10-12	
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FORM CMS-2552-10

4090 (Cont.)

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim						FORM APPROVED	
payments made since	the beginning of the co	ost reporting period being de	eemed overpayments (42 USC 1395g).			OMB NO. 0938-0050	
HOSPITAL AND	HOSPITAL HEAL	TH CARE	PROVIDER CCN:	PERIOD		WORKSHEET S	
COMPLEX COST	OMPLEX COST REPORT CERTIFICATION			FROM		PARTS I, II & III	
AND SETTLEME	ENT SUMMARY			то			
PART I - COST	REPORT STATUS	S					
Provider use only		1. [] Electronicall	y filed cost report		Date:	Time:	
2. [] Manually s		2. [] Manually sul	omitted cost report				
3. [] If this is an			mended report enter the number of times the	provider resubmitted t	his cost report		
		4 [] Medicare Ut	ilization. Enter "F" for full or "L" for low.				
Contractor	5. [] Cost Report	rt Status	6. Date Received:		10. NPR Date:		
use only	(1) As Submitte	d	7. Contractor No.:		11. Contractor's Vend	dor Code:	
	(2) Settled with	out audit	8. [] Initial Report for this Provider CCN		12. [] If line 5, colu	mn 1 is 4: Enter number of	
	(3) Settled with	audit	9. [] Final Report for this Provider CCN		times reopene	ed = 0-9.	
	(4) Reopened				-		
	(5) Amended						
PART II CERT	IFICATION				-		
MISREPRESENT	ATION OR FALSI	FICATION OF ANY IN	FORMATION CONTAINED IN THIS COS	ST REPORT MAY BE	PUNISHABLE BY C	RIMINAL,	
CIVIL AND ADM	IINISTRATIVE AC	TION, FINE AND/OR	IMPRISONMENT UNDER FEDERAL LAV	W. FURTHERMORE	, IF SERVICES IDEN	TIFIED IN	
THIS REPORT W	ERE PROVIDED	OR PROCURED THRO	OUGH THE PAYMENT DIRECTLY OR IN	DIRECTLY OF A KIO	CKBACK OR WERE	OTHERWISE	
ILLEGAL, CRIM	INAL, CIVIL AND	ADMINISTRATIVE A	CTION, FINES AND/OR IMPRISONMENT	Г MAY RESULT.			

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Officer or Administrator of Provider(s)

Title

Date

		TITLE	XVIII			
	TITLE V	PART A	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 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
OUTPATIENT REHABILITATION 12 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. FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4003.1-4003.3)

4090	O(Cont.)		FORM CMS-2552-	-10						10-12
	ITAL AND HOSPITAL HEALTH CARE PLEX IDENTIFICATION DATA				PROVIDER CCN:	PERIOD FROM TO		WORKSHEET : PART I	S-2	
Hospit	al and Hospital Health Care Complex Address:									
	Street:	P.O. Box:								1
	City:	State:	Zip Code:	County:						2
Hospit	al and Hospital-Based Component Identification:		1							-
		Component	CCN	CBSA	Provider	Date	Pavmen	nt System (P, T, C), or N)	Т
	Component	Name	Number	Number	Туре	Certified	V	XVIII	XIX	-
	0	1	2	3	4	5	6	7	8	-
3	Hospital			5		5	0		Ű	3
4	1									4
_	Subprovider- IRF									5
	Subprovider- (Other)									6
	Swing Beds-SNF									7
	Swing Beds-NF									8
	Hospital-Based SNF									9
	Hospital-Based NF									10
	Hospital-Based OLTC									11
	Hospital-Based HHA				-					11
	Separately Certified ASC									12
	Hospital-Based Hospice									13
	Hospital-Based Hospice Hospital-Based Health Clinic-RHC									14
	Hospital-Based Health Clinic-FOHC									15
-	1								 	
	Hospital-Based (CMHC, <i>CORF and OPT</i>)								L	17
	Renal Dialysis									18
19	Other									19
	~ ~								<u> </u>	
20		From:	To:							20
	Type of control (see instructions)									21
	nt PPS Information							1	2	<u> </u>
22	Does this facility qualify and is it currently receiving payn								1	22
	In column 1, enter "Y" for yes or "N" for no. Is this facili					0.				<u> </u>
23	Which method is used to determine Medicaid days on line			· · · ·	0				1	23
	Is the method of identifying the days in this cost reporting	, period different from the metho	od used in the prior cost reporting	g period? In column 2, e	enter "Y" for yes or "N'	' for no.			L	
				In-State	In-State	Out-of State	Out-of State	Medicaid	Other	1
				Medicaid	Medicaid eligible	Medicaid	Medicaid eligible	HMO	Medicaid	
				paid days	unpaid days	paid days	<i>unpaid</i> days	days	days	_
				1	2	3	4	5	6	
24									1	24
	eligible unpaid days in col. 2, out-of-state Medicaid paid		· ·						1	
	in col. 4, Medicaid HMO paid and eligible but unpaid da								 	4
25	If this provider is an IRF, enter the in-state Medicaid paid								1	25
	days in col. 2, out-of-state Medicaid paid days in col. 3, o	0	* *						1	
	in col. 4 Medicaid HMO paid and eligible but unpaid day	ys in col. 5 and other Medicaid	days in col. 6.						L	
	Enter your standard geographic classification (not wage) s									26
27	Enter your standard geographic classification (not wage) s		orting period. Enter in column 1,	"1" for urban or "2" for	r rural.					27
	If applicable enter the effective date of the geographic re-	classification in column 2.								

		FORM CMS-2552-10)					4090 (0	ont.)
HOSPITAI	L AND HOSPITAL HEALTH CARE		P	ROVIDER CCN:	PERIOD		WORKSHEET	S-2	
COMPLEX	X IDENTIFICATION DATA				FROM		PART I (CONT	`.)	
					ТО				
35 If t	this is a sole community hospital (SCH), enter the number of periods SCH stat	us in effect in the cost reporting period.							35
	ter applicable beginning and ending dates of SCH status. Subscript line 36 for	1 21	subsequent dates.		Beginning:		Ending:		36
	this is a Medicare dependent hospital (MDH), enter the number of periods MD	•	1				0		37
	ther applicable beginning and ending dates of MDH status. Subscript line 38 for		r subsequent dates		Beginning:		Ending:		38
50 Ent	ter appreade degramme and ending dates of MD11 statust publicity inte 50 re	Thanker of periods in encess of one and encer	subsequent autes.						
						V	XVIII	XIX	
Prospective	ve Payment System (PPS)-Capital					1	2	3	1
45 Do	bes this facility qualify and receive capital payment for disproportionate share i	in accordance with 42 CFR §412.320? (see ins	structions)						45
46 Is t	this facility eligible for additional payment exception for extraordinary circun	nstances pursuant to 42 CFR §412.348(f)? If y	yes, complete Workshee	et L, Part III and L	-1, Parts I through III.				46
	this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or '			,	, <u>v</u>				47
	the facility electing full federal capital payment? Enter "Y" for yes or "N" for								48
Teaching H	Hospitals					1	2	3	
	this a hospital involved in training residents in approved GME programs? Enter	er "Y" for yes or "N" for no.				1			56
	line 56 is yes, is this the first cost reporting period during which residents in ap		Enter "Y" for yes or "N	N" for no in colum	n 1.				57
	column 1 is "Y" did residents start training in the first month of this cost report								1
	column 2 is "N", complete Worksheet D, Parts III & IV and D-2, Part II, if ap			, , , , , , , , , , , , , , , , , , ,					1
58 If l	line 56 is yes, did this facility elect cost reimbursement for physicians' services	as defined in CMS Pub. 15-1, section 2148?	· · ·						58
If y	yes, complete Worksheet D-5.								1
59 Are	re costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2	, Part I.							59
60 Are	re you claiming nursing school and/or allied health costs for a program that mee	ets the provider-operated criteria under §413.8.	5? Enter "Y" for yes or	"N" for no. (see i	nstructions)				60
								Direct	1
						Y/N	IME Average	GME Average	l
61 Did	d your facility receive additional FTE slots under ACA section 5503? Enter "	Y" for yes or "N" for no in column 1. If "Y", e	ffective for portions of c	cost reporting perio	ods beginning				61
on	or after July 1, 2011 enter the average number of primary care FTE residents	for IME in column 2 and direct GME in colum-	n 3, from the hospital's	three most recent					l
cos	st reports ending and submitted before March 23, 2010. (see instructions)								1
						,			
ACA Prov	visions Affecting the Health Resources and Services Administration (HRSA)								
62 Ent	ter the number of FTE residents that your hospital trained in this cost reporting	g period for which your hospital received HRS/	A PCRE funding (see in	structions)					62
62 Ent	ter the number of FTE residents that rotated from a Teaching Health Center (T	HC) into your hospital during in this cost report	rting period of HRSA T	HC program. (see	instructions)				62.01
	Hospitals that Claim Residents in Non-Provider Settings								
63 Has	as your facility trained residents in non-provider settings during this cost report	ing period? Enter "Y" for yes or "N" for no. If	f yes, complete lines 64	-67. (see instruction	ons)				63
						Unweighted	Unweighted	Ratio	l
						FTEs	FTEs	(col. 1/	I
Section 55	504 of the ACA Base Year FTE Residents in Nonprovider settingsThis base					Nonprovider Site	in Hospital	(col. 1 + col. 2))	1
64 Enter in column 1, <i>if line 63 is yes, or your facility trained residents in the base year period</i> , the number of unweighted non-primary care resident FTEs attributable to rotations occurring			rimary care resident FTI	Es attributable to re	otations occurring				64
	all non-provider settings. Enter in column 2 the number of unweighted non-pr	imary care resident FTEs that trained in your h	ospital.						I
64 Ent	nter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see	e instructions)							1
64 Ent in a						Unweighted	Unweighted	Ratio	1
64 Ent in a						FTEs	FTEs	(col. 3/	1
64 Ent in a		_							i i
64 Ent in a	· · · · · ·]	Program N	Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	•
64 Ent in a			Program N 1	Jame	Program Code 2	Nonprovider Site 3	in Hospital 4	(col. 3 + col. 4)) 5	۱
64 Ent in a Ent	nter in column 1, if line 63 is yes, or your facility trained residents in the base	year period, the program name.	Program N 1	Vame		· ·			65
64 Ent in a Ent 65 Ent	nter in column 1, <i>if line 63 is yes, or your facility trained residents in the base</i> atter in column 2 the program code, enter in column 3 the number of unweighted		Program N 1	Vame		· ·			65
64 Ent in a Ent 65 Ent Ent		d primary care FTE residents attributable to	Program N 1	Name		· ·			65
64 Ent in a Ent 65 Ent Ent rota	nter in column 2 the program code, enter in column 3 the number of unweighted	d primary care FTE residents attributable to unweighted primary care resident FTEs that	Program N 1	Vame		· ·			6

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

	-10					1	0-12
HOSPITAL AND HOSPITAL HEALTH CARE	F	ROVIDER CCN:	PERIOD		WORKSHEET	S-2	
COMPLEX IDENTIFICATION DATA			FROM		PART I (CONT	`.)	
	_		ТО				
				Unweighted	Unweighted	Ratio	
				FTEs	FTEs	(col. 1/	
				Nonprovider Site	in Hospital	(col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settingsEffective 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 non-p	rovider settings. Enter in co	olumn 2 the numb	er of				66
unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided b	y (column 1 + column 2)).	(see instructions)					
				Unweighted	Unweighted	Ratio	
				FTEs	FTEs	(col. 3/	
	Program I	Name	Program Code	Nonprovider Site	in Hospital	(col. 3 + col. 4))	
	1		2	3	4	5	
67 Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of							67
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)							
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 n	0.					-	70
71 If line 70 ves:							71
Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004?	Enter "Y" for yes or "N" for	no					
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)?	-						
Column 2: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers							
in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	the beginning of the fourth	year, enter 4					
in country, of it the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)							
Inpatient Rehabilitation Facility PPS							
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for	or no						75
76 If line 75 yes:	51 110.						76
Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November	15 000 10 5						70
, , , , , , , , , , , , , , , , , , , ,							
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" fo	r no.					
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers	Enter "Y" for yes or "N" fo	r no.					
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR \$412.424 (d)(1)(iii)(D)?	Enter "Y" for yes or "N" fo	r no.					
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Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	Enter "Y" for yes or "N" fo	r no.					80
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers	Enter "Y" for yes or "N" fo	r no.					
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	Enter "Y" for yes or "N" fo the beginning of the fourth	r no.					85
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers	Enter "Y" for yes or "N" fo the beginning of the fourth	r no.					
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Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "?" Title V and XIX Inpatient Services	Enter "Y" for yes or "N" fo	r no.			V 1	XIX 2	85 86
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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 Did this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column	Enter "Y" for yes or "N" fo the beginning of the fourth	r no. year, enter 4			V 1		85 86 90
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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" 86 Did this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column 91 90 Does this facility have title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in applicable column 91	Enter "Y" for yes or "N" fo the beginning of the fourth "for no.	r no. year, enter 4			V 1		85 86 90 91
Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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" 7 Title V and XIX Inpatient Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column 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 yes or "N" 92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N"	Enter "Y" for yes or "N" fo the beginning of the fourth N" for no.	r no. year, enter 4			V 1		85 86 90 91 92
 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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" 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column 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" 93 Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applic 	Enter "Y" for yes or "N" fo the beginning of the fourth N" for no.	r no. year, enter 4			V 1		85 86 90 91 92 93
 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions) Long Term Care Hospital PPS 80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no. TEFRA Providers 85 Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 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" Title V and XIX Inpatient Services 90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column 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" 	Enter "Y" for yes or "N" fo the beginning of the fourth N" for no.	r no. year, enter 4			V 1		85 86 90 91 92 93 94
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10-12	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE	PROVIDER CCN:	PERIOD	WORKSHEET S-2
COMPLEX IDENTIFICATION DATA		FROM	PART I (CONT.)
		то	

Rural	l Providers			1	2	1
105	Does this hospital qualify as a Critical Access Hospital (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	Column 1: 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					107
	instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2,	Part II.				
	Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for					
	yes or "N" for no in column 2. (see instructions)					
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	
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
Misce	ellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.					115
	If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term h	hospitals				
	providers) based on the definition in CMS 15-1 §2208.1.					
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
118.01	List amounts of malpractice premiums and paid losses:		Premiums	Paid losses	Self insurance	118.01
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 containe	d 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			120
	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	2 "Y" for yes or "N" for	no.			
121						121
	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.					
Trans	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no. splant Center Information					
-						125
125	splant Center Information					125 126
125 126	plant Center Information 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.					
125 126 127	plant Center Information 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. 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
125 126 127 128	plant Center Information 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. If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126 127
125 126 127 128 129	plant Center Information 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. If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126 127 128
125 126 127 128 129 130	plant Center Information 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. If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126 127 128 129
125 126 127 128 129 130 131	plant Center Information 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. If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126 127 128 129 130
125 126 127 128 129 130 131 132	plant Center Information 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. If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126 127 128 129 130 131

4090 (Cont.)	FORM CMS-2						10-1
HOSPITAL AND HOSPITAL HEALTH CARE		PROVIDER CO			WORKSHEET		
COMPLEX IDENTIFICATION DATA			FROM	-	PART I (CON	T.)	
			TO	-			
All Providers						-	
					1	2	
140 Are there any related organization or home office costs as If yes, and home office costs are claimed, enter in column		or "N" for no in column 1.					14
If yes, and nome once costs are claimed, enter in column	2 the nome office chain number. (see instructions)						
f this facility is part of a chain organization, enter on lines 141 th	rough 143 the name and address of the home office and en	ter the home office contractor name and contract	or number.				
141 Name:	*	Contractor's Name:		Contractor's Nur	mber:	_	14
142 Street:	P. O. Box:						14
143 City:	State:	Zip Code:					14
144 Are provider based physicians' costs included in Workshe							14
145 If costs for renal services are claimed on Worksheet A, lin							14
146 Has the cost allocation methodology changed from the pre-		in column 1. (See CMS Pub. 15-2, section 4020))				14
If yes, enter the approval date (mm/dd/yyyy) in column 2.							
147 Was there a change in the statistical basis? Enter "Y" for	ves or "N" for no						1
148 Was there a change in the order of allocation? Enter "Y"	•						1
149 Was there a change in the order of uncertaint. Enter 1 149 Was there a change to the simplified cost finding method							1
1.) ···································							· ·
Does this facility contain a provider that qualifies for an exemption	on from the application of the lower of costs or charges?		Title	XVIII			Т
Enter "Y" for yes or "N" for no for each component for Part A an			Part A	Part B	Title V	Title XIX	
			1	2	3	4	٦
155 Hospital							15
156 Subprovider - IPF							1:
157 Subprovider - IRF							1
158 Subprovider - Other							1
159 SNF							1
160 HHA							1
161 CMHC							10
Multicampus	in the one of the second						1
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.					10
166 If line 165 is yes, for each campus enter the name in colur	nn 0, county in column 1, state in column 2, zip in column	3, CBSA in column 4, FTE/Campus in column 5.					1
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	1
					,		
Health Information Technology (HIT) incentive in the American							_
167 Is this provider a meaningful user under §1886 (n)? Enter							16
168 If this provider is a CAH (line 105 is "Y") and is a meanin 169 If this provider is a meaningful user (line 167 is "Y") and							16

10-12	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2
REIMBURSEMENT QUESTIONNAIRE		FROM	Part II
		то	

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?					1
If yes, enter the date of the change in column 2. (see instructions)					
		Y/N	Date	V/I	
		1	2	3	
2 Has the provider terminated participation in the Medicare Program?					2
If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3 Is the provider involved in business transactions, including management contracts, with individuals or entiti					3
(e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers,					5
staff, management personnel, or members of the board of directors through ownership, control, or family an					
other similar relationships? (see instructions)					
		Y/N	Туре	Date	
Financial Data and Reports		1	2	3	
4 Column 1: Were the financial statements prepared by a Certified Public Accountant?					4
Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy o	or enter				
date available in column 3. (see instructions) If no, see instructions.					
5 Are the cost report total expenses and total revenues different from those on the filed financial statements?					5
If yes, submit reconciliation.					
			Y/N	Y/N	1
Approved Educational Activities			1/1	2	
6 Column 1: Are costs claimed for nursing school?			1	2	6
Column 2: If yes, is the provider is the legal operator of the program?					Ŭ
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	od?				8
If yes, see instructions.					
9 Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.					9
10 Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instruct	ctions.				10
11 Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Wo	orksheet A?				11
If yes, see instructions.					
Ded Debte				V/NI	
				Y/N	12
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.	es submit conv			Y/N	12
13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye	es, submit copy.			Y/N	13
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions.	es, submit copy.			Y/N	13
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. 	es, submit copy.			Y/N	
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. 	es, submit copy.			Y/N	13 14
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 	es, submit copy.			Y/N	13 14
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 		rt A	Part		13 14
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 	Pa Y/N	Date	Y/N	B Date	13 14
 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 15 Did total beds available change from the prior cost reporting period? If yes, see instructions. PS&R Report Data 	Pa			B	13 14 15
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 15 15 Did total beds available change from the prior cost reporting period? If yes, see instructions. PS&R Report Data 16 16 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Pa Y/N	Date	Y/N	B Date	13 14
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 15 15 Did total beds available change from the prior cost reporting period? If yes, see instructions. PS&R Report Data 16 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)	Pa Y/N	Date	Y/N	B Date	13 14 15 16
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 15 15 Did total beds available change from the prior cost reporting period? If yes, see instructions. PS&R Report Data 16 16 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the	Pa Y/N	Date	Y/N	B Date	13 14 15
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12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement	Pa Y/N	Date	Y/N	B Date	13 14 15 16 17
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 12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement 15 Did total beds available change from the prior cost reporting period? If yes, see instructions. PS&R Report Data 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) 17 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? 18 If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 20 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? 	Pa Y/N	Date	Y/N	B Date	13 14 15 16 17 17 18 18
12 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yet 14 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Bed Complement	Pa Y/N	Date	Y/N	B Date	13 14 15 16 17 18 19

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4004.2) Rev. 3

4090 (Cont.)	FORM CMS-2552-10			10-12
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD	WORKSHEET S-2	
REIMBURSEMENT QUESTIONNAIRE		FROM	Part II (CONT.)	
		ТО		

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

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

22	Have assets been relifed for Medicare purposes? If yes, see instructions.			22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period?			23
	If yes, see instructions.			
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
Intere	st 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
				20
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?			33
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33
	If no, see instructions.			33
	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.			34
Provi	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost			
Provi 34	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.			34
Provi 34	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost	Y/N	Date	34
Provid 34 35	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost	<u>Y/N</u> 1	Date 2	34
Provie 34 35 Home	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. 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.	<u>Y/N</u> 1		34
Provie 34 35 Home	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. 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. Coffice Costs Are home office costs claimed on the cost report?	Y/N 1		34 35
Provie 34 35 Home 36	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. 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.	Y/N 1		34 35 36
Provid 34 35 Home 36 37	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. 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. Coffice Costs Are home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y/N 1		34 35 36 37
Provie 34 35 Home 36 37	If no, see instructions. der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions. 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. Office Costs Are home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. If line 36 is yes , was the fiscal year end of the home office different from that of the provider?	Y/N 1		34 35 36 37

Cost I	Kepori Preparer Coniaci Informa	lion			
41	First name:	Last name:		Title:	41
42	Employer:				42
43	Phone number:		E-mail Address:		43

10-1	2					FORM	CMS-2	552-10								4090 (C	ont.)
	PITAL AND HOSPITAL HEALTH CARE CO ISTICAL DATA	OMPLEX									PROVIDE	R CCN:	PERIOD FROM TO		WORKSH PART I	EET S-3	
						Inpatier	nt Days / Out	patient Visit	s / Trips	Full	Time Equiva	lents	10	Disc	harges		
		Worksheet A Line	No. of	Bed Days	САН		Title	Title	Total All	Total Interns &	Employees On	Nonpaid		Title	Title	Total All	
	Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents	Payroll	Workers	Title V	XVIII	XIX	Patients	
	1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5,																1
	6, 7 and 8 exclude Swing Bed,																
	Observation Bed and Hospice days)																
	HMO																2
	HMO IPF <i>Subprovider</i>																3
	HMO IRF <i>Subprovider</i>																4
5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds. Swing Bed NF																6
7	Total Adults and Peds. (exclude																7
	observation beds) (see instructions)																
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
	Skilled Nursing Facility																19
	Nursing Facility																20
	Other Long Term Care																21
	Home Health Agency																22
	ASC (Distinct Part)																23
	Hospice (Distinct Part)																24
25	СМНС																25
	RHC/FQHC (specify)																26
	Total (sum of lines 14-26)																27
	Observation Bed Days																28
	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days -IRF																31
	Labor & delivery days (see instructions)																32
33	LTCH non-covered days																33

4090	(Cont.)	FOR	M CMS-25	52-10				10-12
	AL WAGE INDEX INFORMATION		PROVIDER C	CN:	PERIOD FROM TO		WORKSHEET PART II	S-3
Part II -	Wage Data				•			
		Worksheet A Line Number	Amount Reported 2	Reclassification of Salaries (from Worksheet A-6) 3	Salaries (column 2 ±	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 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-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)							7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF							9
10	Excluded area salaries (see instructions)							10
	OTHER WAGES AND RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
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) Worksheet S-3, Part IV line 24							17
18	Wage-related costs (other) Worksheet S-3, Part IV line 25							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

10-12			FOI	RM CMS-255	52-10		4090 (Cont.)		
	AL WAGE INDEX INFORMATION		PROVIDER C	CN:	PERIOD FROM TO		WORKSHEET S-3 PART II & III		
Part II - '	Wage Data								
		Worksheet A Line Number 1	Amount Reported 2	Reclassification of Salaries (from Worksheet A-6) 3	Adjusted Salaries (column $2 \pm$ column 3) 4	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5) 6		
	OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits	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								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	

4090 (Cont.)	FORM CMS-2552-10			10-12
HOSPITAL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD	WORKSHEET S-3,	
		FROM	PART IV	
		то		
Part IV - Wage Related Cost				

Part A - Core List

			Т
		Amount	
		Reported	
	RETIREMENT COST	•	
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
	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
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 -23)		24

Part B	- Other than Core Related Cost	
25	Other Wage Related Costs (specify)	25

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

Part V - Contract Labor and Benefit Cost

		Contract	Benefit	
	Component	Labor	Cost	
	0	1	2	
1 To	otal facility contract labor and benefit cost			1
2 Ho	ospital			2
3 Su	ibprovider- IPF			3
4 Su	ibprovider- IRF			4
5 Su	abprovider- (Other)			5
6 Sv	ving Beds-SNF			6
7 Sv	ving Beds-NF			7
8 Ho	ospital-Based SNF			8
9 Ho	ospital-Based NF			9
10 Ho	ospital-Based OLTC			10
11 Ho	ospital-Based HHA			11
12 Se	eparately Certified ASC			12
13 Ho	ospital-Based Hospice			13
14 Ho	ospital-Based Health Clinic RHC			14
15 Ho	ospital-Based Health Clinic FQHC			15
16 Ho	ospital-Based-CMHC			16
17 Re	enal Dialysis			17
18 Ot	ther			18

