages, and fees payable | | | | | 38 |
| 39 | Payroll taxes payable | | | | | 39 |
| 40 | Notes and loans payable (short term) | | | | | 40 |
| 41 | Deferred income | | | | | 41 |
| 42 | Accelerated payments | | | | | 42 |
| 43 | Due to other funds | | | | | 43 |
| 44 | Other current liabilities | | | | | 44 |
| 45 | Total current liabilities (sum of lines 37 thru 44) | | | | | 45 |
| | LONG TERM LIABILITIES | | | | | |
| 46 | Mortgage payable | | | | | 46 |
| 47 | Notes payable | | | | | 47 |
| 48 | Unsecured loans | | | | | 48 |
| 49 | Other long term liabilities | | | | | 49 |
| 50 | Total long term liabilities (sum of lines 46 thru 49) | | | | | 50 |
| 51 | Total liabilities (sum of lines 45 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 |

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

| | | GENERAL FUND | | SPECIFIC 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 Worksheet G-3, line 29) | | | | | | | | | 2 |
| 3 | Total (sum of line 1 and line 2) | | | | | | | | | 3 |
| 4 | Additions (credit adjustments) (specify) | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | Total additions (sum of lines 4-9) | | | | | | | | | 10 |
| 11 | Subtotal (line 3 plus line 10) | | | | | | | | | 11 |
| 12 | Deductions (debit adjustments) (specify) | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | Total deductions (sum of lines 12-17) | | | | | | | | | 18 |
| 19 | Fund balance at end of period per balance sheet (line 11 minus 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 | Hospital | | | | 1 |
| 2 | Subprovider IPF | | | | 2 |
| 3 | Subprovider IRF | | | | 3 |
| 4 | Subprovider (Other) | | | | 4 |
| 5 | Swing bed - SNF | | | | 5 |
| 6 | Swing bed - NF | | | | 6 |
| 7 | Skilled nursing facility | | | | 7 |
| 8 | Nursing facility | | | | 8 |
| 9 | Other long term care | | | | 9 |
| 10 | Total general inpatient care services (sum of lines 1-9) | | | | 10 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | |
| 11 | Intensive care unit | | | | 11 |
| 12 | Coronary care unit | | | | 12 |
| 13 | Burn intensive care unit | | | | 13 |
| 14 | Surgical intensive care unit | | | | 14 |
| 15 | Other special care (specify) | | | | 15 |
| 16 | Total intensive care type inpatient hospital services (sum of of lines 11-15) | | | | 16 |
| 17 | Total inpatient routine care services (sum of lines 10 and 16) | | | | 17 |
| 18 | Ancillary services | | | | 18 |
| 19 | Outpatient services | | | | 19 |
| 20 | Rural Health Clinic (RHC) | | | | 20 |
| 21 | Federally Qualified Health Center (FQHC) | | | | 21 |
| 22 | Home health agency | | | | 22 |
| 23 | Ambulance | | | | 23 |
| 24 | Outpatient rehabilitation providers | | | | 24 |
| 25 | ASC | | | | 25 |
| 26 | Hospice | | | | 26 |
| 27 | Other (specify) | | | | 27 |
| 28 | Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1) | | | | 28 |

PART II - OPERATING EXPENSES

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

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

| | Description | | |
|---|---|---|---|
| 1 | Total patient revenues (from Worksheet G-2, Part I, column 3, line 28) | | 1 |
| 2 | Less contractual allowances and discounts on patients' accounts | | 2 |
| 3 | Net patient revenues (line 1 minus line 2) | | 3 |
| 4 | Less total operating expenses (from Worksheet G-2, Part II, line 43) | | 4 |
| 5 | Net income from service to patients (line 3 minus line 4) | | 5 |
| | OTHER INCOME | | |
| 6 | Contributions, donations, bequests, etc | | 6 |
| 7 | Income from investments | | 7 |
| 8 | Revenues from telephone and other miscellaneous communication services | | 8 |
| 9 | Revenue from television and radio service | | 9 |
| 10 | Purchase discounts | | 10 |
| 11 | Rebates and refunds of expenses | | 11 |
| 12 | Parking lot receipts | | 12 |
| 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, flowers, coffee shops, and canteen | | 20 |
| 21 | Rental of vending machines | | 21 |
| 22 | Rental of hospital space | | 22 |
| 23 | Governmental appropriations | | 23 |
| 24 | Other (specify) | | 24 |
| 25 | Total other income (sum of lines 6-24) | | 25 |
| 26 | Total (line 5 plus line 25) | | 26 |
| 27 | Other expenses (specify) | | 27 |
| 28 | Total other expenses (sum of line 27 and subscripts) | | 28 |
| 29 | Net income (or loss) for the period (line 26 minus line 28) | | 29 |

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

PROVIDER CCN: _____
HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H

| | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | EMPLOYEE BENEFITS | TRANSPOR-TATION (see instructions) | CONTRACTED/ PURCHASED SERVICES | OTHER COSTS | TOTAL (sum of cols. 1 thru 5) | RECLASS-IFICATIONS | 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 |
| | HHA NONREIMBURSABLE SERVICES | | | | | | | | | | | |
| 15 | Home Dialysis Aide Services | | | | | | | | | | | 15 |
| 16 | Respiratory Therapy | | | | | | | | | | | 16 |
| 17 | Private Duty Nursing | | | | | | | | | | | 17 |
| 18 | Clinic | | | | | | | | | | | 18 |
| 19 | Health Promotion Activities | | | | | | | | | | | 19 |
| 20 | Day Care Program | | | | | | | | | | | 20 |
| 21 | Home Delivered Meals Program | | | | | | | | | | | 21 |
| 22 | Homemaker Service | | | | | | | | | | | 22 |
| 23 | All Others | | | | | | | | | | | 23 |
| 24 | Total (sum of lines 1 through 23) | | | | | | | | | | | 24 |

Column, 6 line 24, should agree with the Worksheet A, column 3, line 101, 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. 0-4) | 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 (see instructions) | | | | | | | | | 12 |
| 13 | Drugs | | | | | | | | | 13 |
| 14 | DME | | | | | | | | | 14 |
| | HHA NONREIMBURSABLE SERVICES | | | | | | | | | |
| 15 | Home Dialysis Aide Services | | | | | | | | | 15 |
| 16 | Respiratory Therapy | | | | | | | | | 16 |
| 17 | Private Duty Nursing | | | | | | | | | 17 |
| 18 | Clinic | | | | | | | | | 18 |
| 19 | Health Promotion Activities | | | | | | | | | 19 |
| 20 | Day Care Program | | | | | | | | | 20 |
| 21 | Home Delivered Meals Program | | | | | | | | | 21 |
| 22 | Homemaker Service | | | | | | | | | 22 |
| 23 | All Others | | | | | | | | | 23 |
| 24 | Totals (sum of lines 1 through 23) | | | | | | | | | 24 |

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART I

| | HHA COST CENTER (omit cents) | From Wkst. H-1 Part I, col. 6, line | HHA TRIAL BALANCE (1) | CAPITAL RELATED COSTS | | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols. 0-4) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | | |
| | | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | 8 | |
| 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 | Home Dialysis Aide Services | 15 | | | | | | | | | | 11 |
| 12 | Respiratory Therapy | 16 | | | | | | | | | | 12 |
| 13 | Private Duty Nursing | 17 | | | | | | | | | | 13 |
| 14 | Clinic | 18 | | | | | | | | | | 14 |
| 15 | Health Promotion Activities | 19 | | | | | | | | | | 15 |
| 16 | Day Care Program | 20 | | | | | | | | | | 16 |
| 17 | Home Delivered Meals Program | 21 | | | | | | | | | | 17 |
| 18 | Homemaker Service | 22 | | | | | | | | | | 18 |
| 19 | All Others | 23 | | | | | | | | | | 19 |
| 20 | Totals (sum of lines 1-19) (2) | | | | | | | | | | | 20 |
| 21 | Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20, minus column 26, line 1, rounded to 6 decimal places. | | | | | | | | | | | 21 |

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

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

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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART I

| | HHA COST CENTER (omit cents) | NURSING SCHOOL | INTERNS & RESIDENTS SALARY AND FRINGES | INTERNS & RESIDENTS PROGRAM COSTS | PARAMEDICAL EDUCATION (SPECIFY) | SUBTOTAL (sum of cols. 4a-23) | INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS | SUBTOTAL (cols. 23 ± 24) | ALLOCATED HHA A&G (see Part II) | TOTAL HHA COSTS | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | 6 |
| 7 | Home Health Aide | | | | | | | | | | 7 |
| 8 | Supplies | | | | | | | | | | 8 |
| 9 | Drugs | | | | | | | | | | 9 |
| 10 | DME | | | | | | | | | | 10 |
| 11 | Home Dialysis Aide Services | | | | | | | | | | 11 |
| 12 | Respiratory Therapy | | | | | | | | | | 12 |
| 13 | Private Duty Nursing | | | | | | | | | | 13 |
| 14 | Clinic | | | | | | | | | | 14 |
| 15 | Health Promotion Activities | | | | | | | | | | 15 |
| 16 | Day Care Program | | | | | | | | | | 16 |
| 17 | Home Delivered Meals Program | | | | | | | | | | 17 |
| 18 | Homemaker Service | | | | | | | | | | 18 |
| 19 | All Others | | | | | | | | | | 19 |
| 20 | Totals (sum of lines 1-19) (2) | | | | | | | | | | 20 |
| 21 | Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20, minus column 26, line 1, rounded to 6 decimal places. | | | | | | | | | | 21 |

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

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 COST | | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL (ACCUM. COST) | MAIN-TENANCE & REPAIRS (SQUARE FEET) | OPERATION OF PLANT (SQUARE FEET) | |
|---|---|---|---|---|---|---|---|---|---|
| | | BLDGS. & FIXTURES (SQUARE FEET) | MOVABLE EQUIPMENT (DOLLAR VALUE) | | | | | | |
| | | 1 | 2 | 4 | 4A | 5 | 6 | 7 | |
| 1 | Administrative and General | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | 6 |
| 7 | Home Health Aide | | | | | | | | 7 |
| 8 | Supplies | | | | | | | | 8 |
| 9 | Drugs | | | | | | | | 9 |
| 10 | DME | | | | | | | | 10 |
| 11 | Home Dialysis Aide Services | | | | | | | | 11 |
| 12 | Respiratory Therapy | | | | | | | | 12 |
| 13 | Private Duty Nursing | | | | | | | | 13 |
| 14 | Clinic | | | | | | | | 14 |
| 15 | Health Promotion Activities | | | | | | | | 15 |
| 16 | Day Care Program | | | | | | | | 16 |
| 17 | Home Delivered Meals Program | | | | | | | | 17 |
| 18 | Homemaker Service | | | | | | | | 18 |
| 19 | All Others | | | | | | | | 19 |
| 20 | Totals (sum of lines 1-19) | | | | | | | | 20 |
| 21 | Total cost to be allocated | | | | | | | | 21 |
| 22 | Unit Cost Multiplier | | | | | | | | 22 |

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H-2, PART II (CONT.)