0.5P	0 (Cont.) FORM CM. PITAL-BASED HOME HEALTH AGENCY	PROVIDE	P CCN-	PERIOD:		WORKSHE		0-
	ISTICAL DATA	FROVIDE	K CCN.	FROM		WORKSHE	EI 3-4	
A11	BICAL DATA	HHA CCN		ТО				
			•	10				
	HOME HEALTH AGENCY STATISTICAL DATA			County	/:			
			Title V	Title XVIII	Title XIX	Other	Total	
	Description		1	2	3	4	5	
1	Home Health Aide Hours							
2	Unduplicated Census Count (see instructions)							L
_	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							1
	Enter the number of hours in					nber of Emplo l Time Equiva	-	
	your normal work week				Staff	Contract	Total	1
					1	2	3	1
3	Administrator and Assistant Administrator(s)					-	2	t
_								F
5								ŀ
6								t
7	0							t
8								t
-	Physical Therapy Supervisor							ſ
-	Occupational Therapy Service							
-	Occupational Therapy Supervisor							
	Speech Pathology Service							
	Speech Pathology Supervisor							ŀ
	Medical Social Service							
	Medical Social Service Supervisor							
	Home Health Aide							
_	Other (specify)							t
.0								
	· · · ·							
	HOME HEALTH AGENCY CBSA CODES	ng period						
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting							F
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta							
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reporting		Full E	pisodes			Total	
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta			pisodes With	LUPA	PEP only	Total (columns 1	
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta		Without	With	LUPA Episodes	PEP only Episodes	(columns 1	
19	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta				LUPA Episodes 3	PEP only Episodes 4	(columns 1 through 4)	
.9 20	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY		Without Outliers	With Outliers	Episodes	Episodes	(columns 1	
19 20	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits Physical Therapy Visit Charges		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits Occupational Therapy Visit Charges		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visits Speech Pathology Visit Charges		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
20 21 22 23 24 25 26 27 28 29 30	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
21 22 23 24 25 26 27 28 29 30 31	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visits Medical Social Service Visit Charges Home Health Aide Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29 30 31 32	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visits Speech Pathology Visits Medical Social Service Visits Medical Social Service Visits Home Health Aide Visits Home Health Aide Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29 30 31 32 33	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visits Occupational Therapy Visits Speech Pathology Visits Speech Pathology Visits Medical Social Service Visits Medical Social Service Visits Home Health Aide Visits Home Health Aide Visits		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Home Health Aide Visits Home Health Aide Visits Home Health Aide Visits Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29 30 31 32 33	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Home Health Aide Visits Home Health Aide Visits Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	
19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35	HOME HEALTH AGENCY CBSA CODES Enter the number of CBSAs where you provided services during the cost reportin List those CBSA code(s) serviced during this cost reporting period (line 20 conta PPS ACTIVITY Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visits Home Health Aide Visits Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Number of Episodes (standard/non-outlier)		Without Outliers	With Outliers	Episodes	Episodes	(columns 1 through 4)	

D-12 DSPITAL RENAL DIALYSIS DEPARTMENT ATISTICAL DATA		FURM CI	MS-2552-10 PROVIDER CO	PROVIDER CCN:		PERIOD: FROM TO		Cont ET S-5
RENAL DIA	LYSIS STATISTICS				10			
		Outpat	ent	Train	ing	Hom	e	
DESC	RIPTION	Regular	High Flux	Hemo- dialysis 3	CAPD CCPD 4	Hemo- dialysis 5	CAPD CCPD 6	
1 Number of p	atients in program at	-				U		
	eporting period							
2 Number of ti	mes per week patient							
receives dial	ysis							
3 Average pati	ent dialysis time including setup							
4 CAPD excha	nges per day							
5 Number of d	ays in year dialysis furnished							E
6 Number of st	tations							
7 Treatment ca	pacity per day per station							
8 Utilization (s	ee instructions)							
9 Average time	es dialyzers re-used							
10 Percentage o	f patients re-using dialyzers							
11 Number of p	NT INFORMATION atients on transplant list atients transplanted during the cost reporting p	period						
EPOETIN								
13 Net costs of	Epoetin furnished to all maintenance dialysis	patients by the provider						
14 Epoetin amo	unt from Worksheet A for home dialysis prog	ram						
15 Number of E	PO units furnished relating to the renal dialyst	is department						
16 Number of E	PO units furnished relating to the home dialys	is department						
ARANESP	ARANESP furnished to all maintenance dialy	sis patients by the provi	lor				T	–
	mount from Worksheet A for home dialysis p	1 7 1	ICI					
	RANESP units furnished relating to the renal	0					+	+
	RANESP units furnished relating to the renal RANESP units furnished relating to the home						+	-

_		PHI SICIAN PAYM	TENT METHOD (Enter X for applicable method(s))	
	21	MCP	INITIAL METHOD	21

4090 (Cont.)	FORM CMS-2552-10				10-12
HOSPITAL-BASED COMMUNITY MENTAL HEALTH CEN	ITER AND	PROVIDER CCN:	PERIOD:	WORKSHEET S-6	
OTHER OUTPATIENT REHABILITATION			FROM		
PROVIDER STATISTICAL DATA		COMPONENT CCN:	то		

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

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

Enter the number of hours in your normal workweek _____

		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

10-12	FORM CMS-2552-10		4090 (Cont.)
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	-
		то	

		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			1
	utilization? Enter "Y" for yes and do not complete the rest of this worksheet.			
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for			2
	yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			

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

4090	O (Cont.) FOI	RM CMS-2552-10		1	0-12
	PECTIVE PAYMENT FOR SNF ISTICAL 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	CBSA on/after	
		Beginning of	October 1 of the	
		Cost Reporting	Cost Reporting	
		Period	Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning			201
	of the cost reporting period.			
	Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			

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

	Associated with	
202 Staffing	Direct Patient Care	
Ŭ	nd Related Expenses?	
Ŭ	3	
202 Descritment		202
203 Kechulment		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 RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER PROVIDER CCN: PERIOD: FROM	-	090 (Co.	
applicable box: [] FQHC Clinic Address and Identification:			—
1 Street: 2 City: State: Zip Code: County: 3 FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban Source of Federal Funds: Grant Award 1 4 Community Health Center (Section 330(d), PHS Act) 1 5 Migrant Health Center (Section 329(d), PHS Act) 6 6 Health Services for the Homeless (Section 340(d), PHS Act) 1 7 Appalachian Regional Commission 1			
2 City: State: Zip Code: County: 3 FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban Source of Federal Funds: Grant Award 4 Community Health Center (Section 330(d), PHS Act) I I 5 Migrant Health Center (Section 329(d), PHS Act) I 6 Health Services for the Homeless (Section 340(d), PHS Act) I 7 Appalachian Regional Commission I			1
Grant Award 1 4 Community Health Center (Section 330(d), PHS Act) 5 Migrant Health Center (Section 329(d), PHS Act) 6 Health Services for the Homeless (Section 340(d), PHS Act) 7 Appalachian Regional Commission			1 2 3
1 4 Community Health Center (Section 330(d), PHS Act) 5 Migrant Health Center (Section 329(d), PHS Act) 6 Health Services for the Homeless (Section 340(d), PHS Act) 7 Appalachian Regional Commission			
5 Migrant Health Center (Section 329(d), PHS Act) 6 Health Services for the Homeless (Section 340(d), PHS Act) 7 Appalachian Regional Commission	Da 2	ate	
 6 Health Services for the Homeless (Section 340(d), PHS Act) 7 Appalachian Regional Commission 	2	-	4
7 Appalachian Regional Commission			5
· · · · · · · · · · · · · · · · · · ·			6
o Look antes			8
9 Other (specify)			9
	1	2	
10 Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1.			10
If yes, indicate the number of other operations in column 2.			
Facility hours of operations (1)			
Sunday Monday Tuesday Wednesday Thursday Friday		ırday	
Type Operationfromtofromtofromtofromtofromto012345678910111	o from 2 13	to 14	
11 Clinic	- 10		11
(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.			
	1	2	
 Have you received an approval for an exception to the productivity standard? Is this a consolidated cost report as defined in CMS Pub. <i>104-04, chapter 9, section 30.8</i>? Enter "Y" for yes or "N" for no in column 1. 			12 13
Is this a consolidated cost report as defined in CMS Pub. 104-04, <i>chapter 9</i> , section 50.8? Effect 1 for yes of 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.			15
14 Provider name: CCN number:			14
		Total	
	/III XIX	Visits	
1 2 3 15 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. 1	3 4	5	15
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. <i>Enter in colum 5 the number of total visits for this provider</i> . (see instructions)			

4090 (Cont.)	FORM CMS-2552-10		10-12
HOSPICE IDENTIFICATION DATA	PROVIDER CCN: HOSPICE NO.:	PERIOD: FROM TO	WORKSHEET S-9 PARTS I & II

PART I - ENROLLMENT DAYS

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

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous							7
	Care Hours Billable to Medicare							
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

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

10-12 FORM CMS-2552-1	0		4090 (0	Cont.)
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-10	
····				
Uncompensated and indigent care cost computation	0			— ·
1 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column	n 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 or supplemental payments from Medicaid?				4
 5 If line 4 is no, enter DSH 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 (<i>line 7 minus lines 2 a</i>	nd 5)			8
If line 7 is less than the sum of lines 2 and 5, then enter zero.				Ŭ
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9 Net revenue from stand-alone SCHIP				9
10 Stand-alone SCHIP charges				10
11 Stand-alone SCHIP cost (line 1 times line 10)				11
12 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9)				12
If line 11 is less than line 9, then enter zero.				
			•	-
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)			16
If line 15 is less than line 13, then enter zero.				
Uncompensated care (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, SCHIP and state and local indigent care program	s (sum of lines 8, 12 and 1	6)		19
	Uninsured	Insured	Total	
	patients	patients	(col. 1 + col. 2)	
	1	2	3	
20 Total initial obligation of patients approved for charity care (at full charges excluding				20
non-reimbursable cost centers) for the entire facility				
21 Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22 Partial payment by patients approved for charity care				22
23 Cost of charity care (line 21 minus line 22)				23
24 Does the amount in line 20, column 2 include charges for patient days beyond a length of	of stay limit imposed on pa	tients covered		24
by Medicaid or other indigent care program?				
25 If line 24 is yes, enter charges for patient days beyond an indigent care program's length	of stay limit (see instructi	ons)		25
26 Total bad debt expense for the entire hospital complex (see instructions)				26
27 Medicare bad debts for the entire hospital complex (see instructions)				27
28 Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)				28
29 Cost of non-Medicare bad debt expense (line 1 times line 28)				29
30 Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				30
31 Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

4090) (Coi	nt.)		FORM CI		10-1				
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE OF	F EXPENSES		PROVIDER CCN:	-	PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 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								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14		Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
		Nonphysician Anesthetists								19
20	02000	Nursing School								20
21		Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31		Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33		Burn Intensive Care Unit								33
34	03400	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	04600	Other Long Term Care								46

10-1	2			FORM C	4090 (Cont.)					
RECL	ASSIFI	CATION AND ADJUSTMENT OF TRIAL BALANCE	OF EXPENSES		PROVIDER CCN:		PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6) 7	
		ANCILLARY SERVICE COST CENTERS	1		5	-	5	0	,	
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		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	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88		Rural Health Clinic (RHC)								88
89		Federally Qualified Health Center (FQHC)	1							89
90	09000	Clinic								90
91		Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

4090	0 (Coi	nt.)		FORM CI	MS-2552-10				10	0-12
RECL	ASSIFI	CATION 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. $3 \pm$ col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
			1	2	3	4	5	6	7	
		OTHER REIMBURSABLE COST CENTERS								
94		Home Program Dialysis	_							94
95		Ambulance Services	_							95
96		Durable Medical Equipment-Rented								96
97	09700	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	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS				-				
105		Kidney Acquisition								105
106		1								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 1-117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191		Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)				- 0 -				200

10-12			FORM	CMS-2	2552-10			-			4090 (C	<u>'ont</u>
ECLASSIFI	CATIONS						PROVIDER CCN:	PERIOD FROM _ TO		WORKSHEET	A-6	
			INCREASES				DECREASES				Wkst.	T
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	A-7 Ref.	
		1	2	3	4	5	6	7	8	9	10	┶
1												┢
2											_	┢
3											_	┢
4											_	_
5										_	_	_
6										_	_	_
7										_	_	+
8								╉──╉				+
								+			-	┢
10 11								+ +		-	-	
11 12												┢
12												┢
13											-	
14 15										-	-	
16		_						+ +				┢
17												┢
18											-	t
19												t
20												t
20												t
22												T
23												
23 24												
25												
26												
27				I I		1					1	
28				1								
29												
30												
31												
32												
31 32 33 34												
34												
35												
	eclassifications (sum of columns 4 and 5 qual sum of columns 8 and 9)											5

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

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

4090 (Cont.)		FO	RM CMS-255	2-10				1	0-12
RECONCILIATION OF CAPITAL COSTS CENTERS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET A-7, PARTS I, II & III	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	ET BALANCES								
				Acquisitions		Disposals		Fully	ł
Description		Beginning Balances	Purchases 2	Donation 3	Total 4	and Retirements 5	Ending Balance 6	Depreciated Assets 7	
1 Land		1	2	5	4	5	0	/	
2 Land Improvements									
3 Buildings and Fixtures									
4 Building Improvements									
5 Fixed Equipment									
6 Movable Equipment									-
7 HIT-designated Assets									-
8 Subtotal (sum of lines 1-7)									
9 Reconciling Items									-
10 Total (line 7 minus line 9)									1
PART II - RECONCILIATION OF AMOUNTS FROM V	VORKSHEET & COL	IIMN 2 I INES 1 A	ND 2						
ART II - RECONCILIATION OF AMOUNTS FROM V	VORKSHEET A, COL	Contra 2, LINES I A			SUMMARY OF CAI	DITAI			
					Insurance	Taxes	Other Capital- Related Costs	Total (1) (sum of	
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	
		9	10	11	12	13	14	15	<u> </u>
1 Capital Related Costs-Buildings and Fixtures									
2 Capital Related Costs-Movable Equipment 3 Total (sum of lines 1-2)									
 (1) The amount in columns 9 through 14 must equal the am column 2, lines 1 and 2. * All lines numbers are to be consistent with Worksheet A PART III - RECONCILIATION OF CAPITAL COSTS CONTRACT 	A line numbers for capita		2. Enter in each colu	mn the appropriate am	ounts including any d	lirectly assigned cost t	hat may have been incl	uded in Worksheet A,	
		COMPUTAT	ION OF RATIOS			ALLOCATION O	F OTHER CAPITAL		í
Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital- Related Costs	Total (sum of cols. 5 through 7)	
*	1	2	3	4	5	6	7	8	i i
1 Capital Related Costs-Buildings and Fixtures			-		-			-	
2 Capital Related Costs-Movable Equipment									
3 Total (sum of lines 1-2)				1.000000					
				S	UMMARY OF CA	PITAL			
							Other Capital-	Total (2)	i i
					Insurance	Taxes	Related Costs	(sum of	ł
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	i
*		9	10	11	12	13	14	15	ł
1 Capital Related Costs-Buildings and Fixtures			10	11	12	15	17	15	-
2 Capital Related Costs-Durlings and Fixtures									-
3 Total (sum of lines 1-2)			1						

Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.) FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4015)

DJU	ISTMENTS TO EXPENSES	PROVIDER CCN:		PERIOD:	WORKS)90 (C heet a	
				FROM			
				то			
				EXPENSE CLASSIFICAT	TON ON		Г
	DESCRIPTION (1)			WORKSHEET A TO/FROM	M WHICH	Wkst.	
				THE AMOUNT IS TO BE A	DJUSTED	A-7	
		BASIS/CODE (2)	AMOUNT	COST CENTER	LINE #	Ref.	
		1	2	3	4	5	T
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		Γ
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		
3	Investment income - other (chapter 2)						Γ
4	Trade, quantity, and time discounts (chapter 8)						
5	Refunds and rebates of expenses (chapter 8)						
6	Rental of provider space by suppliers (chapter 8)						Γ
7	Telephone services (pay stations excluded) (chapter 21)						
8	Television and radio service (chapter 21)						
9	Parking lot (chapter 21)						
10	Provider-based physician adjustment	Worksheet A-8-2					
11	Sale of scrap, waste, etc. (chapter 23)						
12	Related organization transactions (chapter 10)	Worksheet A-8-1					Γ
13	Laundry and linen service						
4	Cafeteria-employees and guests						
15	Rental of quarters to employee and others						
16	Sale of medical and surgical						
	supplies to other than patients						
17	Sale of drugs to other than patients						
18	Sale of medical records and abstracts						
19	Nursing school (tuition, fees, books, etc.)						
20	Vending machines						
21	Income from imposition of interest,						
	finance or penalty charges (chapter 21)						
22	Interest expense on Medicare overpayments and						
	borrowings to repay Medicare overpayments						
23	Adjustment for respiratory therapy						Γ
	costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		
24	Adjustment for physical therapy costs						Г
	in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		
27	Depreciation - movable equipment			Movable Equipment	2		
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		ſ
29	Physicians' assistant						Γ
30							Г
	in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		
31	Adjustment for speech pathology costs						Г
	in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		
32	CAH HIT Adjustment for Depreciation						
33							Γ
50	TOTAL (sum of lines 1 thru 49)						Г
	(Transfer to Worksheet A, column 6, line 200)						

(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 thru 49 and subscripts thereof.

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

4090 (Cont.)	FORM CMS-2552-10	4S-2552-10					
STATEMENT OF COSTS OF SERVICES	PROVIDER CCN	PERIOD:	WORKSHEET A-8-1				
FROM RELATED ORGANIZATIONS AND		FROM					
HOME OFFICE COSTS		ТО					

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center 2	Expense Items	Amount of Allowable Cost 4	Amount included in Wkst. A column 5 5	Net Adjustments (col. 4 minus col. 5) * 6	Wkst. A-7 Ref. 7	
1								1
2								2
3								3
4								4
5		sum of lines 1-4) Transfer column 6, m 2, line 12.	line 5 to Worksheet					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						
			Percentage		Percentage					
	Symbol		of		of	Type of				
	(1)	Name	Ownership	Name	Ownership	Business				
	1	2	3	4	5	6				
6							6			
7							7			
8							8			
9							9			
10							10			

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

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

FORM CMS-255 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 oreanization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify _____

10-1	2		FO	RM CMS-255	2-10				4090 (0	Cont.)
PROV	/IDER-BASE	ED PHYSICIANS ADJUSTMENTS			PROVIDER CCN:		PERIOD:		WORKSHEET A-	-8-2
							FROM			
							ТО			
		Cost Center/					Physician/		5 Percent of	
	Wkst. A	Physician	Total	Professional	Provider	RCE	Provider	Unadjusted	Unadjusted	
	Line #	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

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

4090 (Cont.)		FORM CMS-2552-	10				10-12
REASONABLE COST DETERMINAT FURNISHED BY OUTSIDE SUPPLIE				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8- PARTS I & II	.3,
Check applicable box:	[] Occupational [] Physical []	Respiratory [] Speech Patho	ology				-
PART I - GENERAL INFORMATIC							
	(excluding aides) (see instructions)						1
2 Line 1 multiplied by 15 hours pe	r week which supervisor or therapist was on provider site						2
	which supervisor or therapist was on provider site which therapy assistant was on provider site but n						-
1 1	which therapy assistant was on provider site but n visits - supervisors or therapists (see instructions)	either supervisor nor therapist was	on provider site (see in	nstructions)			4
1	visits - supervisors of therapists (see instructions) visits - therapy assistants (include only visits made	here the second second second is the					5
-	not present during the visit(s)) (see instructions)	by therapy assistant and on which					0
7 Standard travel expense rate	not present during the visit(s)) (see histractions)						7
8 Optional travel expense rate per							/ 8
8 Optional travel expense fate per	Inne	Supervisors	Therapists	Assistants	Aides	Trainees	0
			2	3	Aides 4	5	
9 Total hours worked		1	2	5	4		9
10 AHSEA (see instructions)							10
· · · · · · · · · · · · · · · · · · ·	nns 1 and 2, one-half of column 2,						11
line 10; column 3, one-half of co							
12 Number of travel hours (see inst							12
13 Number of miles driven (see inst	,						13
PART II - SALARY EQUIVALENC	Y COMPUTATION						
14 Supervisors (column 1, line 9 tin							14
15 Therapists (column 2, line 9 time							15
16 Assistants (column 3, line 9 time	es 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 co	lumn 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 ph	ysical therapy, speech pathology o	r occupational therapy	, line 9, is greater than lin	e 2,		
make no entries on lines 21 and 2	22 and enter on line 23 the amount from line 20. O	Otherwise complete lines 21 through	123.				
21 Weighted average rate excluding	g aides and trainees (line 17 divided by sum of colu	umns 1 and 2, line 9 for respiratory	therapy or columns 1	through 3, line 9 for all ot	hers)		21
22 Weighted allowance excluding a	ides and trainees (line 2 times line 21)						22
23 Total salary equivalency (see ins	structions)						23
-							

10-12			FO	RM CMS-2552-10				4090	O (Cont.)
REASONABLE COST DETERMINATI FURNISHED BY OUTSIDE SUPPLIER		ICES				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A PARTS III & IV	-8-3,
Check applicable box:	[] Occupational	[] Physical	[] Respiratory	[] Speech Pathology					
PART III - STANDARD AND OPTIC	ONAL TRAVEL ALLOWA	ANCE AND TI	RAVEL EXPENSE	COMPUTATION - PROV	IDER SITE				
Standard Travel Allowance									
24 Therapists (line 3 times column 2	<u> </u>								24
25 Assistants (line 4 times column 3	. ,								25
26 Subtotal (line 24 for respiratory t									26
27 Standard travel expense (line 7 ti									27
28 Total standard travel allowance a		t the provider s	ite (sum of lines 26 a	nd 27)					28
Optional Travel Allowance and Option									
29 Therapists (column 2, line 10 tim		2, line 12)							29
30 Assistants (column 3, line 10 time	, ,								30
31 Subtotal (line 29 for respiratory t									31
32 Optional travel expense (line 8 tin			therapy or sum of co	lumns 1-3, line 13 for all oth	ners)				32
33 Standard travel allowance and sta									33
34 Optional travel allowance and sta									34
35 Optional travel allowance and op	tional travel expense (sum of	lines 31 and 32	2)						35
PART IV - STANDARD AND OPTIC		NCE AND TI	DAVEL EVDENCE	COMPLETATION CEDU	ICES OUTSIDI	DROVIDED STE			
Standard Travel Expense	NAL IKAVEL ALLOWA	INCE AND TI	KAVEL EAFENSE	COMPUTATION - SERV	ICES OUTSIDE	L PROVIDER SITE			
36 Therapists (line 5 times column 2	line 11)								36
37 Assistants (line 6 times column 3	, ,								30
38 Subtotal (sum of lines 36 and 37)	, ,								37
39 Standard travel expense (line 7 ti)							39
Optional Travel Allowance and Option		/							57
40 Therapists (sum of columns 1 and		ne 10)							40
41 Assistants (column 3, line 9 times		le 10)							41
42 Subtotal (sum of lines 40 and 41)	, ,								42
43 Optional travel expense (line 8 tin		line 13)							43
Total Travel Allowance and Travel Ex			he following					ļ	-15
three lines 44, 45, or 46, as appropriate									
44 Standard travel allowance and sta		f lines 38 and 3	(see instructions)						44
45 Optional travel allowance and sta									45
46 Optional travel allowance and op	· · ·								46
or and op			, (111110110)						.0

4090 (Cont.)	FORM CMS-255	52-10				10-12
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8 PARTS V-VI	-3,
Check applicable box: [] Occupational [] Physical [] Respirator	ry [] Speech Pathe	ology				
PART V - OVERTIME COMPUTATION						
	Therapists	Assistants	Aides	Trainees	Total	
	1	2	3	4	5	
47 Overtime hours worked during reporting period (if column 5,						47
line 47, is zero or equal to or greater than 2,080, do not complete						
lines 48-55 and enter zero in each column of line 56)						_
48 Overtime rate (see instructions)						48
49 Total overtime (including base and overtime allowance) (multiply						49
line 47 times line 48)						
CALCULATION OF LIMIT						
50 Percentage of overtime hours by category (divide the hours in each						50
column on line 47 by the total overtime worked in column 5, line 47)						_
51 Allocation of provider's standard work year for one full-time						51
employee times the percentages on line 50) (see instructions)						
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						55
line 47 times line 52)						
56 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the						56
sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						
PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUST	MENT					
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

10-1	2		FO	RM CMS-255	2-10				4090 (C	Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART I	
		NET EXPENSES FOR COST		ITAL D COSTS						
	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7) 0	BLDGS. & FIXTURES			SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	4	-111	5	0	,	
	Capital Related Costs-Buildings and Fixtures						1			1
	Capital Related Costs-Movable Equipment				1					2
	Employee Benefits					1				4
	Administrative and General									5
	Maintenance and Repairs									6
	Operation of Plant									7
	Laundry and Linen Service									8
	Housekeeping									9
	Dietary									10
	Cafeteria									11
	Maintenance of Personnel									12
	Nursing Administration									13
	Central Services and Supply									14
	Pharmacy Medical Records & Medical Records Library									15 16
	Social Service									10
	Other General Service (specify)									18
	Nonphysician Anesthetists									19
	Nursing School									20
	Intern & Res. Service-Salary & Fringes (Approved)									21
	Intern & Res. Other Program Costs (Approved)									22
	Paramedical Education Program (specify)									23
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)									30
	Intensive Care Unit									31
	Coronary Care Unit									32
_	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit								<u> </u>	34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider (specify)					 				42
	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility Other Long Term Care					<u> </u>			+	45 46
46	Other Long Term Care									46

4090	(Cont.)		FO	RM CMS-255	2-10				1	0-12
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART I	
		NET EXPENSES FOR COST				<u> </u>	то			
	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANCILLARY SERVICE COST CENTERS	0	1	2	4	4A	5	6	7	
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization						1			59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
70	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis					ļ				74
	ASC (Non-Distinct Part)					ļ				75
	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									00
	Rural Health Clinic (RHC)						1			88
	Federally Qualified Health Center (FQHC) Clinic									89 90
	Emergency									90
91	Observation Beds									91
92	Observation Beds Other Outpatient Service (specify)									92
93	Other Outpatient Service (specify)									93