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

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

| | HHA COST CENTER | SOCIAL SERVICE (TIME SPENT) | OTHER GENERAL SERVICE (SPECIFY) | NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME) | NURSING SCHOOL (ASSIGNED TIME) | INTERNS & RESIDENTS | | PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | SALARY & FRINGES (ASSIGNED TIME) | PROGRAM COSTS (ASSIGNED TIME) | | |
| | | 17 | 18 | 19 | 20 | 21 | 22 | 23 | |
| 1 | Administrative and General | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | 6 |
| 7 | Home Health Aide | | | | | | | | 7 |
| 8 | Supplies | | | | | | | | 8 |
| 9 | Drugs | | | | | | | | 9 |
| 10 | DME | | | | | | | | 10 |
| 11 | Home Dialysis Aide Services | | | | | | | | 11 |
| 12 | Respiratory Therapy | | | | | | | | 12 |
| 13 | Private Duty Nursing | | | | | | | | 13 |
| 14 | Clinic | | | | | | | | 14 |
| 15 | Health Promotion Activities | | | | | | | | 15 |
| 16 | Day Care Program | | | | | | | | 16 |
| 17 | Home Delivered Meals Program | | | | | | | | 17 |
| 18 | Homemaker Service | | | | | | | | 18 |
| 19 | All Others | | | | | | | | 19 |
| 20 | Totals (sum of lines 1-19) | | | | | | | | 20 |
| 21 | Total cost to be allocated | | | | | | | | 21 |
| 22 | Unit Cost Multiplier | | | | | | | | 22 |

| 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<br>Patient Services | From, Wkst. H-2, Part I, col. 28, line | Facility Costs (from Wkst. H-2, Part I) | Shared Ancillary Costs (from Part II) | Total HHA Costs (cols. 1 + 2) | Total Visits | Average Cost Per Visit (col. 3 ÷ col. 4) | Program Visits Part A | Program Visits Part B Not Subject to Deductibles & Coinsurance | Program Visits Part B Subject to Deductibles & Coinsurance | Cost of Services Part A | Cost of Services Part B Not Subject to Deductibles & Coinsurance | Cost of Services Part B Subject to Deductibles & Coinsurance | Total Program Cost (sum of cols. 9-10) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 Service | 6 | | | | | | | | | | | | | 5 |
| 6 | Home Health Aide | 7 | | | | | | | | | | | | | 6 |
| 7 | Total (sum of lines 1-6) | | | | | | | | | | | | | | 7 |

| | Limitation Cost Computation<br>Patient Services | CBSA No. (1) | Program Visits Part A | Program Visits Part B Not Subject to Deductibles & Coinsurance | Program Visits Part B 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<br>Other Patient Services | From Wkst. H-2 Part I, col. 28, line | Facility Costs (from Wkst. H-2, Part I) | Shared Ancillary Costs (from Part II) | Total HHA Costs (cols. 1 + 2) | Total Charges (from HHA Records) | Ratio (col. 3 ÷ col. 4) | Program Covered Charges Part A | Program Covered Charges Part B Not Subject to Deductibles & Coinsurance | Program Covered Charges Part B Subject to Deductibles & Coinsuranc | Cost of Services Part A | Cost of Services Part B Not Subject to Deductibles & Coinsurance | Cost of Services Part B Subject to Deductibles & Coinsurance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | | |
| 15 | Cost of Medical Supplies | 8 | | | | | | | | | | | | 15 |
| 16 | Cost of Drugs | 9 | | | | | | | | | | | | 16 |

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

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

| 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 thru 20 minus line 21) | | | 22 |
| 23 | Excess reasonable cost (from line 8) | | | 23 |
| 24 | Subtotal (line 22 minus line 23) | | | 24 |
| 25 | Coinsurance billed to program patients (from your records) | | | 25 |
| 26 | Net cost (line 24 minus line 25) | | | 26 |
| 27 | Reimbursable bad debts (from your records) | | | 27 |
| 28 | Reimbursable bad debts for dual eligible (see instructions) | | | 28 |
| 29 | Total costs - current cost reporting period (line 26 plus line 27) | | | 29 |
| 30 | Other adjustments (see instructions) (specify) | | | 30 |
| 30.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 30.50 |
| 30.99 | Demonstration payment adjustment amount before sequestration | | | 30.99 |
| 31 | Subtotal (see instructions) | | | 31 |
| 31.01 | Sequestration adjustment (see instructions) | | | 31.01 |
| 31.02 | Demonstration payment adjustment amount after sequestration | | | 31.02 |
| 32 | Interim payments (see instructions) | | | 32 |
| 33 | Tentative settlement (for contractor use only) | | | 33 |
| 34 | Balance due provider/program (line 31 minus lines 31.01, 31.02, 32, and 33) | | | 34 |
| 35 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 | | | 35 |

| ANALYSIS OF PAYMENTS TO HOSPITAL-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 for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. | | | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero.(1) | Program to Provider | .01 | | | | | 3.01 |
| | | | .02 | | | | | 3.02 |
| | | | .03 | | | | | 3.03 |
| | | | .04 | | | | | 3.04 |
| | | | .05 | | | | | 3.05 |
| | | Provider to Program | .50 | | | | | 3.50 |
| | | | .51 | | | | | 3.51 |
| | | | .52 | | | | | 3.52 |
| | | | .53 | | | | | 3.53 |
| | | | .54 | | | | | 3.54 |
| | Subtotal (sum of lines 3.01-3.49 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 INTERMEDIARY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 (see instructions) | 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 | | | NPR Date: Month, Day, Year | | | 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 RENAL DIALYSIS DEPARTMENT COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET I-1 |
|---|---|---|---|

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

| | | TOTAL COSTS | BASIS | STATISTICS | FTEs per 2080 Hours | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 1 | Registered Nurses | | Hours of Service | | | 1 |
| 2 | Licensed Practical Nurses | | Hours of Service | | | 2 |
| 3 | Nurses Aides | | Hours of Service | | | 3 |
| 4 | Technicians | | Hours of Service | | | 4 |
| 5 | Social Workers | | Hours of Service | | | 5 |
| 6 | Dieticians | | Hours of Service | | | 6 |
| 7 | Physicians | | Accumulated Cost | | | 7 |
| 8 | Non-patient Care Salary | | Accumulated Cost | | | 8 |
| 9 | Subtotal (sum of lines 1-8) | | | | | 9 |
| 10 | Employee Benefits | | Salary | | | 10 |
| 11 | Capital Related Costs-Bldgs. & Fixtures | | Square Feet | | | 11 |
| 12 | Capital Related Costs-Mov. Equip. | | Percentage of Time | | | 12 |
| 13 | Machine Costs & Repairs | | Percentage of Time | | | 13 |
| 14 | Supplies | | Requisitions | | | 14 |
| 15 | Drugs | | Requisitions | | | 15 |
| 16 | Other | | Accumulated Cost | | | 16 |
| 17 | Subtotal (sum of lines 9-16)* | | | | | 17 |
| 18 | Capital Related Costs-Bldgs. & Fixtures | | Square Feet | | | 18 |
| 19 | Capital Related Costs-Mov. Equip. | | Percentage of Time | | | 19 |
| 20 | Employee Benefits Department | | Salary | | | 20 |
| 21 | Administrative and General | | Accumulated Cost | | | 21 |
| 22 | Maint./Repairs-Operation-Housekeeping | | Square Feet | | | 22 |
| 23 | Medical Education Program Costs | | | | | 23 |
| 24 | Central Services & Supplies | | Requisitions | | | 24 |
| 25 | Pharmacy | | Requisitions | | | 25 |
| 26 | Other Allocated Costs | | Accumulated Cost | | | 26 |
| 27 | Subtotal (sum of lines 17-26)* | | | | | 27 |
| 28 | Laboratory (see instructions) | | Charges | | | 28 |
| 29 | Respiratory Therapy (see instructions) | | Charges | | | 29 |
| 30 | Other (see instructions) | | Charges | | | 30 |
| 31 | Total costs (sum of lines 27-30) | | | | | 31 |

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

| ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET I-2 |
|---|---|---|---|

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

| | OUTPATIENT SERVICES COMPOSITE PAYMENT RATE | CAPITAL AND RELATED COSTS | | DIRECT PATIENT CARE SALARY | | EMPLOYEE BENEFITS DEPARTMENT | DRUGS | MEDICAL SUPPLIES | ROUTINE ANCILLARY SERVICES | SUBTOTAL (sum of cols. 1-8) | OVERHEAD | TOTAL (col. 9 + col. 10) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BUILDING | EQUIPMENT | RNs | OTHER | | | | | | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | |
| 1 | Total Renal Department Costs | | | | | | | | | | | | 1 |
| | MAINTENANCE | | | | | | | | | | | | |
| 2 | Hemodialysis | | | | | | | | | | | | 2 |
| *2.01* | *AKI-Hemodialysis* | | | | | | | | | | | | *2.01* |
| 3 | Intermittent Peritoneal | | | | | | | | | | | | 3 |
| *3.01* | *AKI-Intermittent Peritoneal* | | | | | | | | | | | | *3.01* |
| | TRAINING | | | | | | | | | | | | |
| 4 | Hemodialysis | | | | | | | | | | | | 4 |
| 5 | Intermittent Peritoneal | | | | | | | | | | | | 5 |
| 6 | CAPD | | | | | | | | | | | | 6 |
| 7 | CCPD | | | | | | | | | | | | 7 |
| | HOME | | | | | | | | | | | | |
| 8 | Hemodialysis | | | | | | | | | | | | 8 |
| 9 | Intermittent Peritoneal | | | | | | | | | | | | 9 |
| 10 | CAPD | | | | | | | | | | | | 10 |
| 11 | CCPD | | | | | | | | | | | | 11 |
| | OTHER BILLABLE SERVICES | | | | | | | | | | | | |
| 12 | Inpatient Dialysis | | | | | | | | | | | | 12 |
| 13 | Method II Home Patient | | | | | | | | | | | | 13 |
| 14 | ESAs (included in Renal Department) | | | | | | | | | | | | 14 |
| 15 | ARANESP (see instructions) | | | | | | | | | | | | 15 |
| 16 | Other | | | | | | | | | | | | 16 |
| 17 | Total (sum of lines 2 through 16) | | | | | | | | | | | | 17 |
| 18 | Medical Educational Program Costs | | | | | | | | | | | | 18 |
| 19 | Total Renal Costs (line 17 + line 18) | | | | | | | | | | | | 19 |

| DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET I-3 |
|---|---|---|---|

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

| | COMPOSITE PAYMENT SERVICES | CAPITAL AND RELATED COSTS | | DIRECT PATIENT CARE SALARY | | EMPLOYEE BENEFITS DEPARTMENT (SALARY) | DRUGS (REQUIST.) | MEDICAL SUPPLIES (REQUIST.) | ROUTINE ANCILLARY SERVICES (CHARGES) | SUB-TOTAL | OVERHEAD (ACCUM. COST) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BUILDING (SQUARE FEET) | EQUIPMENT (% OF TIME) | RNs (HOURS) | OTHERS (HOURS) | | | | | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 1 | Total Renal Department Costs | | | | | | | | | | | 1 |
| | MAINTENANCE | | | | | | | | | | | |
| 2 | Hemodialysis | | | | | | | | | | | 2 |
| *2.01* | *AKI-Hemodialysis* | | | | | | | | | | | *2.01* |
| 3 | Intermittent Peritoneal | | | | | | | | | | | 3 |
| *3.01* | *AKI- Intermittent Peritoneal* | | | | | | | | | | | *3.01* |
| | TRAINING | | | | | | | | | | | |
| 4 | Hemodialysis | | | | | | | | | | | 4 |
| 5 | Intermittent Peritoneal | | | | | | | | | | | 5 |
| 6 | CAPD | | | | | | | | | | | 6 |
| 7 | CCDP | | | | | | | | | | | 7 |
| | HOME | | | | | | | | | | | |
| 8 | Hemodialysis | | | | | | | | | | | 8 |
| 9 | Intermittent Peritoneal | | | | | | | | | | | 9 |
| 10 | CAPD | | | | | | | | | | | 10 |
| 11 | CCDP | | | | | | | | | | | 11 |
| | OTHER BILLABLE SERVICES | | | | | | | | | | | |
| 12 | Inpatient Dialysis Treatments _____ | | | | | | | | | | | 12 |
| 13 | Method II Home Patient | | | | | | | | | | | 13 |
| 14 | ESAs | | | | | | | | | | | 14 |
| 15 | ARANESP (see instructions) | | | | | | | | | | | 15 |
| 16 | Other | | | | | | | | | | | 16 |
| 17 | Total Statistical Basis | | | | | | | | | | | 17 |
| 18 | Unit Cost Multiplier (line 1 ÷ line 17) | | | | | | | | | | | 18 |

| COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET I-4 |
|---|---|---|---|

Check applicable box: [ ] Renal Dialysis Department [ ] Home Program Dialysis

| | | Number of Total Treatments | Total Cost (from Wkst. I-2, col. 11) | Average Cost of Treatments (col. 2 ÷ col. 1) | Number of Program Treatments | Number of Program Treatments | Number of Program Treatments | Total Program Expenses (see instructions) | Total Program Payment | Total Program Payment | Total Program Payment | Average Payment Rate (col. 6 ÷ col. 4) | Average Payment Rate (col. 6.01 ÷ col. 4.01) | Average Payment Rate (col. 6.02 ÷ col. 4.02) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 4.01 | 4.02 | 5 | 6 | 6.01 | 6.02 | 7 | 7.01 | 7.02 | |
| 1 | Maintenance - Hemodialysis | | | | | | | | | | | | | | 1 |
| 2 | Maintenance - Peritoneal Dialysis | | | | | | | | | | | | | | 2 |
| 3 | Training - Hemodialysis | | | | | | | | | | | | | | 3 |
| 4 | Training - Peritoneal Dialysis | | | | | | | | | | | | | | 4 |
| 5 | Training - CAPD | | | | | | | | | | | | | | 5 |
| 6 | Training - CCPD | | | | | | | | | | | | | | 6 |
| 7 | Home Program - Hemodialysis | | | | | | | | | | | | | | 7 |
| 8 | Home Program - Peritoneal Dialysis | | | | | | | | | | | | | | 8 |
| 9 | Home Program - CAPD | Patient Weeks | | | Patient Weeks | Patient Weeks | Patient Weeks | | | | | | | | 9 |
| 10 | Home Program - CCPD | | | | | | | | | | | | | | 10 |
| 11 | Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instructions) | | | | | | | | | | | | | | 11 |
| 12 | Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions) | | | | | | | | | | | | | | 12 |

| CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET I-5 |
|---|---|---|---|

| | Description | | | |
|---|---|---|---|---|
| 1 | Total expenses related to care of program beneficiaries (see instructions) | | | 1 |
| | | 1 | 2 | |
| 2 | Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions) | | | 2 |
| 2.01 | Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions) | | | 2.01 |
| 2.02 | Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions) | | | 2.02 |
| 2.03 | Total payment due (see instructions) | | | 2.03 |
| 2.04 | Outlier payments | | | 2.04 |
| | | | | |
| 3 | Deductibles billed to Medicare (Part B) patients (see instructions) | | | 3 |
| 3.01 | Deductibles billed to Medicare (Part B) patients (see instructions) | | | 3.01 |
| 3.02 | Deductibles billed to Medicare (Part B) patients (see instructions) | | | 3.02 |
| 3.03 | Total deductibles billed to Medicare (Part B) patients (see instructions) | | | 3.03 |
| 4 | Coinsurance billed to Medicare (Part B) patients (see instructions) | | | 4 |
| 4.01 | Coinsurance billed to Medicare (Part B) patients (see instructions) | | | 4.01 |
| 4.02 | Coinsurance billed to Medicare (Part B) patients (see instructions) | | | 4.02 |
| 4.03 | Total coinsurance billed to Medicare (Part B) patients (see instructions) | | | 4.03 |
| 5 | Bad debts for deductibles and coinsurance, net of bad debt recoveries | | | 5 |
| 5.01 | Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012 | | | 5.01 |
| 5.02 | Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013 | | | 5.02 |
| 5.03 | Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 | | | 5.03 |
| 5.04 | 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014 | | | 5.04 |
| 5.05 | Allowable bad debts (sum of lines 5 through line 5.04) | | | 5.05 |
| 6 | Adjusted reimbursable bad debts (see instructions) | | | 6 |
| 7 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 7 |
| 8 | Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions) | | | 8 |
| 9 | Program payment (see instructions) | | | 9 |
| 10 | Unrecovered from Medicare (Part B) patients (see instructions) | | | 10 |
| 11 | Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33) | | | 11 |

| PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE | | | |
|---|---|---|---|
| 12 | Total allowable expenses (see instructions) | | 12 |
| 13 | Total composite costs (from Wkst. I-4, col. 2, line 11) | | 13 |
| 14 | Facility specific composite cost percentage (line 13 divided by line 12) | | 14 |

| ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-1, PART I |
|---|---|---|---|

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

| | COMPONENT COST CENTER (omit cents) | NET EXPENSES FOR COST ALLOCATION (see instru.) | CAPITAL RELATED COSTS | | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols. 0-4) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | | |
| | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | 8 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21)(1) | | | | | | | | | | 22 |
| 23 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 23 |

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

| ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-1, PART I (CONT.) |
|---|---|---|---|

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

| | COMPONENT COST CENTER (omit cents) | HOUSE-KEEPING | DIETARY | CAFETERIA | MAIN-TENANCE OF PERSONNEL | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | OTHER GENERAL SERVICE | NON-PHYSICIAN ANES-THETISTS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | |
| 1 | Administrative and General | | | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21)(1) | | | | | | | | | | | | 22 |
| 23 | Unit Cost Multiplier (see instructions) | | | | | | | | | | | | 23 |

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

| ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-1, PART I |
|---|---|---|---|

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

| | COMPONENT COST CENTER (omit cents) | NURSING SCHOOL | INTERNS & RESIDENTS | | PARA-MEDICAL EDUCATION (SPECIFY) | SUBTOTAL (sum of cols. 4A-23) | INTERN & RESIDENT COST & POST STEPDOWN ADJ. | SUBTOTAL (sum of cols. 24 ± 25) | ALLOCATED COMPONENT A&G (see Part II) (2) | TOTAL (sum of cols. 26 ± 27) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SALARY & FRINGES | PROGRAM COSTS | | | | | | | |
| | | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21)(1) | | | | | | | | | | 22 |
| 23 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 23 |

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

| ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-1, PART II |
|---|---|---|---|

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

| | CMHC COST CENTER (omit cents) | | CAPITAL RELATED COST | | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL (ACCUM. COST) | MAIN-TENANCE & REPAIRS (SQUARE FEET) | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS & FIXTURES (SQUARE FEET) | MOVABLE EQUIPMENT (SQUARE FEET) | | | | | | | |
| | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | 8 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21) | | | | | | | | | | 22 |
| 23 | Total Cost to be Allocated | | | | | | | | | | 23 |
| 24 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 24 |

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART II (CONT.)

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

| | CORF COST CENTER (omit cents) | HOUSE-KEEPING (HOURS OF SERVICE) | DIETARY (MEALS SERVED) | CAFETERIA (MEALS SERVED) | MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED) | NURSING ADMINIS-TRATION (DIRECT NURS. HRS)* | CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) | PHARMACY (COSTED REQUIS.) | MEDICAL RECORDS & LIBRARY (TIME SPENT) | SOCIAL SERVICE (TIME SPENT) | OTHER GENERAL SERVICE (SPECIFY) | NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | |
| 1 | Administrative and General | | | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21) | | | | | | | | | | | | 22 |
| 23 | Total Cost to be Allocated | | | | | | | | | | | | 23 |
| 24 | Unit Cost Multiplier (see instructions) | | | | | | | | | | | | 24 |

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET J-1, PART II (CONT.)

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

| | CORF COST CENTER (omit cents) | NURSING SCHOOL (ASSIGNED TIME) | INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME) | INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME) | PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Skilled Nursing Care | | | | | | | | | | 2 |
| 3 | Physical Therapy | | | | | | | | | | 3 |
| 4 | Occupational Therapy | | | | | | | | | | 4 |
| 5 | Speech Pathology | | | | | | | | | | 5 |
| 6 | Medical Social Services | | | | | | | | | | 6 |
| 7 | Respiratory Therapy | | | | | | | | | | 7 |
| 8 | Psychiatric/Psychological Services | | | | | | | | | | 8 |
| 9 | Individual Therapy | | | | | | | | | | 9 |
| 10 | Group Therapy | | | | | | | | | | 10 |
| 11 | Individualized Activity Therapies | | | | | | | | | | 11 |
| 12 | Family Counseling | | | | | | | | | | 12 |
| 13 | Diagnostic Services | | | | | | | | | | 13 |
| 14 | Approved Patient Training & Education | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | 18 |
| 19 | Durable Medical Equipment-Rented | | | | | | | | | | 19 |
| 20 | Durable Medical Equipment-Sold | | | | | | | | | | 20 |
| 21 | All Others | | | | | | | | | | 21 |
| 22 | Totals (sum of lines 1-21) | | | | | | | | | | 22 |
| 23 | Total Cost to be Allocated | | | | | | | | | | 23 |
| 24 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 24 |

| COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-2, PART I |
|---|---|---|---|

PART I - APPORTIONMENT OF CMHC COST CENTERS

| | | (From Wkst. J-1, Pt. I, col. 28) | Total Component Charges | Ratio of Costs to Charges (col. 1 ÷ col. 2) | Title V Component Charges | Title V Component Costs (col. 3 x col. 4) | Title XVIII Component Charges | Title XVIII Component Costs (col. 3 x col. 6) | Title XIX Component Charges | Title XIX Component 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 | Approved Patient Training & Education | | | | | | | | | | 14 |
| 15 | Prosthetic and Orthotic Devices | | | | | | | | | | 15 |
| 16 | Drugs and Biologicals | | | | | | | | | | 16 |
| 17 | Medical Supplies | | | | | | | | | | 17 |
| 18 | Medical Appliances | | | | | | | | | | 18 |
| 19 | All Others (1) | | | | | | | | | | 19 |
| 20 | Totals (sum of lines 1 through19) | | | | | | | | | | 20 |

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

| COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-2, PART II |
|---|---|---|---|

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

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

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

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

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

| CALCULATION OF REIMBURSEMENT SETTLEMENT 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 29) | | 1 |
| 2 | PPS payments received excluding outliers | | 2 |
| 3 | Outlier payments | | 3 |
| 4 | Primary payer payments | | 4 |
| 5 | Total reasonable cost (see instructions) | | 5 |
| 6 | Total charges for program services | | 6 |
| | CUSTOMARY CHARGES | | |
| 7 | Aggregate amount actually collected from patients liable for services on a charge basis | | 7 |
| 8 | Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | | 8 8 |
| 9 | Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions) | | 9 |
| 10 | Total customary charges (see instructions) | | 10 |
| 11 | Excess of customary charges over reasonable cost (see instructions) | | 11 |
| 12 | Excess of reasonable cost over customary charges (see instructions) | | 12 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 13 | Total reasonable cost (from line 5) | | 13 |
| 14 | Part B deductible billed to program patients | | 14 |
| 15 | Net cost (line 13 minus line 14) | | 15 |
| 16 | Excess of reasonable cost over customary charges (from line 12) | | 16 |
| 17 | Subtotal (line 15 minus line 16) | | 17 |
| 18 | 80 percent of costs (80% of line 17) (see instructions) | | 18 |
| 19 | Actual coinsurance billed to program patients (from provider records) | | 19 |
| 20 | Net cost less actual billed coinsurance (line 17 minus line 19) | | 20 |
| 21 | Allowable bad debts (from provider records) (see instructions) | | 21 |
| 22 | Adjusted reimbursable bad debts (see instructions) | | 22 |
| 23 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | 23 |
| 24 | Net reimbursable amount (see instructions) | | 24 |
| 25 | Other adjustments (see instructions) (specify) | | 25 |
| 25.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | 25.50 |
| 25.99 | Demonstration payment adjustment amount before sequestration | | 25.99 |
| 26 | Total cost (see instructions) | | 26 |
| 26.01 | Sequestration adjustment (see instructions) | | 26.01 |
| 26.02 | Demonstration payment adjustment amount after sequestration | | 26.02 |
| 27 | Interim payments (see instructions) | | 27 |
| 28 | Tentative settlement (for contractor use only) | | 28 |
| 29 | Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) | | 29 |
| 30 | Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2) | | 30 |

| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET J-4 |
|---|---|---|---|

Check applicable boxes: [ ] Title XVIII

| | DESCRIPTION | | | Part B 1 mm/dd/yyyy | Part B 2 Amount | |
|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to providers | | | | | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or 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 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 Worksheet J-3, line 27) | | | | | 4 |