10-1	2		FO	RM CMS-255	2-10				4090 (C	Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART I		
		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS				ADMINIS-	MAIN-		
	COST CENTER DESCRIPTIONS	(from Wkst. A col. 7)	BLDGS. & MOVABLE FIXTURES EQUIPMENT		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	
	OTHER REIMBURSABLE COST CENTERS	0	1	2	4	4A	5	6	7	
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment Vented									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
- 101	SPECIAL PURPOSE COST CENTERS									101
105	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition						1			108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1-117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
	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 118-201)									202

4090) (Cont.)			FOR	M CMS-25	52-10					1	10-12
COST	ALLOCATION - GENERAL SERVICE COSTS	-			PROVIDER CCN:			PERIOD: FROM TO	WORKSHEET B, PART I			
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS	0	,	10	11	12	15	14	15	10	17	
	Capital Related Costs-Buildings and Fixtures											1
	Capital Related Costs-Movable Equipment	-1										2
	Employee Benefits	1										4
5	Administrative and General											5
6	Maintenance and Repairs											6
	Operation of Plant											7
	Laundry and Linen Service											8
	Housekeeping				1							9
	Dietary											10
	Cafeteria											11
	Maintenance of Personnel											12
	Nursing Administration											13
	Central Services and Supply Pharmacy									-		14 15
	Medical Records & Medical Records Library											15
	Social Service											10
	Other General Service (specify)											18
	Nonphysician Anesthetists											10
	Nursing School											20
	Intern & Res. Service-Salary & Fringes (Approved)											21
	Intern & Res. Other Program Costs (Approved)											22
	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											
	Adults and Pediatrics (General Routine Care)											30
	Intensive Care Unit											31
	Coronary Care Unit											32
	Burn Intensive Care Unit											33
	Surgical Intensive Care Unit							I				34
	Other Special Care Unit (specify)	+				ļ						35
	Subprovider IPF	+										40
	Subprovider IRF											41 42
	Subprovider (specify) Nursery											42
	Skilled Nursing Facility	+										43
	Nursing Facility	+										44
	Other Long Term Care	+										45

10-1	2			FOR	M CMS-25	52-10					4090 (C	Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CO	CN:		PERIOD: FROM TO			WORKSHEET PART I	`В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	,	10		12	15	11	15	10	17	
50	Operating Room											50
	Recovery Room			1	1			1			1	51
52	Labor Room and Delivery Room											52
	Anesthesiology							1			1	53
	Radiology-Diagnostic											54
55	Radiology-Therapeutic											55
56	Radioisotope			1	1							56
	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
	Intravenous Therapy											64
65	Respiratory Therapy											65
	Physical Therapy											66
	Occupational Therapy											67
68	Speech Pathology											68
	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
-	Clinic							ļ			ļ	90
	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93

4090) (Cont.)			FOR	M CMS-25	52-10					1	10-12
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CO	CN:		PERIOD: FROM TO			WORKSHEET PART I	`В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	_
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition											105
	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition				1							108
109	Pancreas Acquisition											109
110	Intestinal Acquisition				1							110
111	Islet Acquisition				1							111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice				1							116
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1-117)											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 118-201)											202

10-1	2			FO	RM CMS-255	2-10				4090 (0	Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD: FROM TO		WORKSHEET B PART I	,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS		- /								
	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
	Employee Benefits										4
	Administrative and General										5
	Maintenance and Repairs										6
	Operation of Plant										7
_	Laundry and Linen Service										8
_	Housekeeping	-									9
	Dietary	-									10
	Cafeteria										11
	Maintenance of Personnel										12
	Nursing Administration	-									13
	Central Services and Supply	-									14
	Pharmacy										15
	Medical Records & Medical Records Library										16
	Social Service	-									17
	Other General Service (specify)										18
	Nonphysician Anesthetists										19
	Nursing School				1						20
	Intern & Res. Service-Salary & Fringes (Approved)										21
	Intern & Res. Other Program Costs (Approved)						1				22
	Paramedical Education Program (specify)							1			23
	INPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)										30
	Intensive Care Unit										31
-	Coronary Care Unit					1	1		1		32
	Burn Intensive Care Unit	Ì			l	1		l .			33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)				İ	1	1	İ			35
	Subprovider IPF										40
	Subprovider IRF	Ì			İ	i i	l	İ	l	İ	41
	Subprovider (specify)				İ	1	İ	İ	1	İ	42
	Nursery	Ì			İ	i –	l	İ	l	İ	43
	Skilled Nursing Facility										44
	Nursing Facility										45
	Other Long Term Care										46

4090	(Cont.)			FO	RM CMS-255	2-10					10-12
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	:	PERIOD: FROM TO		WORKSHEET B PART I	,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS										
	Operating Room										50
	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
	Blood Storing, Processing, & Trans.										63
	Intravenous Therapy										64
65	Respiratory Therapy										65
	Physical Therapy										66
	Occupational Therapy										67
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients						ļ			ļ	71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)				ļ	ļ			ļ	ļ	75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										4
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
_	Emergency										91
92	Observation Beds										92
93	Other Outpatient Service (specify)										93

	VORKSHEET B, ART I	
TO TO TO TO TO TO TO TO TO TO TO TO TO COST CENTER DESCRIPTIONS OTHER GENERAL SERVICE NURSING PHYSICIAN ANES- THETISTS NURSING SCHOOL SALARY AND FRINGES PARAMEDICAL EDUCATION (SPECIFY) SUBTOTAL ADJUSTMENTS OTHER REIMBURSABLE COST CENTERS INTERNS & THETISTS SCHOOL FRINGES COSTS COSTS SUBTOTAL ADJUSTMENTS 94 Home Program Dialysis INTERN & INTERN & SCHOOL INTERN & RESIDENTS SUBTOTAL ADJUSTMENTS 95 Ambulance Services INTERN & INTERN & SCHOOL INTERN & RESIDENTS SUBTOTAL INTERN & ADJUSTMENTS 96 Durable Medical Equipment-Rented INTERN & INTERN & INTERN & SCHOOL INTERN & RESIDENTS INTERN & RESIDENTS INTERN & RESIDENTS INTERN & RESIDENTS INTERN & RESIDENTS 97 Durabl	ARTI	
COST CENTER DESCRIPTIONS NON- OTHER GENERAL SERVICE NON- PHYSICIAN ANES- THETISTS INTERNS & RESIDENTS SALARY AND FRINGES INTERNS & RESIDENTS PROGRAM COSTS PARAMEDICAL EDUCATION (SPECIFY) INTERN & RESIDENT SUBTOTAL 0 0 18 19 20 21 22 23 24 25 94 Home Program Dialysis 18 19 20 21 22 23 24 25 95 Ambulance Services 1 </td <td></td> <td></td>		
OTHER REIMBURSABLE COST CENTERSImage: Cost of the section of the sectio	TOTAL	
94Home Program DialysisImage: Construction of the program DialysisImage: Construction of the program DialysisImage: Construction of the program DialysisImage: Construction of the program Dialysis95Ambulance ServicesImage: Construction of the program DialysisImage: Construction of the program DialysisImage: Construction of the program DialysisImage: Construction of the program Dialysis96Durable Medical Equipment-SoldImage: Construction of the program DialysisImage: Cons	26	1
95 Ambulance Services Image: constraint of the service of the service (not appvd. tchng. prgm.) Image: constraint of the service of the serv		0.1
96 Durable Medical Equipment-Rented Image: Constraint of the second		94
97 Durable Medical Equipment-Sold Image: Constraint of the section of the sectin of the section of the section of the section		95
98 Other Reimbursable (specify) Image: Constraint of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specific of the		96
99 Outpatient Rehabilitation Provider (specify) <		97
100 Intern-Resident Service (not appvd. tchng. prgm.) 101 Home Health Agency		98
101 Home Health Agency		99
		100
SPECIAL PURPOSE COST CENTERS		101
105 Kidney Acquisition Contract Contrac		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 1-117)		118
NONREIMBURSABLE COST CENTERS		
190 Gift, Flower, Coffee Shop, & Canteen		190
191 Research Contract Contra		191
192 Physicians' Private Offices	t	192
193 Nonpaid Workers		193
194 Other Nonreimbursable (specify)	t	194
200 Cross Foot Adjustments		200
201 Negative Cost Centers		201
202 TOTAL (sum lines 118-201)		

4090) (Cont.)		FO	RM CMS-255	2-10				1	10-12
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		TTAL D COSTS			то			Τ
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	211		5	0	,	
	Capital Related Costs-Buildings and Fixtures									1
	Capital Related Costs-Movable Equipment									2
4	Employee Benefits									4
5	Administrative and General							<u> </u>		5
	Maintenance and Repairs								<u> </u>	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							1		14
	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
	Subprovider IPF									40
41	Subprovider IRF									41
	Subprovider (specify)									42
	Nursery									43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

10-1	2		FO	RM CMS-255	2-10				4090 (C	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		PITAL ED COSTS						
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
	ANOUL ADVICE COST CENTERS	0	1	2	2A	4	5	6	7	<u> </u>
	ANCILLARY SERVICE COST CENTERS Operating Room									50
	Recovery Room									51
										51
	Labor Room and Delivery Room Anesthesiology									52
	Radiology-Diagnostic									54
	Radiology-Diagnostic Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
	Laboratory									60
	PBP Clinical Laboratory Services-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
	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
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

4090 (Cont.)		FO	RM CMS-255	2-10				1	10-12
ALLOCATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:	-	PERIOD: FROM TO		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS		PITAL ED COSTS MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT 7	
OTHER REIMBURSABLE COST CENTERS	0	1	2	2A	4	5	6	/	<u> </u>
94 Home Program Dialysis									94
95 Ambulance Services									94
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold									90
98 Other Reimbursable (specify)									98
99 Outpatient Rehabilitation Provider (specify)									99
100 Intern-Resident Service (not appvd. tchng. prgm.)									100
100 Intern-Resident Service (not appvd. tening. prgm.)									100
SPECIAL PURPOSE COST CENTERS									101
105 Kidney Acquisition									105
106 Heart Acquisition									105
107 Liver Acquisition									100
108 Lung Acquisition									107
109 Pancreas Acquisition									100
110 Intestinal Acquisition									110
111 Islet Acquisition									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 1-117)									118
NONREIMBURSABLE COST CENTERS									
190 Gift, Flower, Coffee Shop, & Canteen									190
191 Research			1						191
192 Physicians' Private Offices									192
193 Nonpaid Workers			1						193
194 Other Nonreimbursable (specify)									194
200 Cross Foot Adjustments									200
201 Negative Cost Centers									201
202 TOTAL (sum lines 118-201)									202

10-1	2			FOR	M CMS-25	52-10					4090 (0	Cont.)
ALLC	CATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD:			WORKSHEET	B,
								FROM			PART II	
		-				-	1	то				
		LAUNDRY				MAIN-	NURSING	CENTRAL		MEDICAL		
	COST CENTER DESCRIPTIONS	& LINEN	HOUSE-			TENANCE OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	
	COST CERTER DESCRIPTIONS	SERVICE	KEEPING	DIETARY	CAFETERIA		TRATION	SUPPLY	PHARMACY		SERVICE	
		8	9	10	11	12	13	14	15	16	17	1
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures											1
2	Capital Related Costs-Movable Equipment											2
4	Employee Benefits											4
	Administrative and General	4										5
	Maintenance and Repairs	4			1							6
-	Operation of Plant											7
_	Laundry and Linen Service			1								8
	Housekeeping											9
	Dietary					4						10
	Cafeteria						1					11
	Maintenance of Personnel							-				12
	Nursing Administration Central Services and Supply											13
	Pharmacy											14
	Medical Records & Medical Records Library										-	16
	Social Service					1						17
	Other General Service (specify)											18
	Nonphysician Anesthetists											19
	Nursing School											20
	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
	Intensive Care Unit											31
-	Coronary Care Unit											32
	Burn Intensive Care Unit											33
	Surgical Intensive Care Unit				l	l				l		34
	Other Special Care Unit (specify)				I	 	ļ	l		l		35
	Subprovider IPF				l							40
	Subprovider IRF											41 42
	Subprovider (specify) Nursery					<u> </u>						42
	Nursery Skilled Nursing Facility			 	1	ł		1		1	+	43
	Nursing Facility	+		<u> </u>	l	<u> </u>				l		44
-	Other Long Term Care	1		1								45

4090	(Cont.)			FOR	M CMS-25	52-10					1	0-12
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM TO			WORKSHEET E PART II	В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	,	10	11	12	15	17	15	10	17	
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology		-									53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catheterization							1			1	59
	Laboratory							ľ				60
61	PBP Clinical Laboratory Services-Program Only											61
	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
	Respiratory Therapy											65
66	Physical Therapy										1	66
	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
70	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
	Clinic				ļ							90
_	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93

10-12				FOR	M CMS-25	52-10					4090 (C	Cont.)
ALLOCATIO	ON OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM TO			WORKSHEET I PART II	В,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
OTHE	R REIMBURSABLE COST CENTERS											
94 Home	Program Dialysis											94
95 Ambu	lance Services											95
96 Durab	le Medical Equipment-Rented											96
	le Medical Equipment-Sold											97
	Reimbursable (specify)											98
99 Outpat	tient Rehabilitation Provider (specify)											99
100 Intern-	-Resident Service (not appvd. tchng. prgm.)											100
101 Home	Health Agency											101
SPECI	AL PURPOSE COST CENTERS											
105 Kidne	y Acquisition											105
106 Heart	Acquisition											106
107 Liver	Acquisition											107
108 Lung	Acquisition											108
109 Pancre	eas Acquisition											109
110 Intesti	inal Acquisition											110
111 Islet A	Acquisition											111
	Organ Acquisition (specify)											112
115 Ambu	latory Surgical Center (Distinct Part)											115
116 Hospie												116
	Special Purpose (specify)											117
	OTALS (sum of lines 1-117)											118
	EIMBURSABLE COST CENTERS											
190 Gift, F	Flower, Coffee Shop, & Canteen											190
191 Resear												191
	cians' Private Offices											192
193 Nonpa												193
	Nonreimbursable (specify)											194
	Foot Adjustments											200
	ive Cost Centers											201
202 TOTA	L (sum lines 118-201)											202

409	0 (Cont.)		FOF	RM CMS-255	52-10						10-12
ALLC	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS	10		20			20	2.		20	
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4											4
5											5
6	Maintenance and Repairs	7									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	1									14
15	Pharmacy	7									15
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
	Nursing School										20
	Intern & Res. Service-Salary & Fringes (Approved)										21
	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
	Intensive Care Unit										31
	Coronary Care Unit										32
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit										34
	Other Special Care Unit (specify)										35
	Subprovider IPF										40
	Subprovider IRF										41
	Subprovider (specify)										42
	Nursery										43
	Skilled Nursing Facility										44
	Nursing Facility										45
46	Other Long Term Care										46

10-1	2		FOR	M CMS-255	52-10					4090 (C	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET I PART II	B,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10		20			20	21	20	20	
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology				1						53
	Radiology-Diagnostic										54
	Radiology-Therapeutic				1						55
56	Radioisotope				1						56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)				1						58
59	Cardiac Catheterization										59
	Laboratory										60
	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
	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)									ļ	88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
92	Observation Beds										92
93	Other Outpatient Service (specify)										93

409	0 (Cont.)		FOR	M CMS-255	52-10					1	10-12
ALLC	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET I PART II	В,
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	OTHER REIMBURSABLE COST CENTERS	10	17	20	21	22	23	24	25	20	
94	Home Program Dialysis										94
	Ambulance Services										95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold								1	1	97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency										100
101	SPECIAL PURPOSE COST CENTERS										101
105	Kidney Acquisition										105
	Heart Acquisition										105
	Liver Acquisition										107
	Lung Acquisition										108
	Pancreas Acquisition										109
	Intestinal Acquisition										110
	Islet Acquisition										111
	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
	Hospice										116
117	Other Special Purpose (specify)				1						117
	SUBTOTALS (sum of lines 1-117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
	Research								1	1	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 118-201)										202

10-1	2	FO	RM CMS-255	2-10				4090 (C	Cont.)
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	1
					_	то			
		CAPITAL RE	LATED COST			ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	REPAIRS	OF PLANT	
	COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)	
		1	2	4	5A	5	6	7	
	GENERAL SERVICE COST CENTERS								<u> </u>
	Capital Related Costs-Buildings and Fixtures								1
	Capital Related Costs-Movable Equipment				-				2
	Employee Benefits					_	4		4
	Administrative and General							4	5
_	Maintenance and Repairs			 	ł				6
	Operation of Plant								7
	Laundry and Linen Service								8
	Housekeeping								9
	Dietary								10
	Cafeteria								11
	Maintenance of Personnel								12
	Nursing Administration								13
	Central Services and Supply								14
	Pharmacy								15
	Medical Records & Medical Records Library								16
_	Social Service								17
	Other General Service (specify)								18
	Nonphysician Anesthetists								19
	Nursing School								20
	Intern & Res. Service-Salary & Fringes (Approved)								21
	Intern & Res. Other Program Costs (Approved)								22
23	Paramedical Education Program (specify)								23
	INPATIENT ROUTINE SERVICE COST CENTERS								<u> </u>
	Adults and Pediatrics (General Routine Care)								30
	Intensive Care Unit							-	31
	Coronary Care Unit								32
	Burn Intensive Care Unit								33
	Surgical Intensive Care Unit								34
	Other Special Care Unit (specify)								35
	Subprovider IPF								40
	Subprovider IRF								41
	Subprovider (specify)			ļ					42
	Nursery								43
	Skilled Nursing Facility								44
	Nursing Facility								45
46	Other Long Term Care					1			46

409	0 (Cont.)	FO	RM CMS-255	2-10				1	10-12
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	1
						TO			
			LATED COST			ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	TENANCE &	OPERATION	
	COST CENTER DESCRIPTIONS	FIXTURES (SQUARE	EQUIPMENT (DOLLAR	BENEFITS (GROSS	RECONCIL-	GENERAL (ACCUM.	REPAIRS (SQUARE	OF PLANT	
	COST CENTER DESCRIPTIONS	(SQUARE FEET)	(DOLLAR VALUE)	(GROSS SALARIES)	IATION	COST)	(SQUARE FEET)	(SQUARE FEET)	
		1	2	4	5A	5	6	7	4
	ANCILLARY SERVICE COST CENTERS		-			5	0	,	
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
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
-	Cardiac Catheterization								59
	Laboratory								60
	PBP Clinical Laboratory Services-Program Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Trans.								63
	Intravenous Therapy								64
	Respiratory Therapy								65
	Physical Therapy Occupational Therapy								66 67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged to Patients								71
	Implantable Devices Charged to Patients								72
	Drugs Charged to Patients	1	1	1	1	1	1	1	73
	Renal Dialysis	1							74
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90									90
91	Emergency								91
	Observation Beds								92
93	Other Outpatient Service (specify)								93

10-12	FOI	RM CMS-255	2-10				4090 (C	Cont.)
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-	1
					то			
	CAPITAL RE	LATED COST			ADMINIS-	MAIN-		
	BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	TENANCE &	OPERATION	
	FIXTURES	EQUIPMENT	BENEFITS		GENERAL	REPAIRS	OF PLANT	
COST CENTER DESCRIPTIONS	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	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 1-117)								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

4090	0 (Cont.)			FOR	RM CMS-25	52-10					1	10-12
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEE	T 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)	
	CENED AL GEDUIGE COOT CENTERS	8	9	10	11	12	13	14	15	16	17	-
	GENERAL SERVICE COST CENTERS											1
	Capital Related Costs-Buildings and Fixtures	_										1
-	Capital Related Costs-Movable Equipment	_										2
4	1 1911 1 1 10	_										4
5	Administrative and General				1							
<u>6</u> 7	1				1							6 7
	Laundry and Linen Service			•								8
	Housekeeping				4							9
	Dietary	_				ł						10
11		_					-					11
-	Maintenance of Personnel											12
-	Nursing Administration								4			13
14	** *									4		14
	Pharmacy Medical Records & Medical Records Library	-					-		<u> </u>		-	15
	Social Service	-										10
18												17
	Nonphysician Anesthetists											18
	Nursing School											20
	Intern & Res. Service-Salary & Fringes (Approved)											20
	Intern & Res. Other Program Costs (Approved)											21
	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											23
30	Adults and Pediatrics (General Routine Care)											30
-	Intensive Care Unit				1	1						31
					<u> </u>		<u> </u>		<u> </u>		<u> </u>	32
	Burn Intensive Care Unit				1		†		<u> </u>		<u> </u>	33
	Surgical Intensive Care Unit				1		ł		1		ł	34
	Other Special Care Unit (specify)	1			1	1	1	1	1	1	1	35
-	Subprovider IPF				1		ł		1		<u> </u>	40
41	* *				1		ł		ł		ł	41
	Subprovider (specify)	1			1	1	1	1	1	1	1	42
	Nursery	1			1	1	1	1	1	1		43
	Skilled Nursing Facility	1			1	1	1	1	1		1	44
	Nursing Facility	1	1	1	1	1	1	1	1	1	1	45
46		1			1		1	1	†		1	46

10-1	12			FOR	M CMS-25	52-10					4090 (C	Cont.)
COST	TALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
-	ANCILLARY SERVICE COST CENTERS			-					-			
50	Operating Room							1				50
	Recovery Room											51
	Labor Room and Delivery Room											52
53	Anesthesiology											53
54	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
56	Radioisotope											56
	Computed Tomography (CT) Scan											57
	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
	Electrocardiology											69
	Electroencephalography											70
	Medical Supplies Charged to Patients											71
	Implantable Devices Charged to Patients											72
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)				ļ		ļ	ļ				88
	Federally Qualified Health Center (FQHC)											89
	Clinic				ļ			ļ				90
	Emergency											91
92												92
93	Other Outpatient Service (specify)											93

409	0 (Cont.)			FOR	M CMS-25	52-10					1	0-12
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	Г В-1
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	SOCIAL SERVICE (TIME SPENT) 17	
	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
	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)								1			112
115	Ambulatory Surgical Center (Distinct Part)								1			115
116	Hospice											116
117	Other Special Purpose (specify)								1			117
118	SUBTOTALS (sum of lines 1-117)								1	1		118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
	Physicians' Private Offices											192
	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

10-1	2		FOR	RM CMS-255	52-10					4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
		OTHER	NON- PHYSICIAN	NURSING	INTERNS & SALARY AND	RESIDENTS PROGRAM	PARA- MEDICAL		INTERN & RESIDENT		Т
	COST CENTER DESCRIPTIONS	GENERAL SERVICE (SPECIFY)	ANES- THETISTS (ASGND TIME)	SCHOOL (ASSIGNED TIME)	FRINGES (ASSIGNED TIME)	COSTS (ASSIGNED TIME)	EDUCATION (ASSIGNED TIME)	SUBTOTAL	COST & POST STEPDOWN ADJUSTMENTS		
	GENERAL SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	<u> </u>
	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Dundings and Fixtures	-									2
	Employee Benefits	-									4
	Administrative and General										5
_	Maintenance and Repairs	1									6
	Operation of Plant	1									7
	Laundry and Linen Service						1				8
9	Housekeeping										9
	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
	Pharmacy										15
	Medical Records & Medical Records Library										16
	Social Service										17
	Other General Service (specify)										18
	Nonphysician Anesthetists										19
	Nursing School										20
	Intern & Res. Service-Salary & Fringes (Approved)										21
	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
	INPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)										30
-	Intensive Care Unit										31
	Coronary Care Unit										32
	Burn Intensive Care Unit				1						33
	Surgical Intensive Care Unit Other Special Care Unit (specify)				<u> </u>		<u> </u>				34 35
	Subprovider IPF										40
	Subprovider IPF Subprovider IRF	-					<u> </u>				40
	Subprovider IRF Subprovider (specify)				 		 				41
	Nursery				<u> </u>		 				42
	Skilled Nursing Facility				1		 				43
	Nursing Facility				1		 				44
	Other Long Term Care						<u> </u>				45

4090) (Cont.)		FOR	M CMS-255	52-10						10-12
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10	17	20	21	22	25	24	25	20	
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
54	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
56											56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization					1					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
	Speech Pathology										68
69											69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)		ļ			ļ	ļ				88
	Federally Qualified Health Center (FQHC)		ļ				ļ				89
90							ļ				90
	Emergency										91
92	Observation Beds										92
93	Other Outpatient Service (specify)										93

10-12	2		FOR	M CMS-255	52-10					4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY) 18	NON- PHYSICIAN ANES- THETISTS (ASGND TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY AND FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (ASSIGNED TIME) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
(OTHER REIMBURSABLE COST CENTERS										
	Home Program Dialysis										94
	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)					1					100
101	Home Health Agency										101
5	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
	Other Special Purpose (specify)										117
	SUBTOTALS (sum of lines 1-117)										118
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen										190
_	Research										191
	Physicians' Private Offices										192
	Nonpaid Workers				ļ	ļ	ļ				193
	Other Nonreimbursable (specify)										194
	Cross foot adjustments										200
	Negative cost centers										201
	Cost to be allocated (per Worksheet B, Part I)										202
	Unit cost multiplier (Worksheet B, Part I)										203
	Cost to be allocated (per Worksheet B, Part II)										204
205	Unit cost multiplier (Worksheet B, Part II)										205

4090 (Cont.)	FORM CMS-2552				10-12
POST STEPDOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD:		WORKSHEET B-2	
		FROM			
		то			
		WORK			
DESCRIPTIO	DN	PART	LINE NO.	AMOUNT	
1		2	3	4	
1 Adjustment for EPO costs in Renal Dialysis cost cer	nter	1	74		1
2 Adjustment for EPO costs in Home Program Dialys	is cost center	1	94		2
3 Adjustment for ARANESP costs in Renal Dialysis		1	74		3
4 Adjustment for ARANESP costs in Home Program		1	94		4
5	•				4
6					6
7					7
8					8
9					9
10					10
11			1		11
12					12
13			1	1	13
14			1	i	13
15			1	i	15
16			1	1	16
17			1	İ	17
18					18
19					19
20			1		20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50				L	50
51					51
52			1	ļ	52
53					53
54					54
55			1	ļ	55
56				L	56
57					57
58					58
59					59

10-12			FORM	M CMS-25	52-10						4090 (C	
COMPUTATION OF RATIO OF COSTS TO CHARGES							PROVIDER	CCN:	PERIOD: FROM TO		WORKSHEE PART I	ET C
	Total Cost (from Wkst.	Therapy		Costs RCE			Charges	Total		TEFRA	PPS	
COST CENTER DESCRIPTIONS	B, Part I, col. 26)	Limit Adj.	Total Costs	Dis- allowance	Total Costs	Inpatient	Outpatient	(column 6 + column 7)	Cost or Other Ratio	Inpatient Ratio	Inpatient Ratio	
INPATIENT ROUTINE SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	10	11	<u> </u>
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

4090 (Cont.)			FOR	M CMS-25	52-10						1	10-12
COMPUTATION OF RATIO OF COSTS TO CHARGES							PROVIDER	CCN:	PERIOD: FROM TO		WORKSHE PART I	ET C
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj. 2	Total Costs 3	Costs RCE Dis- allowance 4	Total Costs 5	Inpatient 6	Charges Outpatient 7	Total (column 6 + column 7) 8	Cost or Other Ratio	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio 11	
69 Electrocardiology	1	2	5	-	5	0	,	0	,	10	11	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)	1					1		1				76
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
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)						ł	4					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

10-1	2	FOF	RM CMS-25	52-10					4090 (Co	ont.)
	CULATION OF OUTPATIENT SERVICE COST TO RGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[] Title V [] Title XIX	-		PROVIDER CO	CN:	PERIOD: FROM TO		WORKSHEET C PART II	.,
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26) 2	Operating Cost Net of Capital Cost (col. 1 - col. 2) 3	Capital Reduction 4	Operating Cost Reduction Amount 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8) 7	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7) 8	
	ANCILLARY SERVICE COST CENTERS	_		-		-			-	
50	Operating Room									50
	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
56	Radioisotope		1							56
57	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory		1							60
61	PBP Clinical Laboratory Services-Prgm. Only		1							61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.		1							63
64	Intravenous Therapy		1							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
	Drugs Charged to Patients									73
74	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76

409) (Cont.)	FOF	RM CMS-25	52-10					10	0-12
	EULATION OF OUTPATIENT SERVICE COST TO RGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[] Title V [] Title XIX			PROVIDER CO		PERIOD: FROM TO		WORKSHEET C PART II (CONT.)	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26) 1	Capital Cost (Wkst B, Part II, col. 26) 2	Operating Cost Net of Capital Cost (col. 1 - col. 2) 3	Capital Reduction 4	Operating Cost Reduction Amount 5	Cost Net of Capital and Operating Cost Reduction 6	Total Charges (Worksheet C, Part I, column 8) 7	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7) 8	
	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
	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
	Intern-Resident Service (not appvd. tchng. prgm.)			1						100
101	Home Health Agency									101
105	Kidney Acquisition			1						105
106	Heart Acquisition			1						106
	Liver Acquisition			1						107
108	Lung Acquisition									108
109	Pancreas Acquisition			1						109
110	Intestinal Acquisition									110
111	Islet Acquisition			1						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 thru 199)									200
201	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

10-1	2	FOR	M CMS-25	52-10				4090 (C	ont.)
	RTIONMENT OF INPATIENT ROUTINE ICE CAPITAL COSTS			PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET PART I	D,
Check applica boxes:	able [] Title XVIII, Part A	[] 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 INPATIENT ROUTNE SERVICE COST CENTERS	1	2	3	4	5	6	7	<u> </u>
30	Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)								200

	0 (Cont.) DRTIONMENT OF INPATIENT ANC		FORM CMS-255 PROVIDER CCN		PERIOD:		WORKSHEET D,	10-12
	VICE CAPITAL COSTS		I KOVIDEK CCIV		FROM		PART II	,
5LIC V	iel chi inil cosis		COMPONENT CO	٦N·	то		1711(11	
Check	r	[] Title V	COMIONENT	[] Hospital	[] Subprovider (0)ther)	[] PPS	
applic		[] Title XVII	I Part A	[] IIOspital [] IPF		Juici)	[] TEFRA	
boxes		[] Title XIX	1, 1 att 71	[] IRF				
UUACS	•		Capital					1
			Related Cost		Ratio of Cost		Capital	
			(from Wkst.	Total Charges	to Charges	Inpatient	Costs	
			B, Part II,	(from Wkst. C,	ē	1	(column 3 x	
			· · · ·		$(col.1 \div$	Program	(column 3 x column 4)	
(4)	Cost Coston Decemention		col. 26)	Part I, col. 8)	col. 2) 3	Charges 4	· · · · · · · · · · · · · · · · · · ·	_
(A)	Cost Center Description ANCILLARY SERVICE COST CEN	TEDE	1	2	3	4	5	
50		IEKS						50
50	Operating Room							50
51	Recovery Room							51
52 53	Labor Room and Delivery Room				┥───┤			52
	Anesthesiology Rediclosy Discretion							53
<u>54</u> 55	Radiology-Diagnostic Radiology-Therapeutic							54 55
-								
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI)							58
59	Cardiac Catheterization							60
60	Laboratory	0.1	_					60
61	PBP Clinical Laboratory Services-Pr							61
62	Whole Blood & Packed Red Blood @			_				62
63	Blood Storing, Processing, & Transf	using						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 Patient				┥───┤			71
72	Implantable Devices Charged to Pati	ents			+			72
73	Drugs Charged to Patients				┥───┤			73
74	Renal Dialysis				┥───┤			74
75	ASC (Non-Distinct Part)				┥───┤			75
76	Other Ancillary (specify)				┥───┤			76
88	Rural Health Clinic (RHC)				┥───┤			88
89	Federally Qualified Health Center (F	QHC)			┥───┤			89
90	Clinic				┥───┤			90
91	Emergency				┥───┤			91
92	Observation Beds				┥───┤			92
93	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST C	ENTERS					-	
94	Home Program Dialysis							94
95	Ambulance Services						1	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

10-12		FOR	M CMS-255	52-10					4090 (C	ont.)
APPORTIONMENT OF INPATIENT ROUTINE					PROVIDER CC	'N:	PERIOD: FROM		WORKSHEET D, PART III	
SERVICE OTHER PASS THROUGH COSTS							ТО		PARTIII	
] Title V] Title XVIII, Part A	[] PPS [] TEFRA								
] Title XIX	[] IEFKA								
			All Other	Swing-Bed	Total Costs		Per		Inpatient	
			Medical	Adjustment Amount	(sum of cols.	Total	Diem	Inpatient	Program Pass-Through	
	Nursing	Allied Health	Education	(see	1 through 3,	Patient	(col. 5 ÷	Program	Cost	
(A) Cost Center Description	School 1	Cost 2	Cost 3	instructions) 4	minus col. 4) 5	Days 6	col. 6)	Days 8	(col. 7 x col. 8) 9	
INPATIENT ROUTINE SERVICE COST CENTERS										
Adults & Pediatrics 30 (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (Other)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
200 Total (sum of lines 30-199)										200

4090	O (Cont.)		FORM CM	IS-2552-10				1	0-12
APPO	RTIONMENT OF INPATIE	NT/OUTPATIENT ANCILLARY	7	PROVIDER CC	N:	PERIOD:		WORKSHEET D),
SERV	ICE OTHER PASS THROU	GH COSTS				FROM		PART IV	
_				COMPONENT (CCN:	то			
Check		[] Title V	[] Hospital	[] Subprov	vider (Other)	[] ICF/MR	[] PPS		
applica		[] Title XVIII, Part A	[] IPF	[] SNF			[] TEFRA		
boxes:		[] Title XIX	[] IRF	[] NF	T	1		1	
			NY.			All		Total	
			Non			Other	T (1)	Outpatient	
			Physician Anesthetist	Nursing	Allied	Medical Education	Total cost (sum of col 1	Cost (sum of col. 2,	
			Cost	Ŭ	Health	Cost	(sum of col 1 through col. 4)	· · · · · · · · · · · · · · · · · · ·	
(A)	Cost Center Description	on	1	School 2	3	4	5	3 and 4) 6	<u> </u>
	ANCILLARY SERVICE CO		· ·	2	5		5	0	<u> </u>
50	Operating Room								50
51	Recovery Room								51
52	Labor room and Delivery R	oom							52
53	Anesthesiology								53
54	Radiology-Diagnostic					1			54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (C	Г) Scan							57
58	Magnetic Resonance Imagin	ng (MRI)							58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Se	ervPrgm. Only							61
62	Whole Blood & Packed Re								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 Electrocardiology								68 69
69 70	Electrocardiology								70
70	Medical Supplies Charged	To Patients							70
72	Implantable Devices Charge								72
73	Drugs Charged to Patients	ed to Fatients							73
74	Renal Dialysis					1	1		74
75	ASC (Non-Distinct Part)				1	1	1		75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE O	COST CENTERS							
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health	Center (FQHC)							89
90	Clinic								90
91	Emergency								91
92	Observation Beds					I			92
93	Other Outpatient Service (s	pecify)							93
	OTHER REIMBURSABLE	COST CENTERS							
	Home Program Dialysis					 			94
95	Ambulance Services				┨	+			95
96	Durable Medical Equipmen								96
97	Durable Medical Equipmen					+			97
98 200	Other Reimbursable (specific Total (sum of lines 50 through the second s				1	+			98 200
200	Total (sum of times 30 tillou	igii 1 <i>77)</i>							200

10-1	2		FORM CM	S-2552-10				4090 (Co	ont.)
APPO	RTIONMENT OF INPATIENT/OUT	FPATIENT ANCILLARY		PROVIDER CCN	N:	PERIOD:		WORKSHEET D	,
SERV	ICE OTHER PASS THROUGH COS	STS				FROM		PART IV (Cont.)	
				COMPONENT C	CN:	то			
Check	[] Title	V	[] Hospital	[] Subprov	vider (Other)	[] ICF/MR	[] PPS		
applica	able [] Title	XVIII, Part A	[] IPF	[] SNF			[] TEFRA		
boxes:	[] Title	XIX	[] IRF	[] NF					
						Inpatient		Outpatient	
				Outpatient		Program		Program	
		Total	Ratio	Ratio		Pass-		Pass-	
		Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
		(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
		Part I, col. 8)	$(col. 5 \div col. 7)$	$(col. 6 \div col. 7)$	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
50	ANCILLARY SERVICE COST CE	NIERS							50
50 51	Operating Room Recovery Room								50 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 ServPrgm	n. Only							61
62	Whole Blood & Packed Red Blood								62
63	Blood Storing, Processing, & Transf	fusing							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 Patier								71
72	Implantable Devices Charged to Pat	ients							72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)							┨────┤	75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CH	ENTERS							00
88 89	Rural Health Clinic (RHC) Federally Qualified Health Center (F	FOHC)						╂────┤	88 89
90	Clinic	QHC)							90
90	Emergency								90
	Observation Beds								92
	Other Outpatient Service (specify)							1 1	93
	OTHER REIMBURSABLE COST (CENTERS							
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented	1							96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
200	Total (sum of lines 50 through 199)								200

APPORTIONMENT OF MEDICAL AND OTHER PROVIDER CCN PROVIDER CCN PROVIDER CCN PROVIDER CCN PART V Cleck [] Tale V-OP [] Isoprovider(Ohrs) [] Swing Bed SNF PART V Cleck [] Tale X-URL part I [] Isoprovider(Ohrs) [] Swing Bed SNF PART V Cleck [] Tale X-OP [] Isoprovider(Ohrs) [] Swing Bed SNF PART V Cleck [] Tale X-OP [] Isoprovider(Ohrs) [] Swing Bed SNF PART V Cleck [] Tale X-OP [] Isoprovider(Ohrs) [] Swing Bed SNF PART V Clear [Cong Reinburced Reinburced Reinburced PART V Class Cong [Cong PPS Services	4090	(Cont.)		FORM CM	IS-2552-10				1	0-12
Image: Construction of the second s	APPO	RTIONMENT OF MEDICAL AND OTHER			PROVIDER CCI	N:	PERIOD:		WORKSHEET D),
Check [] Tink V - OP [] Hospini [] Soluptovier (Ohm) [] Soluptovier (Ohm) [] Soluptovier (Ohm) boxe: [] Tink XIN - OP [] IIFF [] INF [] Soluptovier (Ohm) [] Soluptovier (Ohm) PRT V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SUBSCIPCES ONTS Program Charges Program Charges Program Charges Program Charges Program Charges Reinbured Sarvices Nat Reinbured Sarvices Nat </td <td>HEAL</td> <td>TH SERVICES COSTS</td> <td></td> <td></td> <td></td> <td></td> <td>FROM</td> <td></td> <td>PART V</td> <td></td>	HEAL	TH SERVICES COSTS					FROM		PART V	
applicable [] Tale XNU, Pu B [] BF [] SNF [] SNF [] SNF APRT V - APPORTIONMENT OF MEDICAL AND OTHER ILEALTI SERVICES COSTS Program Cost Cost Cost Cost Cost Cost Relaboration AND TO APPORTIONMENT OF MEDICAL AND OTHER ILEALTI SERVICES COSTS Eventsors Cost Cost Cost Soly cost Relaboration Relaboration Automatication of the Cost Cost Cost Cost Cost Cost Cost Cost					COMPONENT O	CCN:	то			
Losse: I Tute XN: - OP I IBF I IEF I CFMR PART V - APPORTIONMENT OF MEDICAL - NO PUBL	Check	[] Title V - O/P		[] Hospital	[] Subprov	ider (Other)	[] Swing Be	d SNF		
PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS Program Cost Relindenced Reviews Subject to<	applica	ble [] Title XVIII, Part B		[] IPF			[] Swing Be	d NF		
Cost 10 Charge PPS Ratio from Reinburged Workbeet C, 59rvice ND Cost Charge Reinburged Services ND Ded, & Coins (see inst.) Cost Reinburged Services ND Ded, & Coins (see inst.) Cost Reinburged Services ND Ded, & Coins (see inst.) Cost Reinburged Services ND Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) Cost Reinburged Services ND Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) Cost Cost Services ND Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) PPS Ded, & Coins (see inst.) PPS Ded, & Coins (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost (see inst.) Cost Cost Cost (see inst.) Cost Cost Cost Cost Cost Cost Cost Cost							[] ICF/MR			
Less base base base base base base base b	PART	V - APPORTIONMENT OF MEDICAL A	ND OTHER H	EALTH SERV	ICES COSTS					
o PS Reinburged Notice C Reinburged Subject to Ded. Ecc) Rein					Program Charges	s		Program Cost		
Charge Worksher C. PFS (weight of m) Worksher C. Services (see inst) Services (see in			Cost		Cost	Cost		Cost	Cost	
Ruito from Pur L col. 9 Reimburged Subject to pur L col. 9 Subject to Subject to (see inst.) Subject to Subject to (see inst.) Subject to (see inst.) Subject to (see inst.) Subject to (see inst.) ANCILLARY SERVICE COST CENTERS 1 2 3 4 5 6 7 Solution of the second Sec			to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$			Charge		Services	Services Not	PPS	Services	Services Not	
Part L col. 9 (see inst.)					5	5		5	5	
(A) Cost Centre Description 1 2 3 4 5 6 7 ANCILLARY SERVICE COST CENTERS				Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
AXCILLARY SERVICE COST CENTERS Image: Cost of CENTERS Image: Cost of CENTERS Image: Center CENTERS Image: CentENTERS Image: Center CENTERS			Part I, col. 9	(see inst.)		(see inst.)	(see inst.)	(see inst.)	(see inst.)	
90 Operating Room 90 90 91 91 Recovery Room 91 91 91 91 92 Labor & Delivery Room 91 91 91 91 91 92 Labor & Delivery Room 91 <td></td> <td></td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td></td>			1	2	3	4	5	6	7	
51 Recovery Room 51 52 Labor & Delivery Room 52 53 Anesthesiology 53 54 Radiology-Dargnostic 54 55 Radiology-Derapostic 55 56 Radiology-Derapostic 55 57 Radiology-Derapostic 55 58 Radiology-Derapostic 55 50 Radiology-Derapostic 55 57 Compact Orongraphy (CT) Scan 57 58 Magnetic Resonance Imaging (MRI) 59 50 Cardia Catheterization 59 60 Laboratory 60 61 PBY Cardia Catheterization 61 62 Whole Blood & Packed Red Blood Cells 64 63 Baod String, Processing, & Transfusing 64 64 Intravenous Therapy 64 65 Physical Interapy 64 66 Physical Interapy 64 67 Occupational Therapy 64 68 Packet All Blood Cells										
92 Labor & Delivery Room 93 13 Anesthesiology 93 14 Radiology-Dignostic 94 15 Radiology-Dignostic 94 15 Radiology-Dignostic 95 15 Radiology-Dignostic 95 15 Radiology-Therapeutic 95 15 Radiology-Organyly (CT) Scan 95 15 Cardiac Catheerization 95 16 16 96 17 Stagging (MRI) 96 18 16 96 18 16 161 18 160 61 18 160 62 18 160 62 18 160 62 18 160 63 161 17 163 162 Whole Blood Cells 64 163 160 164 161 164 18 163 163 165 160 164 164 165 160 164 164 <		· · ·								
53 Anssthesiology 53 54 Radiology-Disgnostic 54 55 Radiology-Therapeutic 55 56 Radiology-Therapeutic 56 57 Rodiology-Therapeutic 57 58 Radiology-Therapeutic 57 59 Rodiology-Therapeutic 57 59 Cardiac Catheterization 58 50 Cardiac Catheterization 59 60 1890 Chinica Laboratory Serv-Prgm. Only 60 61 1980 Chinica Laboratory Serv-Prgm. Only 61 62 18000 Könng, Processing, & Transfusing 62 63 1600 Könng, Processing, & Transfusing 63 64 68 66 66 Occupational Therapy 66 67 68 58 68 68 Fiscial Therapy 66 69 16 69 60 61 0ccupational Therapy 66 62 16 68 69 63 Speech Rathology 68 69 71 11 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>										
54 Radiology-Disposit 54 55 Radiology-Disposit 55 56 Radiology-Disposit 55 57 Statisticscope 56 57 Computed Tomography (CT) Scan 57 58 Magnetic Resonance Imaging (MRI) 58 50 Cardiac Catheerization 59 61 50 50 62 Wools Mood & Packet Red Blood Cells 60 63 Blood Storing, Processing, & Transfusing 61 64 63 64 63 66 64 64 63 67 0. 66 66 68 66 66 66 69 66 66 67 60 Cexpaintory Therapy 66 66 61 68 66 67 62 Resplintory Therapy 66 67 70 68 68 68 69 68 68 70 71 Medical Surplies Charged To Patients 71 72 71 73 73 73 Romal Dalayis 73 74 74 73 75 75 75		•								
55 Radiology-Therapeutic 55 56 Radioisotope 56 57 Compared Tomography (CT) Scan 57 58 Magnetic Resonance Imaging (MRI) 58 59 Cardia: Catheterization 59 60 Laboratory 60 61 PBP Chinical Laboratory Serv-Prgm. Only 60 61 PBP Chinical Laboratory Serv-Prgm. Only 61 62 Whole Blood & Packed Red Blood Cells 63 63 Blood Storing. Processing. & Transfusing 63 64 Intravenous Therapy 66 65 Occupational Therapy 66 66 Occupational Therapy 66 67 Occupational Therapy 66 68 Electrocardiology 69 71 Implantable Devices Charged to Patients 71 72 Drugs Charged to Patients 71 73 Torage Charged to Patients 72 74 Renal Dialysis 74 75 Other Ancillary (specify) 74 <td></td> <td></td> <td></td> <td></td> <td></td> <td> </td> <td>ļ</td> <td></td> <td></td> <td></td>							ļ			
56 Radinisotope 56 57 Computed Tomography (CT) Scan 57 58 Magnetic Resonance Imaging (MRI) 58 50 Cardiac Catheterization 59 60 Iaboratory 60 61 Eaboratory 60 62 Whole Blood & Packed Red Blood Cells 61 63 Blood String, Processing, & Transfusing 63 64 Intravenous Therapy 62 65 Go Storing, Processing, & Transfusing 63 66 Physical Therapy 64 67 Occupational Therapy 66 68 66 Coccupational Therapy 66 69 Electrocardiology 68 68 69 Electrocardiology 70 71 71 Implantable Devices Charaged to Patients 71 72 Ipplantable Devices Charaged to Patients 71 73 Drugs Charaged to Patients 73 74 Read Dialysis 74 75 76 Oth		6, 6								
57 Computed Tomography (CT) Scan 57 58 Magnetic Resonance Imaging (MRI) 58 9 Cardiac Catheterization 58 60 Laboratory 60 61 PBP Cinical Laboratory Serv-Prgm. Only 60 61 PBP Cinical Laboratory Serv-Prgm. Only 61 62 Whole Blood & Parked Red Blood Cells 62 63 Biodo Storing. Processing, & Transfusing 63 64 Intravenous Therapy 64 65 Occupational Therapy 64 66 Physical Therapy 66 67 Occupational Therapy 66 68 Pelseid Therapy 66 70 Carladia Supplies Charged to Patients 70 71 Medical Supplies Charged to Patients 71 72 Drugs Charged to Patients 72 71 Patients 73 73 Read Dialysis 74 74 Read Dialysis 74 75 Other Ancillary (specify) 75										
58 Magnetic Resonance Imaging (MRI) 58 59 Cardiac Catheterization 59 61 Laboratory 60 62 Whole Red Blood Cells 60 63 Blood Storing, Processing, & Transfusing 63 64 Intravenous Therapy 63 65 Respiratory Therapy 64 66 Physical Therapy 65 67 Occupational Therapy 66 68 Respiratory Therapy 66 60 Cocupational Therapy 66 70 Cocupational Therapy 66 71 Indianable Devices Charged to Patients 70 71 Indianable Devices Charged to Patients 71 71 Indianable Devices Charged to Patients 71 73 Prage Charged to Patients 73 74 Renal Dialysis 74 75 75 74 76 Other Ancillary (specify) 74 77 Renal Dialysis 74 78 Rest (Nacu										
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94Home Program DialysisImage: Constraint of the system9495AmbulanceImage: Constraint of the system9596Durable Medical Equipment-RentedImage: Constraint of the system9697Durable Medical Equipment-SoldImage: Constraint of the system9798Other Reimbursable Cost CenterImage: Constraint of the system98200Subtotal (see instructions)Image: Constraint of the system1mage: Constraint of the system201Less PBP Clinic Lab. Services-ProgramImage: Constraint of the system201Only ChargesImage: Constraint of the systemImage: Constraint of the system201			S							
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97 Durable Medical Equipment-Sold 97 98 Other Reimbursable Cost Center 98 200 Subtotal (see instructions) 98 201 Less PBP Clinic Lab. Services-Program Only Charges 01										
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200 Subtotal (see instructions) 200 200 201 Less PBP Clinic Lab. Services-Program Only Charges 201					1					
Only Charges					1					
Only Charges	201	Less PBP Clinic Lab. Services-Program								201
202 Net Charges (line 200 - line 201) 202		Only Charges								
	202	Net Charges (line 200 - line 201)								202