) BE COMPLETED BY INTERMEDIARY

| | | | | | | |
|---|---|---|---|---|---|---|
| 5 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter 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 (see instructions). (1) | Program to Provider | .01 | | | 6.01 |
| | | to Program | .02 | | | 6.02 |
| 7 | Total Medicare liability (see instructions) | | | | | 7 |

| 8 | Name of Contractor | Contractor Number | NPR Date (Month, Day, Year) | 8 |
|---|---|---|---|---|
| | | | | |

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K

| | COST CENTER DESCRIPTIONS | SALARIES (from Wkst. K-1) | EMPLOYEE BENEFITS (from Wkst. K-2) | TRANSPOR-TATION (see inst.) | CONTRACTED SERVICES (from Wkst. K-3) | OTHER | TOTAL (cols. 1-5) | 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 | | | | | | | | | | | 25 |
| 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 thru 38) | | | | | | | | | | | 39 |

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-1

| | COST CENTER DESCRIPTIONS (omit cents) | ADMINIS-TRATOR | DIRECTOR | MEDICAL SOCIAL WORKERS | 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 thru 38) | | | | | | | | | | 39 |

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER CCN: _____ COMPONENT CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-2

| | COST CENTER DESCRIPTIONS (omit cents) | ADMINIS-TRATOR | DIRECTOR | MEDICAL SOCIAL WORKERS | 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 thru 38) | | | | | | | | | | 39 |

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

HOSPICE COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-3

| | COST CENTER DESCRIPTIONS (omit cents) | ADMINIS-TRATOR | DIRECTOR | MEDICAL SOCIAL WORKERS | 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 thru 38) | | | | | | | | | | 39 |

(1) Transfer the amount in column 9 to Wkst. K, column 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 ALLOCATION | CAPITAL RELATED COST BUILDINGS & FIXTURES | CAPITAL RELATED COST MOVABLE EQUIPMENT | PLANT OPERATION & MAINT. | TRANS-PORTATION | VOLUNTEER SERVICES COORDI-NATOR | SUBTOTAL (cols. 0 - 5) | ADMINIS-TRATIVE & GENERAL | TOTAL (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 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 thru 38) | | | | | | | | | | 39 |

COST ALLOCATION - HOSPICE STATISTICAL BASIS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET K-4, PART II

| | COST CENTER DESCRIPTIONS | CAPITAL RELATED COST BUILDINGS & FIXTURES (SQ. FT.) | CAPITAL RELATED COST MOVABLE EQUIPMENT ($ VALUE) | PLANT OPERATION & MAINT. (SQ. FT.) | TRANS-PORTATION (MILEAGE) | VOLUNTEER SERVICES COORDINATOR (HOURS) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL (ACC. COST) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6A | 6 | |
| | 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 | | | | | | | | 5 |
| 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, Part I) | | | | | | | | 39 |
| 40 | Unit Cost Multiplier | | | | | | | | 40 |

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET K-5, PART I

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

| | HOSPICE COST CENTER (omit cents) | From Wkst. K-4 Part I, col. 7, line | HOSPICE TRIAL BALANCE (1) | CAPITAL RELATED COSTS | | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL (cols. 0-4) | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | | 0 | 1 | 2 | 4 | 4A | 5 | 6 | 7 | |
| 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 | 15 | | | | | | | | | 10 |
| 11 | Spiritual Counseling | 16 | | | | | | | | | 11 |
| 12 | Dietary Counseling | 17 | | | | | | | | | 12 |
| 13 | Counseling - Other | 18 | | | | | | | | | 13 |
| 14 | Home Health Aide and Homemaker | 19 | | | | | | | | | 14 |
| 15 | HH Aide & Homemaker - Cont. Home Care | 20 | | | | | | | | | 15 |
| 16 | Other | 21 | | | | | | | | | 16 |
| 17 | Drugs, Biological and Infusion Therapy | 22 | | | | | | | | | 17 |
| 18 | Analgesics | 23 | | | | | | | | | 18 |
| 19 | Sedatives / 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 (including 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 1-33) (2) | | | | | | | | | | 34 |
| 35 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 35 |

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

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

| ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET K-5, PART I (Cont.) |
|---|---|---|---|

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

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

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

| ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET K-5, PART I (Cont.) |
|---|---|---|---|

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

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

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

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

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

| | HOSPICE COST CENTER | CAPITAL RELATED COST | | EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL (ACCUM. COST) | MAIN-TENANCE & REPAIRS (SQUARE FEET) | OPERATION OF PLANT (SQUARE FEET) | |
|---|---|---|---|---|---|---|---|---|---|
| | | BLDGS. & FIXTURES (SQUARE FEET) | MOVABLE EQUIPMENT (DOLLAR VALUE) | | | | | | |
| | | 1 | 2 | 4 | 5A | 5 | 6 | 7 | |
| 1 | Administrative and General | | | | | | | | 1 |
| 2 | Inpatient - General Care | | | | | | | | 2 |
| 3 | Inpatient - Respite Care | | | | | | | | 3 |
| 4 | Physician Services | | | | | | | | 4 |
| 5 | Nursing Care | | | | | | | | 5 |
| 6 | Nursing Care-Continuous Home Care | | | | | | | | 6 |
| 7 | Physical Therapy | | | | | | | | 7 |
| 8 | Occupational Therapy | | | | | | | | 8 |
| 9 | Speech/ Language Pathology | | | | | | | | 9 |
| 10 | Medical Social Services | | | | | | | | 10 |
| 11 | Spiritual Counseling | | | | | | | | 11 |
| 12 | Dietary Counseling | | | | | | | | 12 |
| 13 | Counseling - Other | | | | | | | | 13 |
| 14 | Home Health Aide and Homemaker | | | | | | | | 14 |
| 15 | HH Aide & Homemaker - Cont. Home Care | | | | | | | | 15 |
| 16 | Other | | | | | | | | 16 |
| 17 | Drugs, Biological and Infusion Therapy | | | | | | | | 17 |
| 18 | Analgesics | | | | | | | | 18 |
| 19 | Sedatives / Hypnotics | | | | | | | | 19 |
| 20 | Other - Specify | | | | | | | | 20 |
| 21 | Durable Medical Equipment/Oxygen | | | | | | | | 21 |
| 22 | Patient Transportation | | | | | | | | 22 |
| 23 | Imaging Services | | | | | | | | 23 |
| 24 | Labs and Diagnostics | | | | | | | | 24 |
| 25 | Medical Supplies | | | | | | | | 25 |
| 26 | Outpatient Services (including E/R Dept.) | | | | | | | | 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 1-33) (2) | | | | | | | | 34 |
| 35 | Total cost to be allocated | | | | | | | | 35 |
| 36 | Unit Cost Multiplier (see instructions) | | | | | | | | 36 |

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

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

| | HOSPICE COST CENTER | LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) | HOUSE-KEEPING (HOURS OF SERVICE) | DIETARY (MEALS SERVED) | CAFETERIA (MEALS SERVED) | MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED) | NURSING ADMINIS-TRATION (DIRECT NURS. HRS) | CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) | PHARMACY (COSTED REQUIS.) | MEDICAL RECORDS & LIBRARY (TIME SPENT) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| 1 | Administrative and General | | | | | | | | | | 1 |
| 2 | Inpatient - General Care | | | | | | | | | | 2 |
| 3 | Inpatient - Respite Care | | | | | | | | | | 3 |
| 4 | Physician Services | | | | | | | | | | 4 |
| 5 | Nursing Care | | | | | | | | | | 5 |
| 6 | Nursing Care-Continuous Home Care | | | | | | | | | | 6 |
| 7 | Physical Therapy | | | | | | | | | | 7 |
| 8 | Occupational Therapy | | | | | | | | | | 8 |
| 9 | Speech/ Language Pathology | | | | | | | | | | 9 |
| 10 | Medical Social Services | | | | | | | | | | 10 |
| 11 | Spiritual Counseling | | | | | | | | | | 11 |
| 12 | Dietary Counseling | | | | | | | | | | 12 |
| 13 | Counseling - Other | | | | | | | | | | 13 |
| 14 | Home Health Aide and Homemaker | | | | | | | | | | 14 |
| 15 | HH Aide & Homemaker - Cont. Home Care | | | | | | | | | | 15 |
| 16 | Other | | | | | | | | | | 16 |
| 17 | Drugs, Biological and Infusion Therapy | | | | | | | | | | 17 |
| 18 | Analgesics | | | | | | | | | | 18 |
| 19 | Sedatives / Hypnotics | | | | | | | | | | 19 |
| 20 | Other - Specify | | | | | | | | | | 20 |
| 21 | Durable Medical Equipment/Oxygen | | | | | | | | | | 21 |
| 22 | Patient Transportation | | | | | | | | | | 22 |
| 23 | Imaging Services | | | | | | | | | | 23 |
| 24 | Labs and Diagnostics | | | | | | | | | | 24 |
| 25 | Medical Supplies | | | | | | | | | | 25 |
| 26 | Outpatient Services (including E/R Dept.) | | | | | | | | | | 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 1-33) (2) | | | | | | | | | | 34 |
| 35 | Total cost to be allocated | | | | | | | | | | 35 |
| 36 | Unit Cost Multiplier (see instructions) | | | | | | | | | | 36 |