10-	12		FORM CMS-2552	2-10		4090 (Cont.)
COM	IPUTATION OF INPA	TIENT	PROVIDER CCN .:		PERIOD:	WORKSHEET D-1,	
OPEI	RATING COST				FROM	PART I	
			COMPONENT CCN.	:	то		
Chec	k	[] Title V - I/P	[] Hospital	[] Subprovider (other)	[] ICF/MR	[] PPS	
applic	cable	[] Title XVIII, Part A	[] IPF	[] SNF		[] TEFRA	
boxes	8:	[] Title XIX - I/P	[] IRF			[] Other	
PAR	T I - ALL PROVID	ER COMPONENTS					
			INPATIENT DAYS				
1	Inpatient days (includ	ling private room days and swing	g-bed days, excluding newbo	orn)			1
2	Inpatient days (includ	ling private room days, excluding	g swing-bed and newborn da	nys)			2
3	Private room days (ex	xcluding swing-bed and observat	tion bed days). If you have o	nly private room days, do not	complete this line.		3
4	Semi-private room da	ays (excluding swing-bed and ob	servation bed days)				4
5	Total swing-bed SNF	r type inpatient days (including p	private room days) through D	ecember 31 of the cost reporti	ng period		5
6	Total swing-bed SNF	F type inpatient days (including p	private room days) after Dece	ember 31 of the cost reporting	period (if		6
	calendar year, enter () on this line)					
7		type inpatient days (including pri	ivate room days) through De	cember 31 of the cost reportin	g period		7
8	Total swing-bed NF	type inpatient days (including pri	ivate room days) after Decen	nber 31 of the cost reporting p	eriod (if		8
	calendar year, enter () on this line)					
9	Total inpatient days i	ncluding private room days appl	icable to the Program (exclu	ding swing-bed and newborn d	lays)		9
10	Swing-bed SNF type	inpatient days applicable to title	XVIII only (including priva	te room days) through Deceml	ber 31 of the		10
	cost reporting period	l (see instructions).					
11	Swing-bed SNF type	inpatient days applicable to title	XVIII only (including priva	te room days) after December	r 31 of the		11
		l (if calendar year, enter 0 on this					
12	Swing-bed NF type i	npatient days applicable to titles	V or XIX only (including pr	ivate room days) through Dec	ember 31 of		12
	the cost reporting pe	riod.					
13	Swing-bed NF type i	npatient days applicable to titles	V or XIX only (including pr	ivate room days) after Deceml	ber 31 of the		13
	cost reporting period	(if calendar year, enter 0 on this	line)				
14	Medically necessary	private room days applicable to	the Program (excluding swin	ig-bed days)			14
15	Total nursery days (t	itle V or XIX only)					15
16	Nursery days (title V	or XIX only)					16
			SWING BED ADJUS	ГMENT			
17	Medicare rate for sw	ing-bed SNF services applicable	to services through Decemb	er 31 of the cost reporting per	iod		17
18	Medicare rate for sw	ing-bed SNF services applicable	to services after December 1	31 of the cost reporting period			18
19	Medicaid rate for sw	ing-bed NF services applicable t	o services through Decembe	r 31 of the cost reporting perio	od		19
20	Medicaid rate for sw	ing-bed NF services applicable t	o services after December 3	1 of the cost reporting period			20
21	Total general inpatien	nt routine service cost (see instru	(ctions)				21
22	Swing-bed cost appli	cable to SNF type services throu	igh December 31 of the cost	t reporting period (line 5 x line	: 17)		22
23	Swing-bed cost appli	cable to SNF type services after	December 31 of the cost re	porting period (line 6 x line 18	5)		23
24	Swing-bed cost appli	cable to NF type services throug	gh December 31 of the cost i	reporting period (line 7 x line 1	19)		24
25	Swing-bed cost appli	cable to NF type services after I	December 31 of the cost repo	orting period (line 8 x line 20)			25
26	Total swing-bed cost	(see instructions)					26
27	General inpatient rou	tine service cost net of swing-be	ed cost (line 21 minus line 26)			27
				FFERENTIAL ADJUSTMEN	Г		
28		tine service charges (excluding s	swing-bed and observation b	ped charges)			28
29	U	(excluding swing-bed charges)					29
30		narges (excluding swing-bed cha	e ,				30
31	1	tine service cost/charge ratio (lir					31
32		n per diem charge (line 29 ÷ line					32
33	<u> </u>	e room per diem charge (line 30 -					33
34		ivate room charge differential (lin	, ,	structions)			34
35		ivate room cost differential (line	,				35
36		ferential adjustment (line 3 x line	,				36
37	General inpatient rou	tine service cost net of swing-be	ed cost and private room cost	differential (line 27 minus line	e 36)		37

4090 (Cont.)]	FORM CMS-2552-1	0		1	10-12
COMPUTATION OF INPATIENT		PROVIDER CCN:		PERIOD:	WORKSHEET D-1	,
OPERATING COST				FROM	PART II	
	1	COMPONENT CC		ТО		
Check	[] Title V - I/P	[] Hospital	[]Subprovider (othe	er)	[] PPS	
applicable	[] Title XVIII, Part A	[] IPF			[] TEFRA	
boxes:	[] Title XIX - I/P	[] IRF			[] Other	
PART II - HOSPITAL AND SUBP						
PI	ROGRAM INPATIENT OPER				,	
	PASS-THROUGH COST				1	20
	tine service cost per diem (see in tine service cost (line 9 x line 38)	,				38 39
	(/					40
	nt routine service cost (line 39 +					40
41 Total Program general inpatie.	int fourne service cost (line 39 +	lille 40)	A 11040.00	1		41
	Total	Total	Average Dar Diam	Duo autom	Duo onomi Coast	
		Total	Per Diem	Program	Program Cost	
	Inpatient C	1 /	$(\operatorname{col.} 1 \div \operatorname{col.} 2)$	Days	(col. 3 x col. 4)	4
42 Number (title V & VIV1-)	1	2	3	4	5	40
42 Nursery (title V & XIX only)	nt .					42
Intensive Care Type Inpatien	ш					
Hospital Units						42
43 Intensive Care Unit 44 Coronary Care Unit						43
						44
45 Burn Intensive Care Unit 46 Surgical Intensive Care Unit						43
	:6)			+		40
47 Other Special Care Unit (spec	lly)				1	47
48 Program inpatient ancillary se	rvice cost (Worksheet D-3, colur	nn 3 line 200)			1	48
	(sum of lines 41 through 48) (see					49
49 Total Program inpatient costs	(sum of times 41 through 48) (see	(instructions)				49
	PASS-THROUGH COST	ADJUSTMENTS				
50 Pass through costs applicable	to Program inpatient routine serv		of Parts L and III)			50
<u> </u>	to Program inpatient ancillary set		,			51
52 Total Program excludable cos		vices (from vorksheet D, su	in of Funts IF und FV)			52
	ting cost excluding capital related	1 nonphysician anesthetist a	d medical education cos	ts		53
(line 49 minus line 52)	ting cost excluding cupital felates	i, nonpriysienan anesaletist, a	a mealear education cos			55
(line 4) linitas line 52)						-
	TARGET AMOUNT AND LI	MIT COMPLITATION				
54 Program discharges						54
55 Target amount per discharge						55
56 Target amount (line 54 x line 1	55)					56
	npatient operating cost and targe	t amount (line 56 minus line 5	3)			57
58 Bonus payment (see instruction	· · · · · · · · · · · · · · · · · · ·		57			58
	line 55 from the cost reporting pe	riod ending 1996 undated an	d compounded by the ma	rket basket		59
	line 55 from prior year cost report			iner busiter		6
	the lower of lines 55, 59 or 60 e	· · ·		ng costs		6
	d costs (lines 54 x 60), or 1 % of			-8		
(see instructions)		une auget anount (inte 50); e				
62 Relief payment (see instructio	ns)					62
	incentive payment (see instructio	ns)				6.
os i no vaoie nipariem cost pras	meenave payment (see msudens					0.
PI	ROGRAM INPATIENT ROUT	TINE SWING BED COST				
	atient routine costs through Dece		period (see instructions)			64
(title XVIII only)			F (*			
	atient routine costs after Decemb	er 31 of the cost reporting per	iod (see instructions)			65
(title XVIII only)			(1	
	F inpatient routine costs (line 64	plus line 65) (Title XVIII on	v. For CAH. see instruct	ions.)	1	66
	inpatient routine costs (line 04					67
¥	inpatient routine costs after Deco				1	68
	d NF inpatient routine costs (line		1 (10 / into 20	/	1	69
					- 1	

10-12		FOR	M CMS-2552-10			4090 (C	Cont.)		
COMPUTATION O OPERATING COST			PROVIDER CCN:		PERIOD: FROM	WORKSHEET D-1, PARTS III & IV			
			COMPONENT CCN:		TO				
Check	[] Title V - I/P		[] Hospital	[] Subprovider (other)	[] ICF/MR	[] PPS			
applicable boxes:	[] Title XVIII, Part A [] Title XIX - I/P	A	[] IPF [] IRF	[] SNF [] NF		[] TEFRA [] Other			
	ED NURSING FACILIT	Y, OTHER NURSING	11			[] •			
70 Skilled nursi	ng facility/other nursing fac	cility/ICF/MR routine serv	vice cost (line 37)				70		
71 Adjusted gen	eral inpatient routine servio	ce cost per diem (line 70	÷ line 2)				71		
	Program routine service cost (line 9 x line 71)								
ŭ	cessary private room cost a	,	e 14 v line 35)				72 73		
75 Wedically lie	cessary private room cost a	applicable to Flogram (in	ie 14 x line 55)				15		
74 Total Program	m general inpatient routine	service costs (line 72 + li	ne 73)				74		
75 Capital-relate	ed cost allocated to inpatien	nt routine service costs (fr	rom Worksheet B, Parts I	I, column 26, line 45)			75		
76 Per diem cap	ital-related costs (line 75 ÷	line 2)				_	76		
77 Program capi	ital-related costs (line 9 x li	ine 76)					77		
78 Inpatient rout	tine service cost (line 74 m	inus line 77)					78		
79 Aggregate ch	arges to beneficiaries for e	excess costs (from provide	er records)				79		
80 Total Program	n routine service costs for	comparison to the cost lir	nitation (line 78 minus lin	e 79)			80		
81 Inpatient rout	tine service cost per diem l	imitation					81		
82 Inpatient rout	tine service cost limitation	(line 9 x line 81)					82		
83 Reasonable i	npatient routine service cos	sts (see instructions)					83		
84 Program inpa	tient ancillary services (see	e instructions)					84		
85 Utilization re	view - physician compensa	ation (see instructions)					85		
86 Total Program	n inpatient operating costs	(sum of lines 83 through	85)				86		
PART IV - COMP	UTATION OF OBSERV	ATION BED PASS-TH	ROUGH COST						
87 Total observa	ation bed days (see instruct	tions)					87		
88 Adjusted gen	eral inpatient routine cost	per diem (line 27 ÷ line 2))				88		
	bed cost (line 87 x line 88)						89		
•		OBSERVATION BED	PASS THROUGH CO	ST					
					Total	Observation Bed			
			Routine Cost	column 1 ÷	Observation Bed Cost	Pass-Through Cost (col. 3 x col. 4)			
		Cost	(from line 27)	column 1 – column 2	(from line 89)	(col. 3 X col. 4) (see instructions)			
		1	2	3	4	5	1		
90 Capital-relate	ed cost						90		
, capital rolation				1	+				

 91
 Nursing School cost
 91

 92
 Allied Health cost
 92

 93
 All other Medical Education
 93

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4025.3 - 4025.4) Rev. 3

	0 (Cont.) FORM CM	1S-2552-10 PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	10-
	VICES RENDERED BY	FROVIDER CCN.	FROM	PARTS I-III	
	RNS AND RESIDENTS		то		
	Γ I - NOT IN APPROVED TEACHING PROGRAM			-	
		Percent of	Expense	Total Inpatient Days	Т
	Cost Centers	Assigned Time	Allocation 2	All Patients 3	-
1	Total cost of services rendered	100.00			
	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care)				┶
3	Intensive care unit				┿
4	Coronary care unit				+
5	Burn Intensive Care Unit				┿
6 7	Surgical Intensive Care Unit Other Special Care (specify)				┿
8	Nursery				+
9	Subtotal (sum of lines 2 through 8)				t
10	IPF - Inpatient routine service				t
11	IRF - Inpatient routine service				t
12	Subprovider (Other) - Inpatient routine service				T
13	Skilled Nursing Facility				t
14	Nursing Facility				T
15	Other Long Term Care				Г
16	Home Health Agency				
17	Outpatient Rehabilitation Providers				
18	Ambulatory Surgical Center				
19	Hospice				
20	Subtotal (sum of lines 9 through 19)				
				Total Charges	
				(from Worksheet C,	
				Part I, column 8,	
21	Hospital Outpatient Services:			lines 88 through 93)	+
21 22	Rural Health Clinic (RHC) Federally Qualified Health Center (FQHC)				┿
22	Clinic				┿
23	Emergency				╈
25	Observation beds				+
26	Other Outpatient Service (specify)				1
27	Subtotal (sum of lines 21 through 26)				Г
28	Total (sum of lines 20 and 27)	100.00			
ART	T II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PA		STS ONLY)	-	_
		Expenses Allocated			
		to cost centers		Net Cost	
		on Worksheet B, Part	0	(column 1 plus	
		columns 21 and 22	Amount	column 2)	_
20	Hospital Inpatient Routine Services:	1	2	3	╇
29 30	ý,				+
	Swing Bed - SNF Swing Bed - NF				÷
31 32	Intensive care unit				╋
32 33	Coronary care unit				┿
33 34	Burn Intensive Care Unit				+
35	Surgical Intensive Care Unit				+
36	Other Special Care (specify)				t
37	Subtotal (sum of lines 28, and 29 through 36)	1			t
38	IPF - Inpatient routine service				t
39	IRF - Inpatient routine service				Ť
_	Subprovider (Other)- Inpatient routine service				Т
41	Skilled Nursing Facility				Т
	Total (sum of lines 37 through 41)				Τ
RŢ	T III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY	IF BOTH PARTS I AND II ARE			_
_				d Teaching Program	1
			(from Part I)	Amount	
	Hospital		1	2	⊥
	Inpatient		column 9, line 9		L
44	Outpatient		column 9, line 27		L
	Total Hospital (sum of lines 43 and 44)				1
	IPF - Inpatient routine service		column 9, line 10		╇
	IRF - Inpatient routine service		column 9, line 11	1	1
47	Subprovider (Other)- Inpatient routine service		column 9, line 12		+-

48 Subprovider (Other)- Inpatient routine service

49 Skilled Nursing Facility

49

column 9, line 12

column 9, line 13

10-1	2			FORM CMS-2	552-10		4090 (C	Cont.)
APPO	RTIONMENT OF CO	ST OF			PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
	ICES RENDERED BY					FROM	PARTS I-III (Cont.)	
	RNS AND RESIDENT		DOCDAM			ТО	_	
PAKI	T I - NOT IN APPRO Average Cost		h Care Program Inpatier	t Dave	Title V	Title XVIII	Title XIX	T
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)	
	4	5	6	7	8	9	10	
1								1
								<u> </u>
2								2
3								3
5								5
6								6
7								7
8								8
9								9
10								10
11								11
13								13
14								14
15								15
16								16
17								17
18 19							1	18 19
20								20
	Ratio of Cost	Title	es V and XIX Outpatien	t and	Tit	les V and XIX Outpatier	nt and	
	to Charges		Title XVIII Part B Charg			Title XVIII Part B Cos		
	(column 2 ÷	Title	Title XVIII	Title	Title	Title XVIII	Title	
	column 3)	V	Part B	XIX	V	Part B	XIX	
21								21
22 23								22 23
23								23
25								25
26								26
27								27
28								28
PART	TII - IN AN APPROV	Average Cost	OGRAM (TTTLE XV	Expenses	IENT ROUTINE COS	IS ONLY)		-
	Total	Per Day	Title XVIII	Applicable				
	Inpatient Days -	(column 3 ÷	Part B	to Title XVIII				
	All Patients	column 4)	Inpatient Days	(col. 5 x col. 6)				
	4	5	6	7				
29								29
30								30
31								31 32
33								33
34								34
35								35
36								36
37								37
38 39								38
40								39 40
41								41
42								42
					RTS I AND II ARE US	ED)		
	In Approved Te		Total Title					
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				-
42	3 1ing 27	4	5	6				42
43	line 37							43 44
44			line 2					44
46	line 38		line 2					46
47	line 39		line 2					47
48	line 40		line 2					48
49	line 41		line 2					49

4090	0 (Cont.)		FORM CM	S-2552-10			10-12
-	TIENT ANCILLA	RY SERVICE		PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST	APPORTIONME	NT			FROM		
				COMPONENT CCN:	то		
Check		[] Title V	[] Hospital	[] Subprovider (other)	[] Swing-Bed SNF	[] PPS	
applica	able	[] Title XVIII, Part A	[] IPF	[] SNF	[] Swing-Bed NF	[] TEFRA	
boxes:	:	[] Title XIX	[] IRF	[] NF	[] ICF/MR	[] Other	
	COST CENTER	DESCRIPTION		Ratio of Cost	Inpatient	Inpatient Program Cos	sts
(A)	COST CENTER	DESCRIPTION		to Charges	Program Charges 2	(col. 1 x col. 2) 3	-
(11)	INPATIENT ROU	UTINE SERVICE COST CEN	TERS		2	5	
30		trics (General Routine Care)					30
31	Intensive Care U						31
32	Coronary Care U				_		32
33	Burn Intensive Ca Surgical Intensive				_		33 34
35	Other Special Ca						35
40	Subprovider IPF	((F))					40
41	Subprovider IRF						41
42	Subprovider (Spe	ecify)					42
43	Nursery						43
50	T	RVICE COST CENTERS					50
50	Operating Room Recovery Room						50
52	Labor Room and	Delivery Room			1	1	52
53	Anesthesiology	,					53
54	Radiology-Diagn						54
55	Radiology-Therap	peutic					55
56	Radioisotope	1 (07) 0					56
57 58	Computed Tomog	graphy (CT) Scan ance Imaging (MRI)					57 58
59	Cardiac Catheter						59
60	Laboratory	ization					60
61		oratory Services-Prgm. Only					61
62	Whole Blood & I	Packed Red Blood Cells					62
63		rocessing, & Trans.					63
64	Intravenous Ther						64
65 66	Respiratory Thera Physical Therapy					-	65 66
67	Occupational The						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalo						70
71		Charged to Patients					71
72	Implantable Devi Drugs Charged to	ces Charged to Patients					72
	Renal Dialysis						73
75	ASC (Non-Distin	nct Part)			1		75
	Other Ancillary (,					76
		ERVICE COST CENTERS					
88	Rural Health Clin						88
89		ed Health Center (FQHC)					<u>89</u> 90
<u>90</u> 91	Clinic Emergency						90
92		s (see instructions)			1	1	91
93	Other Outpatient						93
		JRSABLE COST CENTERS					
94	Home Program D	-					94
95	Ambulance Servi						95
96 97		Equipment-Rented					96 97
97	Durable Medical Other Reimbursa	••					97
200		es 50-94 and 96-98)					200
201		Laboratory Services-Program o	nly charges (line 61)				201
-		e 200 minus line 201)					202

(A) Worksheet A line numbers

10-12	FOF	RM CMS-	2552-10		4090 (Cont.)		
COMPUTATION OF ORGAN ACQ	UISITION COSTS AND	CHARGES		PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR HOSPITALS WHICH ARE CE	RTIFIED TRANSPLANT	CENTERS			FROM	PART I	
				OPO CCN:	то		
Check	[] HEART	[] LIVER	[] PAN	ICREAS	[] ISLET		
applicable box:	[] KIDNEY	[] LUNG	[] INT	ESTINE	[] OTHER (specify)		

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

	Inpatient			Organ		
Computation of Inpatient	Routine Organ		Per Diem Costs	Acquisition	Cost	
Routine Service Costs	Charges		(from Wkst. D-1, Part II)	Days	(col. 2 x col. 3)	
Applicable to Organ Acquisition	1	D	2	3	4	ĺ
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 1-6)						7

			Ratio of Cost to Charges	Organ Acquisition	Organ Acquisition	
Cor	nputation of Ancillary		(from	Ancillary	Ancillary	
	vice Costs Applicable		Wkst. C)	Charges	Costs	
	Drgan Acquisition	С	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 8-40)					41

C = Worksheet C line numbers

D = Worksheet D-1 line numbers

4090 (Cont.)	FORM	CMS-2552-10			10-12
COMPUTATION OF ORGAN ACQUISIT FOR HOSPITALS WHICH ARE CERTIFI		PROVIDER CCN: OPO CCN:	PERIOD: FROM TO	WORKSHEET D-4, PART II	
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)	

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

	Computation of the Cost of Inpatient		Average Cost Per Day		Organ Acquisition	
	Services of Interns and Residents Not		(from Wkst. D-2,	Organ	Costs	
	In Approved Teaching Program		Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)	
		D	1	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

		0		Ratio of Cost	Organ	
	Computation of the Cost of Outpatient	Organ		to Charges	Acquisition	
	Services of Interns and Residents Not	Charges		from Wkst. D-2,	Costs	
	In Approved Teaching Program	(see instructions)		Part I, col. 4)	(col. 1 x col. 2)	
		1	D	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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4028.2)

10-12		FORM CMS-2552-10				
COMPUTATION OF ORGAN ACQUISITION	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,			
FOR HOSPITALS WHICH ARE CERTIFIED		FROM	PARTS III & IV			
			OPO CCN:	то		
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET		
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)		

PART III - SUMMARY OF COSTS AND CHARGES

		Cost		Cha	irges	
		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 Services of Teaching Physicians (Wkst. D-5, Part II)					60
61	Total (sum of lines 56 thru 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					64
	Organs (line 63 ÷ line 62)					
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 thru 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 are included in the count.

409	0 (Cont.)	F	ORM CMS-2552-	-10			1	10-12
APPC	RTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIAN	18			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART I	
Checl	applicable box: [] Hospital Staff [] Med	ical Staff						
PART	I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION	-		1		1		
Line No.	<u>Specialty</u> 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.	<u>Specialty</u> 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	-
	General Practitioner Family Practice							1
-	Internal Medicine	_						2
	Surgery							3
	Pediatrics							4
	Obstetrics-Gynecology							5
	Radiology							6
	Psychiatry							7
	Anesthesiology							8
	Pathology							9
	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

10-12	4090 (Cont.)			
APPORTIONMENT OF COST FOR THE SERVICE	S OF TEACHING PHYSICIANS	PROVIDER CCN:	PERIOD:	WORKSHEET D-5,
			FROM	PART II
			то	
Check	[] Hospital	[] IPF		
applicable box:	[] IRF	[] Subprovider (other)		

PART II - APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS

		Hospital Staff	Faculty	$(col \ 1 + col \ 2)$	
		1	2	3	
1 Adjusted Cost of Physic	ian's Direct Medical and Surgical Services				1
2 Total Inpatient Days an	1 Outpatient Visit Days				2
3 Average Per Diem (line	1 ÷ line 2)				3

L

Medical School

Total

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 31 to Worksheet D-4, Part III, line 60

4090 (Cont.)	FORM CMS-2552-10			10-12
CALCULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTLEMENT		FROM	PART A	
	COMPONENT CCN:	то		

Check	[] Hospital
applicable box:	[] Subprovider (Other)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG amounts other than outlier payments	1
2	Outlier payments for discharges (see instructions)	2
2.01	Outlier reconciliation amount	2.01
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	5
-	before 12/31/1996 (see instructions)	
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in	6
-	in accordance with 42 CFR 413.79(e)	
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2)	7.01
	If the cost report straddles July 1, 2011 then see instructions.	
8		8
	with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register,	
	page 50069, August 1, 2002.	
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA.	8.01
	If the cost report straddles July 1, 2011, see instructions.	
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under	8.02
	section 5506 of ACA. (see instructions)	
9		9
10	FTE count for allopathic and osteopathic programs in the current year from your records	10
11		11
12		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		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		20
21	Enter the lesser of lines 19 or 20 (see instructions)	21
22	IME payment adjustment (see instructions)	22
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 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 (see instructions)	27
28	IME Adjustment (see instructions)	28
29	Total IME payment (sum of lines 22 and 28)	29
	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 days reported on Worksheet S-2, Part I, line 24. (see instructions)	31
32	Sum of lines 30 and 31	32
33	Allowable disproportionate share percentage (see instructions)	33
34		34

10-12		FORM CMS-	-2552-10		4090 (Cont.)
CALCULATION OF REIMBURS	SEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT				FROM	PART A (Cont.)
			COMPONENT CCN:	то	
Check	[] Hospital	[] IPF			

Check	[] Hospital	[] IPF
applicable box:	[] IRF	[] Subprovider (other)
	-	

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

10	Additional payment for high percentage of ESRD beneficiary discharges	
40	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683,	40
4.4	684 and 685 (see instructions)	
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)	41
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 an 685 (see instructions)	43
44	Ratio of average length of stay to one week (line 43 divided by line 41 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)	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 SCH and MDH only (see instructions)	49
50	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	50
51	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)	51
52	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).	52
53	Nursing and allied health managed care payment	53
54	Special add-on payments for new technologies	54
55	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	55
56	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	56
57	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	57
58	Ancillary service other pass through costs Worksheet D, Part 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 applicable to MS-DRG (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
0.95	Recovery of Accelerated depreciation	70.95
0.96	Low Volume Adjustment for Federal Fiscal year 2011	70.96
0.97	Low Volume Adjustment for Federal Fiscal year 2012	70.97
71	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	71
72		72
73	Tentative settlement (for contractor use only)	73
74	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	75

TO BE COMPLETED BY CONTRACTOR90Operating outlier amount from Worksheet E, Part A line 2 (see instructions).9091Capital outlier from Worksheet L, Part I, line 29192Operating outlier reconciliation adjustment amount (see instructions)9293Capital outlier reconciliation adjustment amount (see instructions)9394The rate used to calculate the Time Value of Money (see instructions)9495Time Value of Money for operating expenses (see instructions)9596Time Value of Money for capital related expenses (see instructions)96

409	0 (Cont.) FORM CMS-2	2552-10		10-12
CALC	CULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,
REIM	BURSEMENT SETTLEMENT		FROM	PART B
		COMPONENT CCN:	то	
Check	applicable box: [] Hospital [] IPF [] IRF [] Subprovid	der (Other) [] SNF		
	Γ 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	PPS payments			3
4				4
5				5
6				6
7	Sum of line 3 and line 4 divided by line 6			7
8				8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 1	13. line 200		9
10				10
11	0 1			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12	Ancillary service charges			12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			12
14				14
	Customary charges			11
15	Aggregate amount actually collected from patients liable for payment for service	es on a charge basis		15
16				16
10	basis had such payment been made in accordance with 42 CFR 413.13(e)	vices on a charge		10
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 exce	and s line 11) (see instructions)		19
20	Excess of customary charges over reasonable cost (complete only if line 1) exce			20
20	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	(see instructions)		20
21	Interns and residents (see instructions)			21
22	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 1.	5 1 82148)		22 23
23		5-1, §2146)		23
24	COMPUTATION OF REIMBURSEMENT SETTLEMENT			24
25	Deductibles and coinsurance (see instructions)			25
25	Deductibles and Coinsurance (see instructions) Deductibles and Coinsurance relating to amount on line 24 (see instructions)			23
20		and 221 (see instructions)		20
_	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 Direct graduate medical education payments (from Workshort E.4, line 50)	and 23} (see instructions)		27
28	Direct graduate medical education payments (from Worksheet E-4, line 50) ESRD direct medical education costs (from Worksheet E-4, line 36)			28
30	Subtotal (sum of lines 27 through 29)			30
30	Primary payer payments			30
31				31
52	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONA	I SERVICES)		32
33	Composite rate ESRD (from Worksheet I-5, line 11)	L SEX (ICEO)		33
33	Allowable bad debts (see instructions)			34
	Adjusted reimbursable bad debts (see instructions)			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)			36
30	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider or	nlv)		37
38	MSP-LCC reconciliation amount from PS&R	шу)		38
39	Other adjustments (specify) (see instructions)			39
40	Subtotal (line 37 plus or minus lines 39 minus 38)			40
40	Interim payments			40
41	1 Y			41 42
	Tentative settlement (for contractors use only) Balance due provider/program (line 40 minus the sum of lines 41, and 42)			42 43
43		the 15 H spotion 115 2		43
44	riolested amounts (nonanowable cost report tients) in accordance with CMS Pu	10. 13-11, Section 113.2		44

10-12		FORM CMS-2	2552-10		4090 (Cont.)
CALCULATION OF			PROVIDER CCN:	PERIOD:	WORKSHEET E,
REIMBURSEMENT SET	TLEMENT			FROM	PART B (Cont.)
			COMPONENT CCN	то	
Check applicable box	[] Hospital [] IPF	[] IRF [] Subprovider(Oth	er) [] SNF		-
PART B - MEDICAL A	ND OTHER HEALTH S	ERVICES			
TO BE COMPLETED BY CONTRACTOR					
00 Original outlier am	ount (see instructions)				90

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

4090 (Cont.)			FORM	CMS	-2552-10				10-12
ANALYSIS OF PAY FOR SERVICES RE		IDERS	PROVIDER CCN:			PERIOD: FROM	-	WORKSHEET E-1, PART I	
			COMPONENT CCN			то	-		
Check	[] Hospital	[] Subprovider (Other)				patient			
applicable	[] IPF	[] SNF				Part A		Part B	
box:	[] IRF	[] Swing-Bed SNF			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Description					1	2	3	4	
	payments paid to pro								1
		idual bills, either submitted or to be supporting period. If none, write "NONE"							2
	y each retroactive			.01					3.01
	ustment amount base	d		.02					3.02
on subsequent	t revision of the		Program to	.03					3.03
	or the cost reporting p	period.	Provider	.04					3.04
Also show dat	te of each payment.			.05					3.05
If none, write	"NONE" or enter a	zero. (1)		.50					3.50
				.51					3.51
			Provider to	.52					3.52
			Program	.53					3.53
			Ũ	.54					3.54
Subtotal (sum	of lines 3.01- 3.49 r	ninus sum of lines 3.50-3.98)		.99					3.99
4 Total interim	payments (sum of lin	es 1, 2, and 3.99)							4
(transfer to W	kst. E or Wkst. E-3,	line							
and column as									
TO BE COM	PLETED BY CONT	RACTOR							
5 List separately	y each tentative settle	ement	Program to	.01					5.01
payment after	desk review. Also sl	how	Provider	.02					5.02
date of each p	ayment.			.03					5.03
If none, write	"NONE" or enter a	zero. (1)		.50					5.50
			Provider to	.51					5.51
			Program	.52					5.52
Subtotal (sum	of lines 5.01-5.49 m	inus sum of lines 5.50 -5.98)		.99					5.99
6 Determined n	et settlement amount	(balance	Program to provider	.01					6.01
	the cost report (1)		Provider to program	.02					6.02
7 Total Medicar	re program liability (see instructions)	·						7
8 Name of Con	tractor				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.