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

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

| | HOSPICE COST CENTER | SOCIAL SERVICE (TIME SPENT) | OTHER GENERAL SERVICE (SPECIFY) | NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME) | NURSING SCHOOL (ASSIGNED TIME) | INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME) | INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME) | PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 17 | 18 | 19 | 20 | 21 | 22 | 23 | |
| 1 | Administrative and General | | | | | | | | 1 |
| 2 | Inpatient - General Care | | | | | | | | 2 |
| 3 | Inpatient - Respite Care | | | | | | | | 3 |
| 4 | Physician Services | | | | | | | | 4 |
| 5 | Nursing Care | | | | | | | | 5 |
| 6 | Nursing Care-Continuous Home Care | | | | | | | | 6 |
| 7 | Physical Therapy | | | | | | | | 7 |
| 8 | Occupational Therapy | | | | | | | | 8 |
| 9 | Speech/ Language Pathology | | | | | | | | 9 |
| 10 | Medical Social Services | | | | | | | | 10 |
| 11 | Spiritual Counseling | | | | | | | | 11 |
| 12 | Dietary Counseling | | | | | | | | 12 |
| 13 | Counseling - Other | | | | | | | | 13 |
| 14 | Home Health Aide and Homemaker | | | | | | | | 14 |
| 15 | HH Aide & Homemaker - Cont. Home Care | | | | | | | | 15 |
| 16 | Other | | | | | | | | 16 |
| 17 | Drugs, Biological and Infusion Therapy | | | | | | | | 17 |
| 18 | Analgesics | | | | | | | | 18 |
| 19 | Sedatives / Hypnotics | | | | | | | | 19 |
| 20 | Other - Specify | | | | | | | | 20 |
| 21 | Durable Medical Equipment/Oxygen | | | | | | | | 21 |
| 22 | Patient Transportation | | | | | | | | 22 |
| 23 | Imaging Services | | | | | | | | 23 |
| 24 | Labs and Diagnostics | | | | | | | | 24 |
| 25 | Medical Supplies | | | | | | | | 25 |
| 26 | Outpatient Services (including E/R Dept.) | | | | | | | | 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 1-33) (2) | | | | | | | | 34 |
| 35 | Total cost to be allocated | | | | | | | | 35 |
| 36 | Unit Cost Multiplier (see instructions) | | | | | | | | 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, Part I, col. 9, line | Cost to Charge Ratio | Total Hospice Charges (Provider Records) | Hospice Shared Ancillary Costs (cols. 1 x 2) | |
|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 1 | Physical Therapy | 66 | | | | 1 |
| 2 | Occupational Therapy | 67 | | | | 2 |
| 3 | Speech/ Language Pathology | 68 | | | | 3 |
| 4 | Drugs, Biological and Infusion Therapy | 73 | | | | 4 |
| 5 | Durable Medical Equipment/Oxygen | 96 | | | | 5 |
| 6 | Labs and Diagnostics | 60 | | | | 6 |
| 7 | Medical Supplies | 71 | | | | 7 |
| 8 | Outpatient Services (including E/R Dept.) | 93 | | | | 8 |
| 9 | Radiation Therapy | 55 | | | | 9 |
| 10 | Other | 76 | | | | 10 |
| 11 | Totals (sum of lines 1-10) | | | | | 11 |

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

| | COMPUTATION OF PER DIEM COST | TITLE XVIII | TITLE XIX | OTHER | TOTAL | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 1 | Total cost (see instructions) | | | | | 1 |
| 2 | Total unduplicated days (Worksheet S-9, column 6, line 5) | | | | | 2 |
| 3 | Average cost per diem (line 1 divided by line 2) | | | | | 3 |
| 4 | Unduplicated Medicare days (Worksheet S-9, column 1, line 5) | | | | | 4 |
| 5 | Aggregate Medicare cost (line 3 times line 4) | | | | | 5 |
| 6 | Unduplicated Medicaid days (Worksheet S-9, column 2, line 5) | | | | | 6 |
| 7 | Aggregate Medicaid cost (line 3 times line 6) | | | | | 7 |
| 8 | Unduplicated SNF days (Worksheet S-9, column 3, line 5) | | | | | 8 |
| 9 | Aggregate SNF cost (line 3 times line 8) | | | | | 9 |
| 10 | Unduplicated NF days (Worksheet S-9, column 4, line 5) | | | | | 10 |
| 11 | Aggregate NF cost (line 3 times line 10) | | | | | 11 |
| 12 | Other Unduplicated days (Worksheet S-9, column 5, line 5) | | | | | 12 |
| 13 | Aggregate cost for other days (line 3 times line 12) | | | | | 13 |

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

| CALCULATION OF CAPITAL PAYMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L |
|---|---|---|---|

| Check applicable boxes: | [ ] Title V<br>[ ] Title XVIII, Part A<br>[ ] Title XIX | [ ] Hospital<br>[ ] Subprovider (other) | [ ] PPS<br>[ ] Cost Method |
|---|---|---|---|

| | | | |
|---|---|---|---|
| PART I - FULLY PROSPECTIVE METHOD | | | |
| | CAPITAL FEDERAL AMOUNT | | |
| 1 | Capital DRG other than outlier | | 1 |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | | 1.01 |
| 2 | Capital DRG outlier payments | | 2 |
| 2.01 | Model 4 BPCI Capital DRG outlier payments | | 2.01 |
| 3 | Total inpatient days divided by number of days in the cost reporting period (see instructions) | | 3 |
| 4 | Number of interns & residents (see instructions) | | 4 |
| 5 | Indirect medical education percentage (see instructions) | | 5 |
| 6 | Indirect medical education adjustment (see instructions) | | 6 |
| 7 | Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions) | | 7 |
| 8 | Percentage of Medicaid patient days to total days (see instructions) | | 8 |
| 9 | Sum of lines 7 and 8 | | 9 |
| 10 | Allowable disproportionate share percentage (see instructions) | | 10 |
| 11 | Disproportionate share adjustment (see instructions) | | 11 |
| 12 | Total prospective capital payments (see instructions) | | 12 |
| PART II - PAYMENT UNDER REASONABLE COST | | | |
| 1 | Program inpatient routine capital cost (see instructions) | | 1 |
| 2 | Program inpatient ancillary capital cost (see instructions) | | 2 |
| 3 | Total inpatient program capital cost (line 1 plus line 2) | | 3 |
| 4 | Capital cost payment factor (see instructions) | | 4 |
| 5 | Total inpatient program capital cost (line 3 x line 4) | | 5 |
| PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | |
| 1 | Program inpatient capital costs (see instructions) | | 1 |
| 2 | Program inpatient capital costs for extraordinary circumstances (see instructions) | | 2 |
| 3 | Net program inpatient capital costs (line 1 minus line 2) | | 3 |
| 4 | Applicable exception percentage (see instructions) | | 4 |
| 5 | Capital cost for comparison to payments (line 3 x line 4) | | 5 |
| 6 | Percentage adjustment for extraordinary circumstances (see instructions) | | 6 |
| 7 | Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) | | 7 |
| 8 | Capital minimum payment level (line 5 plus line 7) | | 8 |
| 9 | Current year capital payments (from Part I, line 12 as applicable) | | 9 |
| 10 | Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) | | 10 |
| 11 | Carryover of accumulated capital minimum payment level over capital payment | | 11 |
| | (from prior year Worksheet L, Part III, line 14) | | |
| 12 | Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) | | 12 |
| 13 | Current year exception payment (if line 12 is positive, enter the amount on this line) | | 13 |
| 14 | Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) | | 14 |
| 15 | Current year allowable operating and capital payment (see instructions) | | 15 |
| 16 | Current year operating and capital costs (see instructions) | | 16 |
| 17 | Current year exception offset amount (see instructions) | | 17 |

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I

| | Cost Center Descriptions | EXTRA-ORDINARY CAPITAL RELATED COSTS | CAPITAL RELATED COSTS | | SUBTOTAL (sum of cols. 0-2) | EMPLOYEE BENEFITS DEPARTMENT | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 2A | 4 | 5 | 6 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | Capital Related Costs-Buildings and Fixtures | | | | | | | | | 1 |
| 2 | Capital Related Costs-Movable Equipment | | | | | | | | | 2 |
| 4 | Employee Benefits Department | | | | | | | | | 4 |
| 5 | Administrative and General | | | | | | | | | 5 |
| 6 | Maintenance and Repairs | | | | | | | | | 6 |
| 7 | Operation of Plant | | | | | | | | | 7 |
| 8 | Laundry and Linen Service | | | | | | | | | 8 |
| 9 | Housekeeping | | | | | | | | | 9 |
| 10 | Dietary | | | | | | | | | 10 |
| 11 | Cafeteria | | | | | | | | | 11 |
| 12 | Maintenance of Personnel | | | | | | | | | 12 |
| 13 | Nursing Administration | | | | | | | | | 13 |
| 14 | Central Services and Supply | | | | | | | | | 14 |
| 15 | Pharmacy | | | | | | | | | 15 |
| 16 | Medical Records & Medical Records Library | | | | | | | | | 16 |
| 17 | Social Service | | | | | | | | | 17 |
| 18 | Other General Service (specify) | | | | | | | | | 18 |
| 19 | Nonphysician Anesthetists | | | | | | | | | 19 |
| 20 | Nursing School | | | | | | | | | 20 |
| 21 | Intern & Res. Service-Salary & Fringes (Approved) | | | | | | | | | 21 |
| 22 | Intern & Res. Other Program Costs (Approved) | | | | | | | | | 22 |
| 23 | Paramedical Ed. Program (specify) | | | | | | | | | 23 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | |
| 30 | Adults and Pediatrics (General Routine Care) | | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | | 41 |
| 42 | Subprovider | | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | | 43 |
| 44 | Skilled Nursing Facility | | | | | | | | | 44 |
| 45 | Nursing Facility | | | | | | | | | 45 |
| 46 | Other Long Term Care | | | | | | | | | 46 |

| ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I |
|---|---|---|---|

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I

| | Cost Center Descriptions | EXTRA-ORDINARY CAPITAL RELATED COSTS | CAPITAL RELATED COSTS | | SUBTOTAL (sum of cols. 0-4) | EMPLOYEE BENEFITS DEPARTMENT | ADMINIS-TRATIVE & GENERAL | MAIN-TENANCE & REPAIRS | OPERATION OF PLANT | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | BLDGS. & FIXTURES | MOVABLE EQUIPMENT | | | | | | |
| | | 0 | 1 | 2 | 2A | 4 | 5 | 6 | 7 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | | 94 |
| 95 | Ambulance Services | | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | | | | 98 |
| 99 | Outpatient Rehabilitation Provider (specify) | | | | | | | | | 99 |
| 100 | Intern-Resident Service (not appvd. tchng. prgm.) | | | | | | | | | 100 |
| 101 | Home Health Agency | | | | | | | | | 101 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 105 | Kidney Acquisition | | | | | | | | | 105 |
| 106 | Heart Acquisition | | | | | | | | | 106 |
| 107 | Liver Acquisition | | | | | | | | | 107 |
| 108 | Lung Acquisition | | | | | | | | | 108 |
| 109 | Pancreas Acquisition | | | | | | | | | 109 |
| 110 | Intestinal Acquisition | | | | | | | | | 110 |
| 111 | Islet Acquisition | | | | | | | | | 111 |
| 112 | Other Organ Acquisition (specify) | | | | | | | | | 112 |
| 115 | Ambulatory Surgical Center (Distinct Part) | | | | | | | | | 115 |
| 116 | Hospice | | | | | | | | | 116 |
| 117 | Other Special Purpose (specify) | | | | | | | | | 117 |
| 118 | SUBTOTALS (sum of lines 1 through 117) | | | | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 190 | Gift, Flower, Coffee Shop, & Canteen | | | | | | | | | 190 |
| 191 | Research | | | | | | | | | 191 |
| 192 | Physicians' Private Offices | | | | | | | | | 192 |
| 193 | Nonpaid Workers | | | | | | | | | 193 |
| 194 | Other Nonreimbursable (specify) | | | | | | | | | 194 |
| 200 | Cross Foot Adjustments | | | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | | | 201 |
| 202 | Total (sum of line 118 and lines 190 through 201) | | | | | | | | | 202 |
| 203 | Total Statistical Basis | | | | | | | | | 203 |
| 204 | Unit Cost Multiplier | | | | | | | | | 204 |

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

| | Cost Center Descriptions | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | MAIN-TENANCE OF PERSONNEL | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 94 | Home Program Dialysis | | | | | | | | | | | 94 |
| 95 | Ambulance Services | | | | | | | | | | | 95 |
| 96 | Durable Medical Equipment-Rented | | | | | | | | | | | 96 |
| 97 | Durable Medical Equipment-Sold | | | | | | | | | | | 97 |
| 98 | Other Reimbursable (specify) | | | | | | | | | | | 98 |
| 99 | Outpatient Rehabilitation Provider (specify) | | | | | | | | | | | 99 |
| 100 | Intern-Resident Service (not appvd. tchng. prgm.) | | | | | | | | | | | 100 |
| 101 | Home Health Agency | | | | | | | | | | | 101 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | | | |
| 105 | Kidney Acquisition | | | | | | | | | | | 105 |
| 106 | Heart Acquisition | | | | | | | | | | | 106 |
| 107 | Liver Acquisition | | | | | | | | | | | 107 |
| 108 | Lung Acquisition | | | | | | | | | | | 108 |
| 109 | Pancreas Acquisition | | | | | | | | | | | 109 |
| 110 | Intestinal Acquisition | | | | | | | | | | | 110 |
| 111 | Islet Acquisition | | | | | | | | | | | 111 |
| 112 | Other Organ Acquisition (specify) | | | | | | | | | | | 112 |
| 115 | Ambulatory Surgical Center (Distinct Part) | | | | | | | | | | | 115 |
| 116 | Hospice | | | | | | | | | | | 116 |
| 117 | Other Special Purpose (specify) | | | | | | | | | | | 117 |
| 118 | SUBTOTALS (sum of lines 1 through 117) | | | | | | | | | | | 118 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 190 | Gift, Flower, Coffee Shop, & Canteen | | | | | | | | | | | 190 |
| 191 | Research | | | | | | | | | | | 191 |
| 192 | Physicians' Private Offices | | | | | | | | | | | 192 |
| 193 | Nonpaid Workers | | | | | | | | | | | 193 |
| 194 | Other Nonreimbursable (specify) | | | | | | | | | | | 194 |
| 200 | Cross Foot Adjustments | | | | | | | | | | | 200 |
| 201 | Negative Cost Centers | | | | | | | | | | | 201 |
| 202 | Total (sum of line 118 and lines 190 through 201) | | | | | | | | | | | 202 |
| 203 | Total Statistical Basis | | | | | | | | | | | 203 |
| 204 | Unit Cost Multiplier | | | | | | | | | | | 204 |

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I (Cont.)