10-12		FORM CMS-2552	-10		4090 (Cont.)
CALCULATION OF REIMBURS	EMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-1,
SETTLEMENT FOR HIT				FROM	PART II
			COMPONENT CCN:	то	
Check	[] Hospital	[] CAH			
Applicable box:					

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I, line 14, column 15	1
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2
3	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	3
4	Total inpatient <i>days</i> from S-3, Part I, column 8 sum of lines 1, 8-12	4
5	Total hospital charges from Wkst C, Part I, column 8 line 200	5
6	Total hospital charity care charges from Wkst S-10, column 3 line 20	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part I line 168	7
8	Calculation of the HIT incentive payment (see instructions)	8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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

4090(Cont.)	FORM CMS-2552-10			
CALCULATION OF REIMBURSEMENT	PR	ROVIDER CCN:	PERIOD:	WORKSHEET E-2
SETTLEMENT - SWING BEDS			FROM	
	CO	COMPONENT CCN:	то	

Т

		PART A	PART B	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	2	1
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, column 3, line 200 for Part A, and sum of Wkst. D, Part V,			3
	columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			
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			11
	services)			
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for			13
	physician professional services)			
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
17	Reimbursable bad debts (see instructions)			17
18	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (sum of lines 15 and 17, plus/minus line 16)			19
20	Interim payments			20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus the sum of lines 20 and 21)			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,			23
	section 115.2			

10-12

T

10-12	FORM CM	MS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSE	MENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART I
		COMPONENT CCN:	то	

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER - TEFRA

1	Inpatient hospital services (see instructions)	
2	Organ acquisition	2
3	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	3
4	Subtotal (sum of lines 1 thru 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 Worksheet 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
18	Total amount payable to the provider (see instructions)	18
19	Interim payments	19
20	Tentative settlement (for contractor use only)	20
21	Balance due provider/program (line 18 minus the sum lines 19 and 20)	21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	22

4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT

FORM CMS-2552-10

PROVIDER CCN: PERIOD: FROM _ PART II COMPONENT CCN: TO

10-12 WORKSHEET E-3,

Check	[] Hospital		
applicable	[] Subprovider IPF		
box:			

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	
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,	4.01
	that would not be counted without a temporary cap adjustment under $\frac{1}{2} \frac$	
5	New teaching program adjustment (see instructions)	5
6	Current year unweighted FTE count of L&R other than FTEs in the first 3 years of a "new teaching program" (see instructions)	6
7	Current year unweighted I&R FTE count for residents within the first 3 years 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	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	10
11	Medical Education 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 instruction)	13
14	Organ acquisition	14
15	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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		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 Worksheet 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
31	Total amount payable to the provider (see instructions)	31
32	Interim payments	32
33	Tentative settlement (for contractor use only)	33
34	Balance due provider/program (line 31 minus the sum lines 32 and 33)	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 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

10-12

FORM CMS-2552-10

4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: PERIOD: ______ FROM _____ COMPONENT CCN: TO _____

PERIOD: WORKSHEET E-3, FROM _____ PART III TO _____

Check	[] Hospital		
applicable	[] Subprovider IRF		
box:			

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	5
	on or prior to November 15, 2004 (see instructions)	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure,	5.01
	that would not be counted without a temporary cap adjustment under $\frac{1}{1} \frac$	
6	New teaching program adjustment (see instructions)	6
7	Current year unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program" (see instructions)	7
8	Current year unweighted I&R FTE count for residents within the first 3 years of a "new teaching program" (see instructions)	8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)	9
10	Average daily census (see instructions)	10
11	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	11
12	Medical Education Adjustment (line 1 multiplied by line 11).	12
13	Total PPS Payment (sum of lines 1, 3, 4 and 12)	13
14	Nursing and Allied Health Managed Care payment (see instructions)	14
15	Organ acquisition	15
16	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (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 Worksheet 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
32	Total amount payable to the provider (see instructions)	32
33	Interim payments	33
34	Tentative settlement (for contractor use only)	34
35	Balance due provider/program (line 32 minus the sum lines 33 and 34)	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	36

	TO BE COMPLETED BY CONTRACTOR	
50	Original outlier amount from Worksheet E-3, Part 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

4090 (Cont.)

FORM CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: PERIOD: WORKSHEET E-3, COMPONENT CCN: FROM ______ PART IV

Check	[] Hospital		
applicable	[] Subprovider (Other)		
box:			

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	1
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	5
6	Cost of teaching physicians	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 Worksheet E-4, line 49 (for freestanding LTCH only)	18
19	Other pass through costs (see instructions)	19
20	Outlier payments reconciliation	20
21	Other adjustments (specify) (see instructions)	21
22	Total amount payable to the provider (see instructions)	22
23	Interim payments	23
24	Tentative settlement (for contractor use only)	24
25	Balance due provider/program (line 22 minus the sum lines 23 and 24)	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	26

TO BE COMPLETED BY CONTRACTOR

	TO BE COMPLETED DT CONTRACTOR		
50	Original PPS payment and outlier amount from Worksheet E-3, Part IV, line 3 (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

10-12		
CALCUL	ATION OF REIMBURSEMENT S	SETT

FORM CMS-2552-10

4090 (Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: PERIOD: WOR _____ FROM ____ PAR' COMPONENT CCN: TO _____

WORKSHEET E-3, PART V

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

1	Inpatient services	1
2	Nursing and allied health managed care payment (see instruction)	2
3	Organ acquisition	3
4	Subtotal (sum of lines 1 thru 3)	4
5	Primary payer payments	5
6	Total cost (line 4 less line 5) (For CAH, 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	12
	a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	13
14	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 teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	Direct graduate medical education payments (from Worksheet E-4, line 49)	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 (<i>line 19 minus line 20</i>)	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
30	Subtotal (line 28, plus or minus line 29)	30
31	Interim payments	31
32	Tentative settlement (for contractor use only)	32
33	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	34

4090	(Cont.))
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FORM CMS-2552-10

10-12

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

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

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

10-12		FORM CMS-2552-10)		4090 (Cont.)
CALCULATION OF RE	EIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
				FROM	PART VII
			COMPONENT CCN:	то	
Check	[] Title V	[] Hospital	[] NF	[] PPS	
applicable	[] Title XIX	[] Subprovider	[] ICF/MR	[] TEFRA	
hoxes.		[].SNF		[] Other	

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

		Inpatient	Outpatient	
		Title V or	Title V or	
	COMPUTATION OF NET COST OF COVERED SERVICES	Title XIX	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			14
	on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			
15	Ratio of line 13 to line 14 (not to exceed 1.000000)			15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16			17
	exceeds line 4) (see instructions)			
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of teaching physicians (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	ļ		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 $36 \pm \text{line } 37$)	ļ		38
39	Direct graduate medical education payments (from Worksheet 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 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	ļ		43

4090 (Co	·		DEDIOD	WORKSTER	10-12
	ADUATE MEDICAL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
	TPATIENT DIRECT MEDICAL		FROM	-	
EDUCATION			ТО	-	
Check	[] Title V [] Title XVIII				
applicable					
box:	[] Title XIX				
	IPUTATION OF TOTAL DIRECT GME AMOUNT veighted resident FTE count for allopathic and osteopathic programs for cost report	ina naniada andina an an	hafara Daaamhar 21, 10	06	1
	veighted FTE - resident cap add-on for new programs per 42 CFR 413.79(e)(1) (se		before December 51, 19	90	2
	bunt of r eduction to Direct GME c ap u nder § 422 of MMA	ee instructions)			3
	ect GME cap reduction amount under ACA §5503 in accordance with CFR §413.7	70 (m) (see instructions			3.01
	cost reporting periods straddling 7/1/2011)	> (m). (see instructions			5.01
4 Adju	ustment (plus or minus) to the FTE cap for allopathic and osteopathic programs di	ue to a Medicare GME			4
-	iation agreement (42 CFR §413.75(b) and § 413.79 (f))				
	\$5503 increase to the direct GME FTE cap (see instructions for cost reporting p	eriods straddling 7/1/20	11)		4.01
	\$5506 number of additional direct GME FTE cap slots (see instructions for cost				4.02
-	Cadjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lin				5
	veighted resident FTE count for allopathic and osteopathic programs for the current				6
	er the lesser of line 5 or line 6	year nom your records	(see instructions)		7
/ Ente		Primary Care	Other	Total	,
		1	2	3	
8 Weis	ghted FTE count for physicians in an allopathic and osteopathic program for			5	8
	current year				0
	the 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times				9
	result of line 5 divided by the amount on line 6				
	ghted dental and podiatric resident FTE count for the current year				10
	Il weighted FTE count				11
	Il weighted resident FTE count for the prior cost reporting year (see instructions)				12
	Il weighted resident FTE count for the penultimate cost reporting year (see instr.)				13
	ing average FTE count (sum of lines 11 through 13 divided by 3)				13
	ustment for residents in initial years of new programs				15
	ustment for residents displaced by program or hospital closure	1			16
	usted rolling average FTE count				17
	resident amount				18
	roved amount for resident costs				19
	itional unweighted allopathic and osteopathic direct GME FTE resident cap slots re	eceived under 42 Sec. 41	3.79(c)(4)		20
	ect GME FTE <u>unweighted</u> resident count over cap (see instructions)				21
	wable additional direct GME FTE resident count (see instructions)				22
	er the locality adjustment national average per resident amount (see instructions)			1	23
	tiply line 22 time line 23			1	24
	al direct GME amount (sum of lines 19 and 24)				25
	MPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
	tient days		Ĭ		26
	al inpatient days (see instructions)				27
28 Ratio	o of inpatient days to total inpatient days				28
	gram direct GME amount				29
30 Redu	uction for direct GME payments for Medicare managed care				30
	Program direct GME amount				31
DIR	ECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURSI	ING SCHOOL AND		
PAR	RAMEDICAL EDUCATION COSTS)				
32 Rena	al dialysis direct medical education costs (from Worksheet B, Part I, sum of column	ns 20 and 23, lines 74 an	d 94)		32
33 Rena	al dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of	lines 74 and 94)			33
34 Ratio	o of direct medical education costs to total charges (line 32 ÷ line 33)				34
35 Med	licare outpatient ESRD charges (see instructions)				35
36 Med	licare outpatient ESRD direct medical education costs (line 34 x line 35)				36

10-12	FORM CMS-2552-10			4090 (Cor	nt.)	
DIREC	F GRADUATE MEDICAL EDUCATION (GME)	I	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRI	O OUTPATIENT DIRECT MEDICAL			FROM	(Cont.)	
EDUCA	ATION COSTS			то		
Check	[] Title V			-		
applical	[] Title XVIII					
box:	[] Title XIX					
	APPORTIONMENT OF MEDICARE REASONABLE COST OF	FGME				
	Part A Reasonable Cost					
37	Reasonable cost (see instructions)					37
38	Organ acquisition costs (Worksheet D-4, Part III, column 1, line	69)				38
39	Cost of teaching physicians (Worksheet D-5, Part II, column 3, lin	ne 20)				39
40	Primary payer payments (see instructions)					40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus lin	ne 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 \div	line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 \div	line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWE	EEN PART A AND PAR	RT 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

4090	0 (Cont.)	FORM CMS-2552-10			10-	-12
BALA	ANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you	are nonproprietary and do not maintain fund-type			FROM	_	
accou	nting records, complete the General Fund column only)			то		
	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit cents)	1	2	3	4	
1	CURRENT ASSETS		1	1		1
2	Cash on hand and in banks			-		2
3	Temporary investments Notes receivable					3
4	Accounts receivable					4
4						5
6						6
0	accounts receivable					0
7	Inventory					7
8	· · · · · · · · · · · · · · · · · · ·					8
9	· · · ·					9
10						10
11	Total current assets (sum of lines 1-10)					11
	FIXED ASSETS					
12						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	· · · · · · · · · · · · · · · · · · ·					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
21	OTHER ASSETS			<u>т</u>	- I	21
	Investments					31
32	Deposits on leases			+		32
33	Due from owners/officers					33
34			_	+		34
35	Total other assets (sum of lines 31-34)			+		35
36	Total assets (sum of lines 11, 30, and 35)					36

10-12 FORM CMS-2552-10		4090 (Co	ont.)			
BALA	NCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you	a are nonproprietary and do not maintain fund-type			FROM	_ (CONT.)	
accou	nting records, complete the General Fund column only	()		то		
			Specific			
	Liabilities and Fund	General	Purpose	Endowment	Plant	
	Balances	Fund	Fund	Fund	Fund	
	(Omit cents)	1	2	3	4	
	CURRENT LIABILITIES					
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					45
	lines 37 thru 44)					
	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					50
	lines 46 thru 49)					
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					54
	balance - restricted					
55	Donor created - endowment fund					55
	balance - unrestricted					
56	Governing body created - endowment					56
	fund balance					
57	Plant fund balance - invested in plant					57
58	*					58
	improvement, replacement, and expansion					
59	Total fund balances (sum of lines 52 thru 58)					59
60	Total liabilities and fund balances (sum of					60
	lines 51 and 59)					

4090 (Cont.)	FORM CMS-2552-10							10-12	
STATEMENT OF CHANGES IN FUND BALANCES				PROVIDER CC	N: -	PERIOD: FROM TO		WORKSHEET	Г G-1
	GENER	AL FUND		JRPOSE FUND		MENT FUND	PLANT F		
	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									19
sheet (line 11 minus line 18)									

10-12	FORM CMS-2552-10	4090 (Cont.)	
STATEMENT OF PATIENT REVENUES	PROVIDER CCN:	PERIOD:	WORKSHEET G-2,
AND OPERATING EXPENSES		FROM	PARTS I & II
		ТО	

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital				1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)				10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive care unit				11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of				16
	of lines 11-15)				
17	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				28
	Worksheet G-3, line 1)				

PART II - OPERATING EXPENSES

		1	2	l l
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

4090 (Cont.)	FORM CMS-2552-10	10-12
STATEMENT OF REVENUES	PROVIDE <i>R CCN:</i> PERIOD:	WORKSHEET G-3
AND EXPENSES	FROM	
	ТО	

	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 <i>other miscellaneous communication</i> 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

10-12 FORM CMS-2552-10											ont.)
ANALYSIS OF PROVIDER-BASED				PROVIDER CO	CN:	PERIOD:		WORKSHEET H			
HOME HEALTH AGENCY COSTS								FROM			
						HHA CCN:		то			
			TRANSPOR-	CONTRACTED/				RECLASSIFIED		NET	
	SALARIES	EMPLOYEE	TATION	PURCHASED		TOTAL		TRIAL		EXPENSES FOR	
COST CENTER DESCRIPTIONS		BENEFITS	(see	SERVICES		(sum of cols.	RECLASS-	BALANCE		ALLOCATION	
(omit cents)			instructions)		OTHER COSTS	1 thru 5)	IFICATIONS	(col. 6 + col. 7)	ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·	
	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											<u> </u>
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			1				l				23
24 Total (sum of lines 1-23)											24

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

4090 (Cont.)			1	0-12					
COST ALLOCATION - HHA GENERAL SERVICE COST				PROVIDER CCN:		PERIOD:		WORKSHEET H-1	l
						FROM		PART I	
				HHA CCN:		ТО			
	NET EXPENSES		ITAL						
	FOR COST	RELATED COSTS							
	ALLOCATION			PLANT			ADMINIS-		
	(from Wkst.	BLDGS. &	MOVABLE	OPERATION &	TRANS-	SUBTOTAL	TRATIVE	TOTAL	
	H, col. 10)	FIXTURES	EQUIPMENT	MAINTENANCE	PORTATION	(cols. 0-4)	& GENERAL	(cols. 4a + 5)	
	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 1-23)									24

10-1	2	FORM CMS-255	4090 (Cont.)					
COST	ALLOCATION - HHA STATISTICAL BASIS		PROVIDER CCN:	PERIOD:		WORKSHEET H-1	,	
					FROM		PART II	
			HHA CCN:		ТО			
			PITAL					
			ED COSTS	PLANT			ADMINIS-	
		BLDGS. &	MOVABLE	OPERATION &			TRATIVE	
		FIXTURES	EQUIPMENT	MAINTENANCE	TRANS-		& GENERAL	
		(SQUARE	(DOLLAR	(SQUARE	PORTATION	RECONCIL-	(ACCUM.	
		FEET)	VALUE)	FEET)	(MILEAGE)	IATION	COST)	_
		1	2	3	4	5a	5	<u> </u>
	GENERAL SERVICE COST CENTERS							
	Capital Related-Bldgs. and Fixtures							1
	Capital Related-Movable Equipment							2
	Plant Operation & Maintenance							3
	Transportation (see instructions)							4
5	Administrative and General							5
	HHA REIMBURSABLE SERVICES							<u> </u>
	Skilled Nursing Care							6
	Physical Therapy							7
	Occupational Therapy							8
	Speech Pathology							9
	Medical Social Services							10
	Home Health Aide							11
	Supplies (see instructions)							12
	Drugs DME							13 14
14								14
15	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services							15
	Respiratory Therapy							15 16
	Private Duty Nursing		}	}			+	16
	Clinic		<u> </u>	<u> </u>				17
_	Health Promotion Activities			<u> </u>				18
	Day Care Program		<u> </u>	<u> </u>				20
	Home Delivered Meals Program		<u> </u>	<u> </u>				20
	Home Derivered Means Program Homemaker Service							21
	All Others							22
	Total (sum of lines 1-23)		1	1				23
	Cost To Be Allocated (per Worksheet H-1, Part I)							25
	Unit Cost Multiplier							26
20	One Cost Multiple		I	1	1			20

409	0 (Cont.)			FORM CI	MS-2552-10						1	0-12
	OCATION OF GENERAL SERVICE 'S TO HHA COST CENTERS							·	WORKSHEET H-2, PART I			
				CAF	HHA CCN: PITAL			то		 		
		From	HHA		D COSTS							
	HHA COST CENTER	Wkst. H-1	TRIAL		MOVADLE		GUDTOTAL	ADMINIS-	MAIN-	ODEDATION	LAUNDRY	
	(omit cents)	Part I, col. 6,	BALANCE (1)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	& LINEN SERVICE	
		line	0	1	2	4	4A	5	6	7	8	1
1	Administrative and General	5										1
2	Skilled Nursing Care	6										2
	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
	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
	Homemaker Service	22										18
19	All Others	23										19
	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1 divided by		, line 20									21
	minus column 26, line 1, rounded to 6 decimal places.											

(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.

10-1	2	FORM CM	MS-2552-10							4090 (Cont.)			
	CATION OF GENERAL SERVICE S TO HHA COST CENTERS			PROVIDER CCN: PERIOD: FROM FROM HHA CCN: TO				WORKSHEET H-2, PART I (CONT.)					
	HHA COST CENTER (omit cents)	HOUSE KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 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
	Home Dialysis Aide Services												11
12	Respiratory Therapy												12
	Private Duty Nursing												13
14	Clinic												14
15	Health Promotion Activities												15
16	Day Care Program												16
	Home Delivered Meals Program												17
	Homemaker Service												18
19	All Others												19
	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1 divided by minus column 26, line 1, rounded to 6 decimal place		nn 26, line 20										21

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

4090	O (Cont.)		FOI	RM CMS-255	2-10					1	10-12
	CATION OF GENERAL SERVICE IS TO HHA COST CENTERS	PROVIDER CCN	:		PERIOD: FROM TO		WORKSHEET H-2, PART I (CONT.)				
	HHA COST CENTER (omit cents)	NURSING SCHOOL 20	INTERNS & SALARY AND FRINGES 21	RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL (sum of cols. 4a-23) 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	SUBTOTAL (cols. 23 ± 24) 26	ALLOCATED HHA A&G (see Part II) 27	TOTAL HHA COSTS 28	
1	Administrative and General										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 minus column 26, line 1, rounded to 6 decimal place								21		

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

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

409	0 (Cont.)	2-10	10-1					0-12			
COST	CATION OF GENERAL SERVICE 'S TO HHA COST CENTERS ISTICAL BASIS					PROVIDER CCN:	:	PERIOD: FROM TO		WORKSHEET H-2, PART II (CONT.)	
	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1	Administrative and General	0	,	10	11	12	15	14	15	10	1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	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

10-12			FOR	M CMS-2552-10	4090 (Cont.)				
COSTS TO I	ON OF GENERAL SERVICE HHA COST CENTERS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET H-2, PART II (CONT.)	
STATISTIC	AL BASIS			HHA CCN: NON-		TO		PARA-	T
	HHA COST CENTER	SOCIAL SER VICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	PHYSICIAN ANES- THETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY & FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
1 Admi	inistrative and General				-*				1
2 Skille	ed Nursing Care								2
3 Physi	ical Therapy								3
4 Occu	ipational Therapy								4
5 Speed	ch Pathology								5
6 Medi	ical Social Services								6
7 Home	e Health Aide								7
8 Supp	lies								8
9 Drug	s								9
10 DME	3								10
11 Home	e Dialysis Aide Services								11
12 Resp	iratory Therapy								12
13 Priva	te Duty Nursing								13
14 Clinic	c								14
15 Healt	th Promotion Activities								15
16 Day (Care Program								16
17 Home	e Delivered Meals Program								17
	emaker Service								18
19 All O									19
	s (sum of lines 1-19)								20
	cost to be allocated								21
22 Unit	Cost Multiplier								22

4090 (Cont.)			FORM	FORM CMS-2552-10						
APPORTIONMENT OF PATIENT	SERVICE COST	S		PROVIDER CCN:	PERIOD:	WORKSHEET H-3,				
					FROM	Parts I & II				
				HHA CCN:	то					
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX							

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

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

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

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

				Total			
			Cost	HHA Charges	HHA Shared	Transfer to	
		From Wkst. C,	to Charge	(from provider	Ancillary Costs	Part I	
		Part I, col. 9,	Ratio	records)	(col. 1 x col. 2)	as Indicated	
		line	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

10-12	FORM CMS-25	S-2552-10 4090 (Con				
CALCULATION OF HHA REIMBURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET H-4,		
SETTLEMENT			FROM	Parts I & II		
		HHA CCN:	то			
Check applicable box:	[] Title V	[] Title XVIII	[] Title XIX			

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
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 beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
31	Subtotal (line 29 plus/minus line 30)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS			35
	Pub. 15-II, section 115.2			

4090	O (Cont.)		FC	ORM CMS-2552	2-10			10-12
	LYSIS OF PAYMENTS TO PROVIDER-				PROVIDER CCN:	PERIOD:	WORKSHEET H-5	
	D HHAs FOR SERVICES					FROM		
RENE	DERED TO PROGRAM BENEFICIARIES				HHA CCN:	ТО		
	Description				art A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills eithe							2
	to be submitted to the intermediary for services r							
	cost reporting period. If none, write "NONE" or	enter a zer						2.01
3	List separately each retroactive lump sum		.01		-		_	3.01
	adjustment amount based on subsequent revision		.02					3.02
	of the interim rate for the cost reporting period.	Program	.03		-			3.03
	Also show date of each payment. If none, write	to	.04		_		_	3.04
	"NONE" or enter a zero.(1)	Provider	.05				_	3.05
			.50		_		_	3.50
			.51		_			3.51
		Provider	.52					3.52
	1	to	.53		_		_	3.53
		Program	.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.	201	.99					3.99
4	(transfer to Wkst. H-4, Part II, column as approp		1 2)					4
	(tutister to wast. 114, 1 art 11, column as approp	flute, fille 5	2)					
	TO BE COMPLETED BY IN	TERMEDL	ARY					
5	List separately each tentative settlement payment	Program	.01					5.01
	after desk review. Also show date of each	to	.02					5.02
	payment. If none, write "NONE" or enter	Provider	.03					5.03
	a zero. (1)	Provider	.50					5.50
		to	.51					5.51
		Program	.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum	<u> </u>						
	of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)	Program						
	based on the cost report (see instructions)	to	.01					
	• • •	Provider						6.01
		Provider						
		to	.02					
		Program						6.02
7	TOTAL MEDICARE PROGRAM LIABILITY		1					7
	(see instructions)							
8	Name of Contractor	Contrac	tor N	umber	NPR Date: Month, D	ay, 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.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4046)

10-1	2	FORM CMS	-2552-10		4090 (0	Cont.)
ANAL	YSIS OF RENAL DIALYSIS DEPARTMENT (COSTS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-1	
Check	applicable box: [] Renal Dialy		Program Dialysis			
		TOTA COST		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		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 26 for line 74 or line 94 as appropriate.

4090 (Cont.)			FOR	M CMS-25	52-10						1	10-12
ALLOCATION OF RENAL DEPARTMENT COST	'S TO TREATMEN	IT MODALITIES				PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	I-2	
Check applicable box:	[] Renal Dial	ysis Department	[] Home F	rogram Dialysis								
OUTPATIENT SERVICES												
COMPOSITE PAYMENT RATE	CAPIT	AL AND	DIRECT	PATIENT				ROUTINE	SUBTOTAL		TOTAL	
		ED COSTS		ALARY	EMPLOYEE		MEDICAL	ANCILLARY	(sum of		(col. 9 +	
	BUILDING	EQUIPMENT	RNs	OTHER	BENEFITS	DRUGS	SUPPLIES	SERVICES	cols. 1-8)	OVERHEAD	col. 10)	
	1	2	3	4	5	6	7	8	9	10	11	
1 Total Renal Department Costs												1
MAINTENANCE												
2 Hemodialysis												2
3 Intermittent Peritoneal												3
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												12
13 Method II Home Patient												13
14 EPO (included in Renal Department)												14
15 ARENESP (included in Renal Department)												15
16 Other												16
17 Total (sum of lines 2-16)												17
18 Medical Educational Program Costs												18
19 Total Renal Costs (line 17 + line 18)												19

10-12			FOR	M CMS-25	52-10					4090 (Cont.)			
DIRECT AND INDIRECT RENAL DIALYSIS CO STATISTICAL BASIS	ST ALLOCATION -					PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET I-3			
Check applicable box:	[] Renal Dialysis Department [] Home Program Dialysis					-			•				
COMPOSITE PAYMENT SERVICES	-		AL AND D COSTS EQUIPMENT (% OF		PATIENT SALARY OTHERS	EMPLOYEE BENEFITS	DRUGS	MEDICAL SUPPLIES	ROUTINE ANCILLARY SERVICES	SUB-	OVERHEAD (ACCUM.		
		FEET)	TIME)	(HOURS)	(HOURS)	(SALARY)	(REQUIST.)	(REQUIST.)	(CHARGES)	TOTAL	COST)		
		1	2	3	4	5	6	7	8	9	10	1	
1 Total Renal Department Costs												1	
MAINTENANCE													
2 Hemodialysis												2	
3 Intermittent Peritoneal												3	
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 EPO												14	
15 ARENESP												15	
16 Other												16	
17 Total Statistical Basis												17	
18 Unit Cost Multiplier (line 1 ÷ line 17)												18	

4090	O (Cont.)		FO	RM CMS-2552	2-10				1	0-12
	PUTATION OF AVERAGE COS DUTPATIENT RENAL DIALYSI				PROVIDER CCN:		PERIOD: FROM TO	_	WORKSHEET I-4	
Check	applicable box:	[] Renal Dialysis Department	[] Home Program Di	alysis			10			
			Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (col. 4 x col. 3)	Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
	N		1	2	3	4	5	6	7	<u> </u>
1	Maintenance - Hemodialysis	-								1
2	Maintenance - Peritoneal Dialysi Training - Hemodialysis	IS								2
	Training - Peritoneal Dialysis									3
	Training - Continuous Ambulato	ry Peritoneal Dialysis								5
6	Training - Continuous Cycling P									6
7	Home Program - Hemodialysis									7
8	Home Program - Peritoneal Dial	ysis								8
9	Home Program - Continuous Am	bulatory Peritoneal Dialysis	Patient Weeks			Patient Weeks				9
	Home Program - Continuous Cy									10
11	Totals (sum of lines 1-8, column (sum of lines 1-10, colu									11

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

Description

1 T	otal expenses related to care of program beneficiaries (see instructions)	1
2 T	otal payment (from Worksheet I-4, column 6, line 11)	2
3 E	Deductibles billed to Medicare (Part B) patients	3
4 C	Coinsurance billed to Medicare (Part B) patients	4
5 B	Bad debts for deductibles and coinsurance, net of bad debt recoveries	5
6		6
7 R	teinbursable bad debts for dual eligible beneficiaries (see instructions)	7
8 N	At deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	8
9 P	rogram payment (line 2 less line 3, times 80 percent)	9
10 U	Jnrecovered from Medicare (Part B) patients (<i>line 1 minus the sum of lines 8 and 9</i>)	10
(i	if negative, enter zero and do not complete line 11)	
11 R	teinbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	11

COMM	ATION OF GENERAL SERVICE COSTS TO UNITY MENTAL HEALTH CENTERS										
	UNITY MENTAL HEALTH CENTERS			PROVIDER C	CN:		PERIOD:		WORKSHEET	J-1,	
							FROM		PART I		
				COMPONENT	Г ССN:		ТО				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTA		FER COST CE	NTERS	-		-				
		NET									1
		EXPENSES		ITAL							1
	COMPONENT COST CENTER	FOR COST		D COSTS			ADMINIS-	MAIN-		LAUNDRY	1
	(omit cents)	ALLOCATION			EMPLOYEE				OPERATION	& LINEN	1
		(see instru.)	FIXTURES	EQUIPMENT				& REPAIRS	OF PLANT	SERVICE	1
<u> </u>		0	1	2	4	4A	5	6	7	8	
	Administrative and General										1
	Skilled Nursing Care										2
	Physical Therapy										3
	Occupational Therapy Speech Pathology										4
	Speech Pathology Medical Social Services										5
											6
	Respiratory Therapy Psychiatric/Psychological Services										/
8	Individual Therapy										8
	Group Therapy										10
	Individualized Activity Therapies										10
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)(1)										22
	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.

10-1	2			FOF	M CMS-25	552-10						4090 (C	ont.)
	CATION OF GENERAL SERVICE COSTS TO MUNITY MENTAL HEALTH CENTERS					PROVIDER C	CN:		PERIOD: FROM TO		WORKSHEET PART I (CON	,	
PAR'	Γ I - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY M	ENTAL HEAL	TH CENTER C				10				
						ODI CLIVILI							
	COMPONENT COST CENTER (omit cents)	HOUSE- KEEPING	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	
1	Administrative and General	, í											1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy	1											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													21
22	Totals (sum of lines 1-21)(1)												22
23	Unit Cost Multiplier (see instructions)												23

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

4090) (Cont.)	FOI	RM CMS-25	52-10						1	0-12
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CC	CN:		PERIOD:		WORKSHEET J	-1,	
COM	MUNITY MENTAL HEALTH CENTERS						FROM		PART I (CONT.)	
				COMPONENT			ТО				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUN	ITY MENTAL I	HEALTH CENT	ER COST CEN	TERS						
							INTERN &				
					PARA-		RESIDENT		ALLOCATED		
	COMPONENT COST CENTER		INTERNS &		MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
	(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
		SCHOOL	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	24 ± 25)	Part II) (2)	26 ± 27)	1
		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
	Speech Pathology										5
											6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapies										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
	All Others										21
	Totals (sum of lines 1-21)(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.

10-	2		FORM CM	AS-2552-10						4090 (C	ont.)
ALLO	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CO	CN:		PERIOD:		WORKSHEET	J-1,	
COM	MUNITY MENTAL HEALTH CENTERS						FROM		PART II		
				COMPONENT	CCN:		ТО				
PAR	FII - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY	MENTAL HEAL	TH CENTER	COST CENTER	RS - STATISTI	CAL BASIS					
			CAF	ITAL							
			RELAT	ED COST			ADMINIS-	MAIN-		LAUNDRY	
			BLDGS &	MOVABLE	EMPLOYEE		TRATIVE &	TENANCE &	OPERATION	& LINEN	
	CMHC COST CENTER		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	REPAIRS	OF PLANT	SERVICE	
	(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	
			FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	
		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
	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
	Drugs and Biologicals										16
	Medical Supplies										17
	Medical Appliances										18
	Durable Medical Equipment-Rented										19
	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)										22
23	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

4090 (Cont.)				FORM CM	IS-2552-10						1	0-12
ALLOCATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEET	,	
COMMUNITY MENTAL HEALTH CENTERS								FROM		PART II (CON	NT.)	
	00000000000				COMPONENT			ТО				
PART II - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY M	ENTAL HEAL	MAIN-	COST CENTER	S - STATISTI	CAL BASIS				NON	— —
					NUDSING	CENTD AL		MEDICAL			NON- PHYSICIAN	
	HOURE			TENANCE	NURSING	CENTRAL		MEDICAL	COCIAL	OTUED		
CORF COST CENTER	HOUSE-	DIFTADY	CAFETERIA	OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL SERVICE	OTHER	ANES-	
	KEEPING	DIETARY		PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY		GENERAL	THETISTS	
(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
	SERVICE) 9	SERVED) 10	SERVED)	HOUSED) 12	NURS. HRS)* 13	REQUIS.) 14	REQUIS.)	SPENT) 16	SPENT) 17	(SPECIFY) 18	TIME) 19	4
1 Administrative and General	9	10	11	12	13	14	15	10	17	18	19	-
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)										ļ		22
23 Total Cost to be Allocated												23
24 Unit Cost Multiplier (see instructions)												24

10-12			FORM CMS	8-2552-10					4090 (0	Cont.)
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS			PROVIDER CCN	N:	-	PERIOD: FROM		WORKSHEET PART II (CONT	· ·	
			COMPONENT O		_	то				
PART II - ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMUNITY	MENTAL HEA	LTH CENTER C	OST CENTERS -	STATISTICAL	BASIS				
				PARA-						
			RESIDENTS	MEDICAL						
	NURSING	SALARY &	PROGRAM	EDUCATION						
CORF COST CENTER	SCHOOL	FRINGES	COSTS	(SPECIFY)						
(omit cents)	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED						
	TIME)	TIME)	TIME)	TIME)						
	20	21	22	23	24	25	26	27	28	
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

409	90 (Cont.)		FOI	RM CMS-255	2-10					1	0-12
COM	PUTATION OF COMMUNITY MENTAL HEALTH CENTE	ER PROVIDER CO	STS		PROVIDER CCM		-	PERIOD: FROM TO		WORKSHEET J PART I	-2,
PAR	FI - APPORTIONMENT OF CMHC COST CENTERS										
		(From Wkst. J-1, Part I, col. 28)	Total Component Charges 2	Ratio of Costs to Charges (col. $1 \div$ col. 2) 3	Title V Component Charges	Title V Component Costs (col. 3 x col. 4) 5	Title XVIII Component Charges 6	Title XVIII Component Costs (col. 3 x col. 6)	Title XIX Component Charges 8	Title XIX Component Costs (col. 3 x col. 8) 9	
1	Administrative and General	1	2	5		5	0	,	0	,	
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
	Respiratory Therapy										7
	Psychiatric/Psychological Services										8
9	Individual Therapy										9
	Group Therapy										10
	Individualized Activity Therapy										11
	Family Counseling										12
	Diagnostic Services										13
	Approved Patient Training & Education										14
	Prosthetic and Orthotic Devices	↓								l	15
	Drugs and Biologicals										16
	Medical Supplies									+	17
	Medical Appliances									+	18
	All Others (1)										19
20	Totals (sum of lines 1-19)									I	20

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

10-12	FORM CMS-2552-10		4090 (Cont.)
COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-2,
		FROM	PART II
	COMPONENT CCN:	ТО	

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

		(From				Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Ratio of	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Part I,	Component	Costs to	Component	costs (col. 3	Component	costs (col. 3	Component	costs (col. 3	
		col. 29)	Charges	Charges (1)	Charges (2)	x col. 4)	Charges (2)	x col. 6)	Charges (2)	x col. 8)	
		1	2	3	4	5	6	7	8	9	
21	Respiratory Therapy										2
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 Part 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.

4090 (Cont.)	FORM CMS	5-2552-10			10-12
CALCULATION OF REIMBURSEMENT SET	TLEMENT COMMUNITY	PROVIDER CCN:	PERIOD:	WORKSHEET J-3	
MENTAL HEALTH CENTER PROVIDER SE	RVICES	COMPONENT CCN:	FROM TO		
Check					

applic	able	[] Title V	[] Title XVIII	[] Title XIX	
boxes:					PROGRAM
					COST
1	Cost of component services (from Work	sheet J-2, Part II, li	ine 29)		
2	PPS payments received excluding outlier	S			
3	Outlier payments				
4	Primary payer payments				
5	Total reasonable cost (see instructions)				
6	Total charges for program services				

CUSTOMARY CHARGES

10 Total customary charges (see instructions)

13 Total reasonable cost (from line 5) 14 Part B deductible billed to program patients

15 Net cost (line 13 minus line 14)

17 Subtotal (line 15 minus line 16)

20

22

24

28

7 Aggregate amount actually collected from patients liable for services on a charge basis 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)

9 Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)

11 Excess of customary charges over reasonable cost (see instructions)

12 Excess of reasonable cost over customary charges (see instructions) COMPUTATION OF REIMBURSEMENT SETTLEMENT

16 Excess of reasonable cost over customary charges (from line 12)

19 Actual coinsurance billed to program patients (from provider records)

23 Reimbursable bad debts for dual eligible beneficiaries (see instructions)

Net cost less actual billed coinsurance (line 17 minus line 19)

21 Reimbursable bad debts (from provider records) (see instructions)

29 Balance due component/program (line 26 minus lines 27 and 28)

30 Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)

18 80 percent of costs (80% of line 17) (see instructions)

Net reimbursable amount (see instructions)

Tentative settlement (for contractor use only)

25 Other adjustments (see instructions) (specify) 26 Total cost (line 24 plus or minus line 25)

27 Interim payments (see instructions)

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4	4055)
40-630	

7

8

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9 10

11 12

13

14 15

16 17

18 19

20 21

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24 25

26 27

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10-12	1	0-	-1	2
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FORM CMS-2552-10

4090 (Cont.)

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

Check							
applic		[] Title XVIII					
boxes					_	_	
						rt B	
	DESCRIPTION				1	2	
					mm/dd/yyyy	Amount	
1	Total interim payments paid						1
2	Interim payments payable or						2
	submitted or to be submitted						
	services rendered in the cost	reporting periods. If					
	none, write "NONE", or enter	er zero.					
3	List separately each retroact	ive		.01			3.01
	lump sum adjustment amoun	t	Program	.02			3.02
	based on subsequent revision	n of	to	.03			3.03
	the interim rate for the		Provider	.04			3.04
	cost reporting period. Also s	how		.05			3.05
	date of each payment.			.50			3.50
	If none, write "NONE",		Provider	.51			3.51
	or enter zero (1).		to	.52			3.52
			Program	.53			3.53
			_	.54			3.54
	Subtotal (sum of lines 3.01-3	3.49					
	minus sum of lines 3.50-3.98	3)		.99			3.99
4	Total interim payments (sum	of lines 1, 2, and 3.99)					4
	(transfer to Worksheet J-3, 1	ine 27)					
	· · · · · · · · · · · · · · · · · · ·	,					
O BE	COMPLETED BY INTERM	EDIARY					
5	List separately each tentative		Program	.01			5.01
	settlement payment after des	k review.	to	.02			5.02
	Also show date of each payr	nent.	Provider	.03			5.03
	If none, write "NONE,"		Provider	.50			5.50
	or enter zero (1).		to	.51			5.51
			Program	.52			5.52
	Subtotal (sum of lines 5.01-5	5.49 minus	<u> </u>				
	sum of lines 5.50-5.98)			.99			5.99
6	Determine net settlement am	ount	Program				
	(balance due) based on the c	ost	to				
	report (see instructions). (1)		Provider	.01			6.01
	1 () ()		to				
			Program	.02			6.02
7	Total Medicare liability (see	instructions)					7
8	Name of Contractor	Contractor Number		NPR I	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.

4090) (Cont.)			FOI	RM CMS-255	52-10					1	10-12
ANAI	YSIS OF PROVIDER-BASED					PROVIDER CC	N:		PERIOD:		WORKSHEET	Κ
HOSP	ICE COSTS								FROM			
						HOSPICE CCN:			то			
			EMPLOYEE		CONTRACTED							
		SALARIES	BENEFITS	TRANSPOR-	SERVICES				SUBTOTAL		TOTAL	
	COST CENTER DESCRIPTIONS	(from	(from	TATION	(from		TOTAL	RECLASSI-	(col. 6	ADJUST-	(col. 8	
		Wkst. K-1)	Wkst. K-2)	(see inst.)	Wkst. K-3)	OTHER	(cols. 1-5)	FICATION	± col. 7)	MENTS	± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											<u> </u>
	Capital Related Costs-Bldg and Fixt.											1
	Capital Related Costs-Movable Equip.											2
	Plant Operation and Maintenance											3
	Transportation - Staff											4
5												5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
	Inpatient - General Care											7
8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
	Nursing Care											10
11	Nursing Care-Continuous Home Care											11
12	Physical Therapy											12
13	Occupational Therapy											13
14	Speech/ Language Pathology											14
15	Medical Social Services										1	15
16	Spiritual Counseling										1	16
17	Dietary Counseling											17
18	Counseling - Other											18
19	Home Health Aide and Homemaker											19
	HH Aide & Homemaker - Cont. Home Care										1	20
21	Other											21
	OTHER HOSPICE SERVICE COSTS											
22	Drugs, Biological and Infusion Therapy											22
23												23
24	Sedatives / Hypnotics											25
25	Other - Specify											25
	Durable Medical Equipment/Oxygen	1	İ	İ	İ	İ		İ			1	26
	Patient Transportation										1	27
	Imaging Services		İ	l	İ	İ		İ	1		1	28
	Labs and Diagnostics		1		1	1		1			1	29
	Medical Supplies				1	1		1			1	30
	Outpatient Services (including E/R Dept.)	1	t		i	1		t	1		1	31
	Radiation Therapy				1	1		1			1	32
	Chemotherapy	1	t		1	1		t	1		1	33
	Other		1		i –	1		1			1	34
	HOSPICE NONREIMBURSABLE SERVICE											<u> </u>
35	Bereavement Program Costs				1				1		1	35
36					1	1					+	36
	Fundraising					1					+	37
	Other Program Costs										+	38
39			<u> </u>	1	+	<u> </u>		1			+	39
39	Total (suil 01 lilles 1 ullu 30)				ļ				ļ			39

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

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

4090 (Cont.)			FORM CM	S-2552-10					1	10-12
HOSPICE COMPENSATION ANALYSIS EMPLOYEE				PROVIDER CCN	N:	_	PERIOD:		WORKSHEET H	K-2
BENEFITS (PAYROLL RELATED)				HOSPICE CCN:			FROM TO			
			MEDICAL	HOSPICE CCN:	r	Т	10			1
COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL(1)	
(onit cents)	1	2	3	4	5	6	7	ALL OTTILK	9	
GENERAL SERVICE COST CENTERS	1	2	5	4	5	0	/	0	,	
1 Capital Related Costs-Bldg and Fixt.										1
2 Capital Related Costs-Moyable 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										Ť
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				1	1				1	28
29 Labs and Diagnostics					1					29
30 Medical Supplies					t					30
31 Outpatient Services (including E/R Dept.)					1					31
32 Radiation Therapy					1				1	32
33 Chemotherapy					İ					33
34 Other					İ					34
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										35
36 Volunteer Program Costs					1					36
37 Fundraising					t				1	37
38 Other Program Costs					İ					38
39 Total (sum of lines 1 thru 38)					1				1	39

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

10-1					ORM CMS-2552-10					4090 (Cont.)	
HOSF	ICE COMPENSATION ANALYSIS		PROVIDER CC	N:		PERIOD:		WORKSHEET H	K-3		
CONT	RACTED SERVICES/PURCHASED SERVICES							FROM			
					HOSPICE CCN:			то			
				MEDICAL							
	COST CENTER DESCRIPTIONS	ADMINIS-		SOCIAL	SUPER-		TOTAL				
	(omit cents)	TRATOR	DIRECTOR	WORKERS	VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	1										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
	Occupational Therapy										13
14	Speech/ Language Pathology										14
	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19											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
	Outpatient Services (including E/R Dept.)										31
	Radiation Therapy										32
	Chemotherapy										33
34	Other										34
	HOSPICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs										35
	Volunteer Program Costs										36
37											37
38											38
39	Total (sum of lines 1 thru 38)										39

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

4090						CMS-2552-10					
COST	ALLOCATION - HOSPICE GENERAL SERVICE COST				PROVIDER CC	N:	_	PERIOD:		WORKSHEET	K-4,
								FROM		PART I	
					HOSPICE CCN:			то			
		NET					VOLUNTEER				
		EXPENSES	CAPITAL RE	LATED COST	PLANT		SERVICES		ADMINIS-	TOTAL	
	COST CENTER DESCRIPTIONS	FOR COST	BUILDINGS	MOVABLE	OPERATION	TRANS-	COORDI-	SUBTOTAL	TRATIVE &	(col. 5	
		ALLOCATION	& FIXTURES	EQUIPMENT	& MAINT.	PORTATION	NATOR	(cols. 0 - 5)	GENERAL	± col. 6)	
		0	1	2	3	4	5	5A	6	7	1
	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
	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
	Occupational Therapy										13
	Speech/ Language Pathology									1	14
	Medical Social Services										15
	Spiritual Counseling									1	16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker									1	19
	HH Aide & Homemaker - Cont. Home Care										20
	Other										21
	OTHER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
	Sedatives / Hypnotics										24
	Other - Specify							l			25
	Durable Medical Equipment/Oxygen							1	1	1	26
	Patient Transportation				1	İ		l	İ	1	27
	Imaging Services				1	İ		1	İ	1	28
	Labs and Diagnostics				1	İ	l	l	İ	1	29
	Medical Supplies							1	İ	1	30
	Outpatient Services (including E/R Dept.)									1	31
	Radiation Therapy							1		1	32
	Chemotherapy							l	İ	1	33
	Other				1						34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
	Volunteer Program Costs				1						36
	Fundraising							1	İ	1	37
	Other Program Costs				1			1	İ	1	38
	Total (sum of lines 1 thru 38)					İ		l			39

10-12		FORM CMS-	2552-10				4090 (C	Cont.)
COST ALLOCATION - HOSPICE STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET K-4 PART II	4,
			HOSPICE CCN:		то			
COST CENTER DESCRIPTIONS	CAPITAL RE BUILDINGS & FIXTURES (SQ. FT.)	LATED COST MOVABLE EQUIPMENT (\$ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS- PORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACC. COST)	
GENERAL SERVICE COST CENTERS	1	2	3	4	5	6A	6	
								1
1 Cuphan Renated Costs Didg and Fina								
2 Capital Related Costs-Movable Equip.								2
3 Plant Operation and Maintenance								
4 Transportation - Staff								5
5 Volunteer Service Coordination								5
6 Administrative and General								6
INPATIENT CARE SERVICE								<u> </u>
7 Inpatient - General Care								7
8 Inpatient - Respite Care								8
VISITING SERVICES								<u> </u>
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

4090) (Cont.)		FC	ORM CMS-2	2552-10					1	0-12
ALLC	CATION OF GENERAL SERVICE		PROVIDER CC	'N:		PERIOD:		WORKSHEET	K-5,		
COST	S TO HOSPICE COST CENTERS							FROM		PART I	
					HOSPICE CCN	:		ТО			
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSE	PICE COST CENT	ERS								
		From	HOSPICE		PITAL						
	HOSPICE COST CENTER	Wkst. K-4	TRIAL		ED COSTS			ADMINIS-	MAIN-		
	(omit cents)	Part I,	BALANCE	BLDGS. &	MOVABLE	EMPLOYEE	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	
		col. 7,	(1)	FIXTURES	EQUIPMENT	BENEFITS	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	
		line	0	1	2	4	4A	5	6	7	
_	Administrative and General	6									1
2	Inpatient - General Care	7									2
3	Inpatient - Respite Care	8									3
4		9									4
	Nursing Care	10						ļ			5
	Nursing Care-Continuous Home Care	11									6
	Physical Therapy	12									7
	Occupational Therapy	13									8
9	Speech/ Language Pathology	14									9
	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
	Durable Medical Equipment/Oxygen	26									21
22	Patient Transportation	27									22
23	Imaging Services	28									23
	Labs and Diagnostics	29									24
25	Medical Supplies	30									25
26	Outpatient Services (including E/R Dept.)	31									26
	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
	Totals (sum of lines 1-33) (2)										34
	Unit Cost Multiplier (see instructions)										35