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

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART I (Cont.)

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

| COMPUTATION OF PROGRAM INPATIENT ROUTINE SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART II |
|---|---|---|---|

Check applicable box:
[ ] Title V
[ ] Title XVIII, Part A
[ ] Title XIX

| | Cost Center Description | Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) | Swing Bed Adjustment | Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2) | Total Patient Days | Per Diem (col. 3 ÷ col. 4) | Inpatient Program Days | Inpatient Program Capital Cost (col. 5 x col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| (A) | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | |
| 30 | Adults & Pediatrics (General Routine Care) | | | | | | | | 30 |
| 31 | Intensive Care Unit | | | | | | | | 31 |
| 32 | Coronary Care Unit | | | | | | | | 32 |
| 33 | Burn Intensive Care Unit | | | | | | | | 33 |
| 34 | Surgical Intensive Care Unit | | | | | | | | 34 |
| 35 | Other Special Care Unit (specify) | | | | | | | | 35 |
| 40 | Subprovider IPF | | | | | | | | 40 |
| 41 | Subprovider IRF | | | | | | | | 41 |
| 42 | Subprovider (Other) | | | | | | | | 42 |
| 43 | Nursery | | | | | | | | 43 |
| 200 | Total (sum of lines 30-199) | | | | | | | | 200 |

(A) Worksheet A line numbers

| COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART III |
|---|---|---|---|

Check applicable boxes: [ ] Hospital [ ] Subprovider [ ] Title V [ ] Title XVIII, Part A [ ] Title XIX

| (A) | Cost Center Description | Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) | Total Charges (from Wkst. C, Part I, col. 6) | Ratio of Cost to Charges (col. 1 ÷ col. 2) | Inpatient Program Charges | Program Extraordinary Capital Cost (col. 3 x col. 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50 | Operating Room | | | | | | 50 |
| 51 | Recovery Room | | | | | | 51 |
| 52 | Labor Room and Delivery Room | | | | | | 52 |
| 53 | Anesthesiology | | | | | | 53 |
| 54 | Radiology-Diagnostic | | | | | | 54 |
| 55 | Radiology-Therapeutic | | | | | | 55 |
| 56 | Radioisotope | | | | | | 56 |
| 57 | Computed Tomography (CT) Scan | | | | | | 57 |
| 58 | Magnetic Resonance Imaging (MRI) | | | | | | 58 |
| 59 | Cardiac Catherization | | | | | | 59 |
| 60 | Laboratory | | | | | | 60 |
| 61 | PBP Clinical Laboratory Service-Program Only | | | | | | 61 |
| 62 | Whole Blood & Packed Red Blood Cells | | | | | | 62 |
| 63 | Blood Storing, Processing, & Trans. | | | | | | 63 |
| 64 | Intravenous Therapy | | | | | | 64 |
| 65 | Respiratory Therapy | | | | | | 65 |
| 66 | Physical Therapy | | | | | | 66 |
| 67 | Occupational Therapy | | | | | | 67 |
| 68 | Speech Pathology | | | | | | 68 |
| 69 | Electrocardiology | | | | | | 69 |
| 70 | Electroencephalography | | | | | | 70 |
| 71 | Medical Supplies Charged to Patients | | | | | | 71 |
| 72 | Implantable Devices Charged to Patients | | | | | | 72 |
| 73 | Drugs Charged to Patients | | | | | | 73 |
| 74 | Renal Dialysis | | | | | | 74 |
| 75 | ASC (Non-Distinct Part) | | | | | | 75 |
| 76 | Other Ancillary (specify) | | | | | | 76 |
| 77 | Allogeneic Stem Cell Acquisition | | | | | | 77 |

(A) Worksheet A line numbers

| COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET L-1, PART III (CONT.) |
|---|---|---|---|

| Check applicable boxes: | [ ] Hospital | [ ] Title V |
|---|---|---|
| | [ ] Subprovider | [ ] Title XVIII, Part A |
| | | [ ] Title XIX |

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

(A) Worksheet A line numbers

| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-1 |
|---|---|---|---|

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

| | | COMPEN-SATION | OTHER COSTS | TOTAL (col. 1 + col. 2) | RECLASS-IFICATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 + col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 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 |
| 20 | Allowable GME Costs | | | | | | | | 20 |
| 21 | Subtotal (sum of lines 15-20) | | | | | | | | 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 |
| 25.01 | Telehealth | | | | | | | | 25.01 |
| 25.02 | Chronic Care Management | | | | | | | | 25.02 |
| 26 | All other nonreimbursable costs | | | | | | | | 26 |
| 27 | Nonallowable GME costs | | | | | | | | 27 |
| 28 | Total Nonreimbursable Costs (sum of lines 23-27) | | | | | | | | 28 |
| | FACILITY OVERHEAD | | | | | | | | |
| 29 | Facility Costs | | | | | | | | 29 |
| 30 | Administrative Costs | | | | | | | | 30 |
| 31 | Total Facility Overhead (sum of lines 29 and 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 hospital-based RHC/FQHC cost center line must equal the total facility costs in column 7, line 32, of this worksheet.

| ALLOCATION OF OVERHEAD TO HOSPTIAL-BASED RHC/FQHC SERVICES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-2 |
|---|---|---|---|

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

VISITS AND PRODUCTIVITY

| | Positions | Number of FTE Personnel | Total Visits | Productivity Standard [1] | Minimum Visits (col. 1 x col. 3) | Greater of col. 2 or col. 4 | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | Physicians | | | | | | 1 |
| 2 | Physician Assistants | | | | | | 2 |
| 3 | Nurse Practitioners | | | | | | 3 |
| 4 | Subtotal (sum of lines 1-3) | | | | | | 4 |
| 5 | Visiting Nurse | | | | | | 5 |
| 6 | Clinical Psychologist | | | | | | 6 |
| 7 | Clinical Social Worker | | | | | | 7 |
| 7.01 | Medical Nutrition Therapist (FQHC only) | | | | | | 7.01 |
| 7.02 | Diabetes Self Management Training (FQHC only) | | | | | | 7.02 |
| 8 | Total FTEs and Visits (sum of lines 4-7) | | | | | | 8 |
| 9 | Physician Services Under Agreements | | | | | | 9 |

DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES

| | | | |
|---|---|---|---|
| 10 | Total costs of health care services (from Worksheet M-1, column 7, line 22) | | 10 |
| 11 | Total nonreimbursable costs (from Worksheet M-1, column 7, line 28) | | 11 |
| 12 | Cost of all services (excluding overhead) (sum of lines 10 and 11) | | 12 |
| 13 | Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) | | 13 |
| 14 | Total hospital-based RHC/FQHC overhead (from Worksheet M-1, column 7, line 31) | | 14 |
| 15 | Parent provider overhead allocated to facility (see instructions) | | 15 |
| 16 | Total overhead (sum of lines 14 and 15) | | 16 |
| 17 | Allowable Direct GME overhead (see instructions) | | 17 |
| 18 | Enter the amount from line 16 | | 18 |
| 19 | Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) | | 19 |
| 20 | Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) | | 20 |

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

| CALCULATION OF REIMBURSEMENT<br>SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES | PROVIDER CCN:<br>_____<br>COMPONENT CCN:<br>_____ | PERIOD:<br>FROM _____<br>TO _____ | WORKSHEET M-3 |
|---|---|---|---|

| Check applicable boxes: | [ ] Hospital-based RHC<br>[ ] Hospital-based FQHC | [ ] Title V<br>[ ] Title XVIII | [ ] Title XIX |
|---|---|---|---|

| | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | |
|---|---|---|---|
| 1 | Total allowable cost of hospital-based RHC/FQHC services (from Worksheet M-2, line 20) | | 1 |
| 2 | Cost of vaccines and their administration (from Worksheet M-4, line 15) | | 2 |
| 3 | Total allowable cost excluding vaccine (line 1 minus line 2) | | 3 |
| 4 | Total visits (from Worksheet M-2, column 5, line 8) | | 4 |
| 5 | Physicians visits under agreement (from Worksheet M-2, column 5, line 9) | | 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 [1] | | |
|---|---|---|---|---|
| | | Payment Limit Period 1 | Payment Limit Period 2 | |
| | | 1 | 2 | |
| 8 | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6, or your contractor) | | | 8 |
| 9 | Rate for Program covered visits (see instructions) | | | 9 |
| | 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 from mental health services (line 9 x line 12) | | | 13 |
| 14 | Limit adjustment for mental health services (see instructions) | | | 14 |
| 15 | Graduate Medical Education pass-through cost (see instructions) | | | 15 |
| 16 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) | | | 16 |
| 16.01 | Total program charges (see instructions)(from contractor's records) | | | 16.01 |
| 16.02 | Total program preventive charges (see instructions)(from provider's records) | | | 16.02 |
| 16.03 | Total program preventive costs (see instructions) | | | 16.03 |
| 16.04 | Total program non-preventive costs (see instructions) | | | 16.04 |
| 16.05 | Total program cost (see instructions) | | | 16.05 |
| 17 | Primary payer amounts | | | 17 |
| 18 | Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) | | | 18 |
| 19 | Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) | | | 19 |
| 20 | Net Medicare cost excluding vaccines (see instructions) | | | 20 |
| 21 | Program cost of vaccines and their administration (from Worksheet M-4, line 16) | | | 21 |
| 22 | Total reimbursable Program cost (line 20 plus line 21) | | | 22 |
| 23 | Allowable bad debts (see instructions) | | | 23 |
| 23.01 | Adjusted reimbursable bad debts (see instructions) | | | 23.01 |
| 24 | Allowable bad debts for dual eligible beneficiaries (see instructions) | | | 24 |
| 25 | Other adjustments (specify) (see instructions) | | | 25 |
| 25.50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | 25.50 |
| 25.99 | Demonstration payment adjustment amount before sequestration | | | 25.99 |
| 26 | Net reimbursable amount (see instructions) | | | 26 |
| 26.01 | Sequestration adjustment (see instructions) | | | 26.01 |
| 26.02 | Demonstration payment adjustment amount after sequestration | | | 26.02 |
| 27 | Interim payments | | | 27 |
| 28 | Tentative settlement (for contractor use only) | | | 28 |
| 29 | Balance due component/program line 26 minus lines 26.01, 26.02, 27, and 28 | | | 29 |
| 30 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, section 115.2 | | | 30 |

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

| COMPUTATION OFHOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-4 |
|---|---|---|---|

| Check applicable boxes: | [ ] Hospital-based RHC | [ ] Title V | [ ] Title XIX |
|---|---|---|---|
| | [ ] Hospital-based FQHC | [ ] Title XVIII | |

| | | PNEUMOCOCCAL | INFLUENZA | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 1 | Health care staff cost (from Worksheet M-1, column 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 (line 3 plus line 4) | | | 5 |
| 6 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, column 7, line 22) | | | 6 |
| 7 | Total overhead (from Worksheet M-2, line 19) | | | 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 costs and their administration costs (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/line 11) | | | 12 |
| 13 | Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries | | | 13 |
| 14 | Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13) | | | 14 |
| 15 | Total cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2) | | | 15 |
| 16 | Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21) | | | 16 |

| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-5 |
|---|---|---|---|

Check applicable box: [ ] Hospital-based RHC [ ] Hospital-based FQHC

| | DESCRIPTION | | | Part B 1 mm/did/ivy | Part B 2 Amount | |
|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to hospital-based RHC/FQHC | | | | | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or 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 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 Worksheet M-3, line 27) | | | | | 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 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 (see instructions). (1) | Program to Provider | .01 | | | 6.01 |
| | | Provider to Program | .02 | | | 6.02 |
| 7 | Total Medicare liability (see instructions) | | | | | 7 |
| 8 | Name of Contractor | | Contractor Number | | NPR Date (Month/Day/Year) | 8 |

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
FOR HOSPITAL-BASED FQHC

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET N-1

| | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | Cap Rel Costs-Bldg and Fix | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | 3 |
| 4 | Administrative and General | | | | | | | | 4 |
| 5 | Plant Operation and Maintenance | | | | | | | | 5 |
| 6 | Janitorial | | | | | | | | 6 |
| 7 | Medical Records | | | | | | | | 7 |
| 8 | Subtotal - Administrative Overhead | | | | | | | | 8 |
| 9 | Pharmacy | | | | | | | | 9 |
| 10 | Medical Supplies | | | | | | | | 10 |
| 11 | Transportation | | | | | | | | 11 |
| 12 | Other General Service | | | | | | | | 12 |
| 13 | Subtotal - Total Overhead | | | | | | | | 13 |
| | DIRECT CARE COST CENTERS | | | | | | | | |
| 23 | Physician | | | | | | | | 23 |
| 24 | Physician Services Under Agreement | | | | | | | | 24 |
| 25 | Physician Assistant | | | | | | | | 25 |
| 26 | Nurse Practitioner | | | | | | | | 26 |
| 27 | Visiting Registered Nurse | | | | | | | | 27 |
| 28 | Visiting Licensed Practical Nurse | | | | | | | | 28 |
| 29 | Certified Nurse Midwife | | | | | | | | 29 |
| 30 | Clinical Psychologist | | | | | | | | 30 |
| 31 | Clinical Social Worker | | | | | | | | 31 |
| 32 | Laboratory Technician | | | | | | | | 32 |
| 33 | Reg Dietician/Cert DSMT/MNT Educator | | | | | | | | 33 |
| 34 | Physical Therapist | | | | | | | | 34 |
| 35 | Occupational Therapist | | | | | | | | 35 |
| 36 | Other Allied Health Personnel | | | | | | | | 36 |
| 37 | Subtotal - Direct Patient Care Services | | | | | | | | 37 |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
FOR HOSPITAL-BASED FQHC

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET N-1

| | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| REIMBURSABLE PASS THR | | | | | | | | | |
| 47 | Pneumococcal Vaccines & Med Supplies | | | | | | | | 47 |
| 48 | Influenza Vaccines & Med Supplies | | | | | | | | 48 |
| 49 | Subtotal - Reimbursable Pass through Costs | | | | | | | | 49 |
| OTHER FQHC SERVICES | | | | | | | | | |
| 60 | Medicare Excluded Services | | | | | | | | 60 |
| 61 | Diagnostic & Screening Lab Tests | | | | | | | | 61 |
| 62 | Radiology - Diagnostic | | | | | | | | 62 |
| 63 | Prosthetic Devices | | | | | | | | 63 |
| 64 | Durable Medical Equipment | | | | | | | | 64 |
| 65 | Ambulance Services | | | | | | | | 65 |
| 66 | Telehealth | | | | | | | | 66 |
| 67 | Drugs Charged to Patients | | | | | | | | 67 |
| 68 | Chronic Care Management | | | | | | | | 68 |
| 69 | Other | | | | | | | | 69 |
| 70 | Subtotal - Other FQHC Services | | | | | | | | 70 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 77 | Retail Pharmacy | | | | | | | | 77 |
| 78 | Other Nonreimbursable | | | | | | | | 78 |
| 79 | Subtotal - Non-Reimbursable Costs | | | | | | | | 79 |
| 100 | TOTAL (sum of lines 13, 37, 49, 70, and 79) | | | | | | | | 100 |

CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT

PROVIDER CCN: _____
COMPONENT CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET N-2

| | Positions | From Wkst. N-1, col. 7, line: | Direct Cost by Practitioner from Wkst. N-1 | Total Medical & Mental Health Visits by Practitioner | Other Direct Care Costs & Pharmacy Costs (see instructions) | General Service Cost (see instructions) | Total Costs by Practitioner | Average Cost Per Visit by Practitioner | Total Visits | | Title XVIII Visits | | Title XVIII Costs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Medical Visits by Practitioner | Mental Health Visits by Practitioner | Medical Visits by Practitioner | Mental Health Visits by Practitioner | Medical Cost by Practitioner | Mental Health Cost by Practitioner | |
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | |
| 1 | Physician | 23 | | | | | | | | | | | | | 1 |
| 2 | Physician Services Under Agreement | 24 | | | | | | | | | | | | | 2 |
| 3 | Physician Assistant | 25 | | | | | | | | | | | | | 3 |
| 4 | Nurse Practitioner | 26 | | | | | | | | | | | | | 4 |
| 5 | Visiting Registered Nurse | 27 | | | | | | | | | | | | | 5 |
| 6 | Visiting Licensed Practical Nurse | 28 | | | | | | | | | | | | | 6 |
| 7 | Certified Nurse Midwife | 29 | | | | | | | | | | | | | 7 |
| 8 | Clinical Psychologist | 30 | | | | | | | | | | | | | 8 |
| 9 | Clinical Social Worker | 31 | | | | | | | | | | | | | 9 |
| 10 | Reg Dietician/Cert DSMT/MNT Educator | 33 | | | | | | | | | | | | | 10 |
| 11 | Totals | | | | | | | | | | | | | | 11 |
| 12 | Unit Cost Multiplier | | | | | | | | | | | | | | 12 |
| 13 | Total Cost Per Visit | | | | | | | | | | | | | | 13 |

| COMPUTATION OF HOSPITAL-BASED FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET N-3 |
|---|---|---|---|

| | | PNEUMOCOCCAL | INFLUENZA | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 1 | Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36) | | | 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 | Vaccines and related medical supplies cost (from Worksheet N-1, column 7, lines 47 and 48, respectively) | | | 4 |
| 5 | Direct cost of pneumococcal and influenza vaccine (line 3 + line 4) | | | 5 |
| 6 | Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8) | | | 6 |
| 7 | Total administrative overhead (from Worksheet N-1, column 7, line 8) | | | 7 |
| 8 | Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 / line 6) | | | 8 |
| 9 | Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) | | | 9 |
| 10 | Total cost of pneumococcal and influenza vaccine and 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 / line 11) | | | 12 |
| 13 | Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries | | | 13 |
| 14 | Cost of pneumococcal and influenza vaccines and their administration costs furnished to Medicare beneficiaries (line 12 x line 13) | | | 14 |
| 15 | Total cost of pneumococcal and influenza vaccines and their administration costs. (sum of columns 1 and 2, line 10) | | | 15 |
| 16 | Total Medicare cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet N-4, line 2) | | | 16 |

| CALCULATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET N-4 |
|---|---|---|---|

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

| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERED | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET N-5 |
|---|---|---|---|

| | Description | | | Part B mm/dd/yyyy 1 | Part B Amount 2 | |
|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to hospital-based FQHC | | | | | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | Program to Provider | .01 | | | 3.01 |
| | | | .02 | | | 3.02 |
| | | | .03 | | | 3.03 |
| | | | .04 | | | 3.04 |
| | | | .05 | | | 3.05 |
| | | Provider to Program | .50 | | | 3.5 |
| | | | .51 | | | 3.51 |
| | | | .52 | | | 3.52 |
| | | | .53 | | | 3.53 |
| | | | .54 | | | 3.54 |
| | Subtotal (sum of lines 3.01 through 3.49 minus sum of lines 3.50 through 3.98) | | .99 | | | 3.99 |
| 4 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. N-4, line 17) | | | | | 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 | | | 5.5 |
| | | | .51 | | | 5.51 |
| | | | .52 | | | 5.52 |
| | Subtotal (sum of lines 5.01 through 5.49 minus sum of lines 5.50 through 5.98) | | .99 | | | 5.99 |
| 6 | Determine net settlement amount (balance due) based on the cost report (1) | Program to provider | .01 | | | 6.01 |
| | | Provider to program | .02 | | | 6.02 |
| 7 | Total Medicare program liability (see instructions) | | | | | 7 |

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN: _____ HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET O

| | | SALARIES | OTHER | SUBTOTAL ( col. 1 plus col. 2 ) | RECLASSI-FICATIONS | SUBTOTAL | ADJUST-MENTS | TOTAL ( col. 5 ± col. 6 ) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt* | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip* | | | | | | | | 2 |
| 3 | Employee Benefits Department* | | | | | | | | 3 |
| 4 | Administrative & General * | | | | | | | | 4 |
| 5 | Plant Operation and Maintenance* | | | | | | | | 5 |
| 6 | Laundry & Linen Service* | | | | | | | | 6 |
| 7 | Housekeeping* | | | | | | | | 7 |
| 8 | Dietary* | | | | | | | | 8 |
| 9 | Nursing Administration* | | | | | | | | 9 |
| 10 | Routine Medical Supplies* | | | | | | | | 10 |
| 11 | Medical Records* | | | | | | | | 11 |
| 12 | Staff Transportation* | | | | | | | | 12 |
| 13 | Volunteer Service Coordination* | | | | | | | | 13 |
| 14 | Pharmacy* | | | | | | | | 14 |
| 15 | Physician Administrative Services* | | | | | | | | 15 |
| 16 | Other General Service* | | | | | | | | 16 |
| 17 | Patient/Residential Care Services | | | | | | | | 17 |
| | DIRECT PATIENT CARE SERVICE COST CENTERS | | | | | | | | |
| 25 | Inpatient Care-Contracted** | | | | | | | | 25 |
| 26 | Physician Services** | | | | | | | | 26 |
| 27 | Nurse Practitioner** | | | | | | | | 27 |
| 28 | Registered Nurse** | | | | | | | | 28 |
| 29 | LPN/LVN** | | | | | | | | 29 |
| 30 | Physical Therapy** | | | | | | | | 30 |
| 31 | Occupational Therapy** | | | | | | | | 31 |
| 32 | Speech/ Language Pathology** | | | | | | | | 32 |
| 33 | Medical Social Services** | | | | | | | | 33 |
| 34 | Spiritual Counseling** | | | | | | | | 34 |
| 35 | Dietary Counseling** | | | | | | | | 35 |
| 36 | Counseling - Other** | | | | | | | | 36 |
| 37 | Hospice Aide and Homemaker Services** | | | | | | | | 37 |
| 38 | Durable Medical Equipment/Oxygen** | | | | | | | | 38 |
| 39 | Patient Transportation** | | | | | | | | 39 |

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET O

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

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-1

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET O-2

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-3

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS
HOSPICE GENERAL INPATIENT CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET O-4

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

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

| COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O-5 | |
|---|---|---|---|---|
| Descriptions | HOSPICE DIRECT EXPENSES ( see instructions ) 1 | GENERAL SERVICE EXPENSES FROM WKST B PART I ( see instructions ) 2 | TOTAL EXPENSES ( sum of cols. 1 + 2 ) 3 | |
| GENERAL SERVICE COST CENTERS | | | | |
| 1 Cap Rel Costs-Bldg & Fixt | | | | 1 |
| 2 Cap Rel Costs-Mvble Equip | | | | 2 |
| 3 Employee Benefits | | | | 3 |
| 4 Administrative & General | | | | 4 |
| 5 Plant Operation and Maintenance | | | | 5 |
| 6 Laundry & Linen Service | | | | 6 |
| 7 Housekeeping | | | | 7 |
| 8 Dietary | | | | 8 |
| 9 Nursing Administration | | | | 9 |
| 10 Routine Medical Supplies | | | | 10 |
| 11 Medical Records | | | | 11 |
| 12 Staff Transportation | | | | 12 |
| 13 Volunteer Service Coordination | | | | 13 |
| 14 Pharmacy | | | | 14 |
| 15 Physician Administrative Services | | | | 15 |
| 16 Other General Service | | | | 16 |
| 17 Patient/Residential Care Services | | | | 17 |
| LEVEL OF CARE | | | | |
| 50 Hospice Continuous Home Care | | | | 50 |
| 51 Hospice Routine Home Care | | | | 51 |
| 52 Hospice Inpatient Respite Care | | | | 52 |
| 53 Hospice General Inpatient Care | | | | 53 |
| NONREIMBURSABLE COST CENTERS | | | | |
| 60 Bereavement Program | | | | 60 |
| 61 Volunteer Program | | | | 61 |
| 62 Fundraising | | | | 62 |
| 63 Hospice/Palliative Medicine Fellows | | | | 63 |
| 64 Palliative Care Program | | | | 64 |
| 65 Other Physician Services | | | | 65 |
| 66 Residential Care | | | | 66 |
| 67 Advertising | | | | 67 |
| 68 Telehealth/Telemonitoring | | | | 68 |
| 69 Thrift Store | | | | 69 |
| 70 Nursing Facility Room & Board | | | | 70 |
| 71 Other Nonreimbursable | | | | 71 |
| 99 Negative Cost Center | | | | 99 |
| 100 Total | | | | 100 |

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O-6 PART I

| | Descriptions | TOTAL EXPENSES | CAP REL BLDG & FIX | CAP REL MVBLE EQUIP | EMPLOYEE BENEFITS DEPARTMENT | SUBTOTAL | ADMINIS-TRATIVE & GENERAL | PLANT OP & MAINT | LAUNDRY & LINEN | HOUSE-KEEPING | DIETARY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 3A | 4 | 5 | 6 | 7 | 8 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | | | 4 |
| 5 | Plant Operation and Maintenance | | | | | | | | | | | 5 |
| 6 | Laundry & Linen Service | | | | | | | | | | | 6 |
| 7 | Housekeeping | | | | | | | | | | | 7 |
| 8 | Dietary | | | | | | | | | | | 8 |
| 9 | Nursing Administration | | | | | | | | | | | 9 |
| 10 | Routine Medical Supplies | | | | | | | | | | | 10 |
| 11 | Medical Records | | | | | | | | | | | 11 |
| 12 | Staff Transportation | | | | | | | | | | | 12 |
| 13 | Volunteer Service Coordination | | | | | | | | | | | 13 |
| 14 | Pharmacy | | | | | | | | | | | 14 |
| 15 | Physician Administrative Services | | | | | | | | | | | 15 |
| 16 | Other General Service | | | | | | | | | | | 16 |
| 17 | Patient/Residential Care Services | | | | | | | | | | | 17 |
| | LEVEL OF CARE | | | | | | | | | | | |
| 50 | Hospice Continuous Home Care | | | | | | | | | | | 50 |
| 51 | Hospice Routine Home Care | | | | | | | | | | | 51 |
| 52 | Hospice Inpatient Respite Care | | | | | | | | | | | 52 |
| 53 | Hospice General Inpatient Care | | | | | | | | | | | 53 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 60 | Bereavement Program | | | | | | | | | | | 60 |
| 61 | Volunteer Program | | | | | | | | | | | 61 |
| 62 | Fundraising | | | | | | | | | | | 62 |
| 63 | Hospice/Palliative Medicine Fellows | | | | | | | | | | | 63 |
| 64 | Palliative Care Program | | | | | | | | | | | 64 |
| 65 | Other Physician Services | | | | | | | | | | | 65 |
| 66 | Residential Care | | | | | | | | | | | 66 |
| 67 | Advertising | | | | | | | | | | | 67 |
| 68 | Telehealth/Telemonitoring | | | | | | | | | | | 68 |
| 69 | Thrift Store | | | | | | | | | | | 69 |
| 70 | Nursing Facility Room & Board | | | | | | | | | | | 70 |
| 71 | Other Nonreimbursable | | | | | | | | | | | 71 |
| 99 | Negative Cost Center | | | | | | | | | | | 99 |
| 100 | Total | | | | | | | | | | | 100 |

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART I

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

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O-6 PART II

| | Cost Center Descriptions | CAP REL BLDG & FIX ( Square Feet ) | CAP REL MVBLE EQUIP ( Dollar Value ) | EMPLOYEE BENEFITS DEPARTMENT ( Gross Salaries ) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL ( Accum. Cost ) | PLANT OP & MAINT ( Square Feet ) | LAUNDRY & LINEN ( In-Facil-ity Days ) | HOUSE-KEEPING ( Square Feet ) | DIETARY ( In-Facil-ity Days ) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4A | 4 | 5 | 6 | 7 | 8 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | | 4 |
| 5 | Plant Operation and Maintenance | | | | | | | | | | 5 |
| 6 | Laundry & Linen Service | | | | | | | | | | 6 |
| 7 | Housekeeping | | | | | | | | | | 7 |
| 8 | Dietary | | | | | | | | | | 8 |
| 9 | Nursing Administration | | | | | | | | | | 9 |
| 10 | Routine Medical Supplies | | | | | | | | | | 10 |
| 11 | Medical Records | | | | | | | | | | 11 |
| 12 | Staff Transportation | | | | | | | | | | 12 |
| 13 | Volunteer Service Coordination | | | | | | | | | | 13 |
| 14 | Pharmacy | | | | | | | | | | 14 |
| 15 | Physician Administrative Services | | | | | | | | | | 15 |
| 16 | Other General Service | | | | | | | | | | 16 |
| 17 | Patient/Residential Care Services | | | | | | | | | | 17 |
| | LEVEL OF CARE | | | | | | | | | | |
| 50 | Hospice Continuous Home Care | | | | | | | | | | 50 |
| 51 | Hospice Routine Home Care | | | | | | | | | | 51 |
| 52 | Hospice Inpatient Respite Care | | | | | | | | | | 52 |
| 53 | Hospice General Inpatient Care | | | | | | | | | | 53 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | | |
| 60 | Bereavement Program | | | | | | | | | | 60 |
| 61 | Volunteer Program | | | | | | | | | | 61 |
| 62 | Fundraising | | | | | | | | | | 62 |
| 63 | Hospice/Palliative Medicine Fellows | | | | | | | | | | 63 |
| 64 | Palliative Care Program | | | | | | | | | | 64 |
| 65 | Other Physician Services | | | | | | | | | | 65 |
| 66 | Residential Care | | | | | | | | | | 66 |
| 67 | Advertising | | | | | | | | | | 67 |
| 68 | Telehealth/Telemonitoring | | | | | | | | | | 68 |
| 69 | Thrift Store | | | | | | | | | | 69 |
| 70 | Nursing Facility Room & Board | | | | | | | | | | 70 |
| 71 | Other Nonreimbursable | | | | | | | | | | 71 |
| 99 | Negative Cost Center | | | | | | | | | | 99 |
| 100 | Cost to be allocated (per Wkst. O-6, Part I) | | | | | | | | | | 100 |
| 101 | Unit cost multiplier | | | | | | | | | | 101 |

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

PROVIDER CCN: _____

HOSPICE CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET O-6 PART II

| | Cost Center Descriptions | NURSING ADMINIS-TRATION ( Direct Nurs. Hrs. ) | ROUTINE MEDICAL SUPPLIES ( Patient Days ) | MEDICAL RECORDS ( Patient Days ) | STAFF TRANS-PORTATION ( Mileage ) | VOLUNTEER SVC COOR-DINATION ( Hours of Service ) | PHARMACY ( Charges ) | PHYSICIAN ADMIN SERVICES ( Patient Days ) | OTHER GENERAL SERVICE ( Specify Basis ) | PATIENT / RESIDENT CARE SVCS ( In-Facil-ity Days ) | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | | | 3 |
| 4 | Administrative & General | | | | | | | | | | | 4 |
| 5 | Plant Operation and Maintenance | | | | | | | | | | | 5 |
| 6 | Laundry & Linen Service | | | | | | | | | | | 6 |
| 7 | Housekeeping | | | | | | | | | | | 7 |
| 8 | Dietary | | | | | | | | | | | 8 |
| 9 | Nursing Administration | | | | | | | | | | | 9 |
| 10 | Routine Medical Supplies | | | | | | | | | | | 10 |
| 11 | Medical Records | | | | | | | | | | | 11 |
| 12 | Staff Transportation | | | | | | | | | | | 12 |
| 13 | Volunteer Service Coordination | | | | | | | | | | | 13 |
| 14 | Pharmacy | | | | | | | | | | | 14 |
| 15 | Physician Administrative Services | | | | | | | | | | | 15 |
| 16 | Other General Service | | | | | | | | | | | 16 |
| 17 | Patient/Residential Care Services | | | | | | | | | | | 17 |
| | LEVEL OF CARE | | | | | | | | | | | |
| 50 | Continuous Home Care | | | | | | | | | | | 50 |
| 51 | Routine Home Care | | | | | | | | | | | 51 |
| 52 | Inpatient Respite Care | | | | | | | | | | | 52 |
| 53 | General Inpatient Care | | | | | | | | | | | 53 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | | | |
| 60 | Bereavement Program | | | | | | | | | | | 60 |
| 61 | Volunteer Program | | | | | | | | | | | 61 |
| 62 | Fundraising | | | | | | | | | | | 62 |
| 63 | Hospice/Palliative Medicine Fellows | | | | | | | | | | | 63 |
| 64 | Palliative Care Program | | | | | | | | | | | 64 |
| 65 | Other Physician Services | | | | | | | | | | | 65 |
| 66 | Residential Care | | | | | | | | | | | 66 |
| 67 | Advertising | | | | | | | | | | | 67 |
| 68 | Telehealth/Telemonitoring | | | | | | | | | | | 68 |
| 69 | Thrift Store | | | | | | | | | | | 69 |
| 70 | Nursing Facility Room & Board | | | | | | | | | | | 70 |
| 71 | Other Nonreimbursable | | | | | | | | | | | 71 |
| 99 | Negative Cost Center | | | | | | | | | | | 99 |
| 100 | Cost to be allocated (per Wkst. O-6, Part I) | | | | | | | | | | | 100 |
| 101 | Unit cost multiplier | | | | | | | | | | | 101 |

| APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O-7 |
|---|---|---|---|

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

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