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

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

10-1	2			FC	ORM CMS-2	CMS-2552-10						Cont.)
	OCATION OF GENERAL SERVICE 'S TO HOSPICE COST CENTERS					PROVIDER CC	2N:		PERIOD: FROM TO		WORKSHEET PART I (Cont.)	
PAR	FI - ALLOCATION OF GENERAL SERVICE C	OSTS TO HOSPIC	E COST CENTI	ERS		HOSFICE CCN	•		10			
	HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		8	9	10	11	12	13	14	15	16	17	<u> </u>
	Administrative and General											1
2												2
3												3
4	Physician Services											4
	Nursing Care											5
	Nursing Care-Continuous Home Care											6
7					ļ						L	7
	Occupational Therapy											8
	Speech/ Language Pathology											9
	Medical Social Services											10
	Spiritual Counseling											11
	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										1	21
	Patient Transportation											22
	Imaging Services											23
	Labs and Diagnostics											24
	Medical Supplies											25
26	**									l		26
	Radiation Therapy				1			1			1	27
28					l			İ		1	1	28
29										l		29
30					1			1		1	i	30
31					İ			İ		İ	1	31
	Fundraising							1			İ	32
33	<u> </u>				1			1		1	i	33
	Totals (sum of lines 1-33) (2)				İ			İ		İ	İ	34
	Unit Cost Multiplier (see instructions)											35

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

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

4090) (Cont.)	RM CMS-2	2552-10					1	0-12				
	CATION OF GENERAL SERVICE S TO HOSPICE COST CENTERS						PROVIDER C	CN:		PERIOD: FROM		WORKSHEET PART I (Cont.)	- /
COST	S TO HOSPICE COST CENTERS						LIOSDICE CCI	NT.		TO		PART I (Cont.))
DADT	I - ALLOCATION OF GENERAL SERVICE	COSTS TO HO	EDICE COST C	ENTEDO			HOSPICE CCI	N:		10			
PARI	1 - ALLOCATION OF GENERAL SERVICE		SPICE COST C	ENTERS			r		INTERN &	r – – – – – – – – – – – – – – – – – – –			
			NON-				PARA-		RESIDENT		ALLOCATED	TOTAL	
	HOSPICE COST CENTER	OTHER	PHYSICIAN		INTERNS &	RESIDENTS	MEDICAL		COST & POST		HOSPICE	HOSPICE	
	(omit cents)	GENERAL	ANES-	NURSING	SALARY &		EDUCATION	SUBTOTAL		SUBTOTAL	A&G (see	COSTS	
	(onit conts)	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)		$(cols. 24 \pm 25)$	Part II)	$(cols. 26 \pm 27)$	
		`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									1			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
22	Patient Transportation												22
23													23
24	Labs and Diagnostics												24
25	Medical Supplies												25
26	Outpatient Services (including E/R Dept.)												26
27	Radiation Therapy												27
28	Chemotherapy						ļ						28
29	Other						ļ						29
30	Bereavement Program Costs												30
31							ļ			l			31
_	Fundraising												32
33	Other Program Costs						ļ						33
34													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.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

10-1	2	FO	RM CMS-255	52-10		4090 (Cont.)			
	CATION OF GENERAL SERVICE COSTS TO ICE COST CENTERS STATISTICAL BASIS			PROVIDER CCN	:	PERIOD: FROM		WORKSHEET K- PART II	-5,
				HOSPICE CCN:		то			
PAR	II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CE					-			
			PITAL ED COST MOVABLE	EMPLOYEE		ADMINIS- TRATIVE &	MAIN- TENANCE &	OPERATION	
	HOSPICE COST CENTER	FIXTURES (SQUARE FEET)	EQUIPMENT (DOLLAR VALUE) 2	EMPLOTEE BENEFITS (GROSS SALARIES) 4	RECONCIL- IATION 5 A	GENERAL (ACCUM. COST) 5	REPAIRS (SQUARE FEET) 6	OF PLANT (SQUARE FEET) 7	
1	Administrative and General	1	2	4	JA	5	0	/	1
2	Inpatient - General Care								2
3	Inpatient - General Care								3
	Physician Services		<u> </u>		 	1	<u> </u>		4
5	Nursing Care								5
	Nursing Care-Continuous Home Care								6
7	Physical Therapy	_							7
8	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
	HH Aide & Homemaker - Cont. Home Care				1				15
16	Other								16
	Drugs, Biological and Infusion Therapy								17
18									18
19	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation		1				1		22
23	Imaging Services		1				1		23
	Labs and Diagnostics								24
25	Medical Supplies								25
	Outpatient Services (including E/R Dept.)								26
	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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

4090 (Cont.)				FOI	RM CMS-255	2-10				1	0-12
ALLOCATION OF GENERAL S HOSPICE COST CENTERS STA						PROVIDER CCN:		PERIOD: FROM		WORKSHEET K PART II (Cont.)	-5,
						HOSPICE CCN: _		то			
PART II - ALLOCATION OF	GENERAL SERVICE COS	TS TO HOSP	ICE COST CENT	ERS - STATISTIC	CAL BASIS						
HOSPICE COS	ST CENTER S (PC	AUNDRY & LINEN SERVICE DUNDS OF AUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	
1 Administrative and Genera	al						-				1
2 Inpatient - General Care	-										2
3 Inpatient - Respite Care											3
4 Physician Services											4
5 Nursing Care								İ	İ	İ	5
6 Nursing Care-Continuous	Home Care								1		6
7 Physical Therapy									1		7
8 Occupational Therapy											8
9 Speech/ Language Patholo	eγ										9
10 Medical Social Services	67										10
11 Spiritual Counseling											11
12 Dietary Counseling											12
13 Counseling - Other											13
14 Home Health Aide and Ho	omemaker										14
15 HH Aide & Homemaker -	Cont. Home Care										15
16 Other											16
17 Drugs, Biological and Infu	sion Therapy										17
18 Analgesics											18
19 Sedatives / Hypnotics											19
20 Other - Specify											20
21 Durable Medical Equipme	nt/Oxygen										21
22 Patient Transportation											22
23 Imaging Services											23
24 Labs and Diagnostics											24
25 Medical Supplies											25
26 Outpatient Services (inclu	ling E/R Dept.)										26
27 Radiation Therapy											27
28 Chemotherapy											28
29 Other											29
30 Bereavement Program Cos	sts										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 i	nstructions)										36

10-1	2	FORM	CMS-2552-10)				4090 (C	Cont.)
	CATION OF GENERAL SERVICE COSTS TO ICE COST CENTERS STATISTICAL BASIS			PROVIDER CCN	·	PERIOD: FROM		WORKSHEET K- PART II (Cont.)	-5,
11051				HOSPICE CCN:		то		Triter if (cont.)	
PART	II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CE	NTERS - STATISTI	CAL BASIS	HODITEL CERT.		10			
1 AKI	I - ALEOCATION OF GENERAL SERVICE COSTS TO HOSTICE COST CE			NON-				PARA-	Τ
	HOSPICE COST CENTER	SOCIAL SERVICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	PHYSICIAN ANES- THETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY & FRINGES (ASSIGNED TIME) 21	RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care-Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services								10
	Spiritual Counseling								11
12	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemaker								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biological and Infusion Therapy								17
	Analgesics								18
19	Sedatives / Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics		1						24
	Medical Supplies								25
	Outpatient Services (including E/R Dept.)		1						26
	Radiation Therapy								27
	Chemotherapy		1						28
	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs		1						31
_	Fundraising		1						32
33	Other Program Costs		1						33
	Totals (sum of lines 1-33) (2)		1						34
35	Total cost to be allocated		1						35
	Unit Cost Multiplier (see instructions)		1						36

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

4090	O(Cont.)	FORM CMS-2	552-10			10-12		
APPO	RTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: _		PERIOD: FROM		WORKSHEET K-5 PART III	,	
		HOSPICE CCN:		то		I AKI III		
PART	III - COMPUTATION OF TOTAL HOSPICE SHAR	ED COSTS						
	COST CENTER		Wkst. C, Part I, col. 9, line 0	Cost to Charge Ratio	Total Hospice Charges (Provider Records) 2	Hospice Shared Ancillary Costs (cols. 1 x 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	

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

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

4090	0 (Cont.)		FORM C	MS-2552-10				10-12
CALC	CULATION OF CAPITAL PA	AYMENT	PROVIDER CCN:		PERIOD:		WORKSHEET L	
					FROM			
			COMPONENT CCN	:	то			
Check		[] Title V		[] Hospital		[] PPS		
applica	ble	[] Title XVIII, P	art A	[] Subprovider (ot	her)	[] Cost Method		
boxes:		[] Title XIX						
PAR	FI - FULLY PROSPECTIV	VE METHOD						
	CAPITAL FEDERAL AMC	DUNT						
1	Capital DRG other than out	lier						1
2								2
3	Total inpatient days divided	l by number of days i	n the cost reporting perio	d (see instructions)				3
4	Number of interns & resider	nts (see instructions))					4
5	Indirect medical education	percentage (see instr	uctions)					5
6	Indirect medical education a	adjustment (line 1 tim	nes line 5)					6
7	Percentage of SSI recipient	patient days to Medi	care Part A patient days (Worksheet E, Part A	line 30) (see instru	ctions)		7
8	Percentage of Medicaid pat	ient days to total day	s (see instructions)					8
9	Sum of lines 7 and 8							9
10	Allowable disproportionate	share percentage (se	ee instructions)					10
11	Disproportionate share adju	stment (line 10 times	lines 1)					11
12	Total prospective capital pa	yments (sum of lines	1-2, 6 and 11)					12
PART	Γ II - PAYMENT UNDER I	REASONABLE CO	OST					
1	Program inpatient routine ca	apital cost (see instru	actions)					1
2	Program inpatient ancillary	capital cost (see inst	ructions)					2
3	Total inpatient program cap	ital cost (line 1 plus l	line 2)					3
4	Capital cost payment factor	(see instructions)						4
5	Total inpatient program cap	ital cost (line 3 x line	24)					5
PART	TIII - COMPUTATION O	F EXCEPTION PA	YMENTS					
1	Program inpatient capital co	osts (see instructions)					1
2	Program inpatient capital co	osts for extraordinary	circumstances (see instr	uctions)				2
3	Net program inpatient capita	al costs (line 1 minus	line 2)					3
4	Applicable exception percent	ntage (see instruction	ns)					4
5	Capital cost for comparison	to payments (line 3	x line 4)					5
6	Percentage adjustment for e	extraordinary circums	tances (see instructions)					6
7	Adjustment to capital minin	num payment level fo	or extraordinary circumsta	nces (line 2 x line 6)				7
8	Capital minimum payment l	evel (line 5 plus line	7)					8
9	Current year capital payment	nts (from Part I, line	12 as applicable)					9
10					9)			10
11	Carryover of accumulated c	apital minimum payn	nent level over capital pay	yment				11
_	(from prior year Worksheet	L, Part III, line 14)						
12	Net comparison of capital n	ninimum payment lev	el to capital payments (lin	ne 10 plus line 11)				12
13	Current year exception pays	ment (if line 12 is pos	sitive, enter the amount or	n this line)				13
14	Carryover of accumulated c	apital minimum payn	nent level over capital pay	yment				14
	for the following period (if I	line 12 is negative, er	nter the amount on this lin	le)				
15	Current year allowable ope	rating and capital pay	yment (see instructions)					15
16	Current year operating and	capital costs (see ins	structions)					16
17	Current year exception offse	et amount (see instru	ictions)					17

10-1	2		CM CMS-2552-10 PROVIDER CCN: PERIOD: WW					4090 (C	ont.)	
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CCM	N:	PERIOD: FROM TO		WORKSHEET L PART I	1,
		EXTRA- ORDINARY		PITAL ED COSTS			10			
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	211		5	0	7	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits									4
	Administrative and General			Ĩ	1		Ĩ	1		5
	Maintenance and Repairs			1	1		1			6
7	Operation of Plant			Ĩ	1		Ĩ			7
8	Laundry and Linen Service			1	1		1			8
9	Housekeeping									9
	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
13	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
16	Medical Records & Medical Records Library							1		16
17	Social Service							1		17
18	Other General Service (specify)									18
19	Nonphysician Anesthetists									19
	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									0
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									35
	Subprovider IPF									40
	Subprovider IRF									41
	Subprovider									42
	Nursery									43
	Skilled Nursing Facility									44
45	Nursing Facility									45
46	Other Long Term Care									46

4690) (Cont.)	8-2552-10					10-12			
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CCM	N:	PERIOD: FROM TO		WORKSHEET L PART I (Cont.)	1,
		EXTRA- ORDINARY		PITAL ED COSTS			10			
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	ANCILLARY SERVICE COST CENTERS	0	1	2	ZA	4	5	0	/	<u> </u>
	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic				ł					55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catherization									59
	Laboratory									60
	PBP Clinical Laboratory Service-Program Only									61
	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
68	Speech Pathology			1						68
69	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients									71
_	Implantable Devices Charged to Patients									72
	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									0
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic								ļ	90
	Emergency									91
92	Observation Beds									92
93	Other Outpatient (specify)									93

10-1	2	IS-2552-10 PROVIDER CCN: PERIOD:					4090 (C	ont.)		
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CCM	J:	PERIOD: FROM TO		WORKSHEET L PART I (Cont.)	1,
		EXTRA- ORDINARY CAPITAL	-	PITAL ED COSTS	SUBTOTAL		ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	(sum of cols. 0-4) 2A	EMPLOYEE BENEFITS 4	TRATIVE & GENERAL 5	TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	OTHER REIMBURSABLE COST CENTERS	0	1	2	ZA	4	5	0	/	<u> </u>
94	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									100
101	SPECIAL PURPOSE COST CENTERS									0
105	Kidney Acquisition									105
	Heart Acquisition									105
	Liver Acquisition									100
	Lung Acquisition						1			107
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
	Hospice									116
117	Other Special Purpose (specify)									117
	SUBTOTALS (sum of lines 1-117)									118
								1		<u> </u>
	NONREIMBURSABLE COST CENTERS									0
190	Gift, Flower, Coffee Shop, & Canteen									190
	Research									191
	Physicians' Private Offices			1	1		1		1	192
	Nonpaid Workers				1				1	193
	Other Nonreimbursable (specify)				1				1	194
	Cross Foot Adjustments									200
_	Negative Cost Centers									201
	Total (sum of line 118 and lines190-201)				1				1	202
	Total Statistical Basis			1			1		1	203
	Unit Cost Multiplier								1	204

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

10-1	2)					4090 (C	ont.)				
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES						PROVIDER C		PERIOD: FROM TO		WORKSHEET L- PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS									-		
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology											53
	Radiology-Diagnostic											54
	Radiology-Therapeutic				1		1					55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
	Cardiac Catherization											59
-	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
	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
	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
	Other Ancillary (specify)											76
0	OUTPATIENT SERVICE COST CENTERS											
	Rural Health Clinic (RHC)											88
	Federally Qualified Health Center (FQHC)											89
90	Clinic											90
91	Emergency											91
92	Observation Beds											92
93	Other Outpatient (specify)											93

4090) (Cont.)			FORM CM	1S-2552-10						1	10-12
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES			_			PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET L-1, PART I (Cont.)	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS	8	,	10	11	12	15	14	15	10	17	<u> </u>
94	Home Program Dialysis											94
	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
	Durable Medical Equipment Rented											97
	Other Reimbursable (specify)							1				98
	Outpatient Rehabilitation Provider (specify)											99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											<u> </u>
	Kidney Acquisition											105
	Heart Acquisition							1				106
	Liver Acquisition											107
108	Lung Acquisition											108
	Pancreas Acquisition											109
	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 1-117)											118
0	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
191	Research											191
192	Physicians' Private Offices											192
	Nonpaid Workers											193
	Other Nonreimbursable (specify)											194
	Cross Foot Adjustments											200
	Negative Cost Centers											201
	Total (sum of line 118 and lines190-201)											202
	Total Statistical Basis											203
204	Unit Cost Multiplier											204

4090) (Cont.)			FORM CM	S-2552-10						10-12
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	,	
	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY & FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARA- MEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
	Laundry and Linen Service										8
	Housekeeping										9
	Dietary										10
	Cafeteria										11
	Maintenance of Personnel										12
-	Nursing Administration										13
14	Central Services and Supply	_									14
	Pharmacy	_									15
	Medical Records & Medical Records Library										16
	Social Service		4								17
	Other General Service (specify)										18
	Nonphysician Anesthetists				4						19
	Nursing School					-					20
	Intern & Res. Service-Salary & Fringes (Approved)						-				21 22
	Intern & Res. Other Program Costs (Approved) Paramedical Ed. Program (specify)							4			22
23	INPATIENT ROUTINE SERVICE COST CENTERS					-					0
30	Adults and Pediatrics (General Routine Care)				-						30
	Intensive Care Unit										31
	Coronary Care Unit										31
	Burn Intensive Care Unit										33
	Surgical Intensive Care Unit							<u> </u>	1	1	34
	Other Special Care Unit (specify)	1						1	1	1	35
	Subprovider IPF	1						l	1	1	40
	Subprovider IRF									1	41
	Subprovider									1	42
	Nursery								İ	1	43
	Skilled Nursing Facility										44
	Nursing Facility										45
	Other Long Term Care										46

4690) (Cont.)			FORM CM	S-2552-10						10-12
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES		PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	,			
	Cost Center Descriptions	OTHER GENERAL SERVICE 18	NONPHYSICIAN ANESTHETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10	19	20	21	22	23	24	23	20	<u> </u>
	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology										53
	Radiology-Diagnostic									Ì	54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
	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
	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										0
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
	Clinic										90
	Emergency										91
	Observation Beds				-						92
93	Other Outpatient (specify)										93

10-12			IS-2552-10					4090 (Cont.)	
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	,
Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
OTHER DEB (DUDG + DI E COOT CENTER)	18	19	20	21	22	23	24	25	26	-
OTHER REIMBURSABLE COST CENTERS										04
94 Home Program Dialysis 95 Ambulance Services										94 95
95 Ambulance Services 96 Durable Medical Equipment-Rented										95
96 Durable Medical Equipment-Kented 97 Durable Medical Equipment-Sold							l		1	96
97 Durable Medical Equipment-Sold 98 Other Reimbursable (specify)										97
99 Outpatient Rehabilitation Provider (specify)										98
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
100 Intern-Resident Service (not appvd. tening. prgm.)										100
SPECIAL PURPOSE COST CENTERS										0
105 Kidney Acquisition	_									105
106 Heart Acquisition										105
107 Liver Acquisition										100
108 Lung Acquisition										107
109 Pancreas Acquisition										100
110 Intestinal Acquisition				1	1					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 1-117)										118
									•	
NONREIMBURSABLE COST CENTERS										0
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 lines190-201)										202
203 Total Statistical Basis										203
204 Unit Cost Multiplier										204

4090 (Cont.) FO COMPUTATION OF PROGRAM INPATIENT ROUTINE SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES				FORM CMS-25	52-10				1	0-12
					PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET L-1, PART II	
Check applica box:		[] Title V [] Title XVIII, Part A [] Title XIX	Δ				-		-	
(A)	Cost Center Description	•	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26) 1	Swing Bed Adjustment 2	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2) 3	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4) 5	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6) 7	
	INPATIENT ROUTINE SER	RVICE								
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 (spec	cify)								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

10-1	2		FORM CMS-255	52-10				4090 (0	Cont.)
		NPATIENT ANCILLARY SERVIO DINARY CIRCUMSTANCES	CE			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET L-1, PART III	
Check		[] Hospital	[] Title V						
applicab	ble	[] Subprovider	[] Title XVIII, Part A						
	Cost Center Description	1	[] Title XIX	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)	ANCILLARY SERVICE COS	OT OENTED O		1	2	3	4	5	<u> </u>
50	Operating Room	SI CENTERS							50
	Recovery Room Labor Room and Delivery Ro	oom							51 52
53	Anesthesiology								53
	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
56	Radioisotope								56
	Computed Tomography (CT)								57
	Magnetic Resonance Imaging	g (MRI)							58
	Cardiac Catherization								59
	Laboratory								60
	PBP Clinical Laboratory Serv								61
	Whole Blood & Packed Red Blood Storing, Processing, &								62
	Intravenous Therapy	Trans.							63 64
	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
	Medical Supplies Charged to	Patients							71
	Implantable Devices Charged								72
	Drugs Charged to Patients								73
	Renal Dialysis								74
	ASC (Non-Distinct Part)								75
	Other Ancillary (specify)								76

(A) Worksheet A line numbers

4090) (Cont.)		FORM CMS-255	52-10					10-12
		NPATIENT ANCILLARY SERVIC DINARY CIRCUMSTANCES	CE			PROVIDER CCN:	PERIOD: FROM	WORKSHEET L-1, PART III (CONT.)	
						COMPONENT CCN:	то		
Check	1.	[] Hospital	[] Title V [] Title XVIII, Part A			.			
applicat boxes:	ble	[] Subprovider	[] Title XVIII, Part 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)	
(A)				1	2	3	4	5	
	OUTPATIENT SERVICE CO	OST CENTERS							
	Rural Health Clinic (RHC)								88
	Federally Qualified Health Ce	enter (FQHC)							89
	Clinic								90
	Emergency								91
	Observation Beds								92
	Other Outpatient (specify)								93
	OTHER REIMBURSABLE C	COST CENTERS							
	Home Program Dialysis								94
	Ambulance Services								95
	Durable Medical Equipment-I								96
	Durable Medical Equipment-S								97
	Other Reimbursable (specify)								98
200	Total (sum of lines 50 through	n 199)							200

(A) Worksheet A line numbers

10-12		FOR	M CMS-2552-10				4090 (C	Cont.)
ANALYSIS OF PROVIDER-BASED RURAL HEALTH CL FEDERALLY QUALIFIED HEALTH CENTER COSTS	INIC/				PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET M-1	
						-		
Check applicable box: [] RHC [] FQ	HC							
	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	<u> </u>
FACILITY HEALTH CARE STAFF COSTS								<u> </u>
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								<u> </u>
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	1							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								22
(sum of lines 10, 14, and 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								
23 Pharmacy					-			23
24 Dental								24
25 Optometry								25
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					_		ļ	29
30 Administrative Costs							ļ	30
31 Total Facility Overhead (sum of lines 29 and 30)						ļ	ļ	31
32 Total facility costs (sum of lines 22, 28 and 31)								32

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

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4066)

409	O (Cont.)	FOR	M CMS-2	552-10			10-12
ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES				PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-2	
				COMPONENT CCN:	то	-	
Check	applicable box:	[] RHC	[] FQHC				
VISIT	TS AND PRODUCTIVITY						
		Number			Minimum	Greater of	
		of FTE	Total	Productivity	Visits (col. 1	col. 2 or	
		Personnel	Visits	Standard (1)	x col. 3)	col. 4	
	Positions	1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						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
DETI	ERMINATION OF ALLOWABLE COST APPLICA	ABLE TO RHC/	FQHC SERVI	CES			
10	Total costs of health care services (from Worksheet M	-1, column 7, line	22)				10
11	Total nonreimbursable costs (from Worksheet M-1, co	olumn 7, line 28)					11
12	Cost of all services (excluding overhead) (sum of lines	10 and 11)					12
13	Ratio of RHC/FQHC services (line 10 divided by line	12)					13
14	Total facility overhead (from Worksheet M-1, column	7, line 31)					14
15	Parent provider overhead allocated to facility (see inst	tructions)					15
16	Total overhead (sum of lines 14 and 15)						16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtract line 17 from line 16						18
19	Overhead applicable to RHC/FQHC services (line 13	x line 18)					19
20	Total allowable cost of RHC/FQHC services (sum of l	ines 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.

10-1	2		FORM CMS-25	52-10		4090(Cont.)		
CALC	ULATION OF REIMBURSEM	ENT		PROVIDER CCN:	PERIOD:	WORKSHEET M-3			
	LEMENT FOR RHC/FQHC SE				FROM				
				COMPONENT CCN:	то	_			
						_			
Check		[] RHC	[] Title V	[] Title XIX					
applica	able boxes:	[] FOHC	[] Title XVIII						
	RMINATION OF RATE FO	R RHC/FOHC SER	VICES						
1	Total allowable cost of RHC/F						1		
2	Cost of vaccines and their adm	inistration (from Wor	ksheet M-4, line 15)				2		
3	Total allowable cost excluding	vaccine (line 1 minus	line 2)				3		
4	Total visits (from Worksheet M	1-2, column 5, line 8)					4		
5	Physicians visits under agreem	ent (from Worksheet]	M-2, column 5, line 9)				5		
6	Total adjusted visits (line 4 plu	s line 5)					6		
7	Adjusted cost per visit (line 3 d	livided by line 6)					7		
					Calculati	tion of Limit (1)			
					Prior to	On or after			
					January 1	January 1			
					1	2			
8	Per visit payment limit (from C	MS Pub. 27, Sec. 505	5 or your contractor)				8		
9	Rate for Program covered visit	s (see instructions)	· · ·				9		
CALC	CULATION OF SETTLEMEN	NT			-	÷			
10	Program covered visits excludi	ng mental health servi	ices (from contractor records)				10		
11	Program cost excluding costs f	or mental health servi	ces (line 9 x line 10)				11		
12	Program covered visits for mer	ntal health services (fr	om contractor records)				12		
13	Program covered cost from me	ntal health services (li	ine 9 x line 12)				13		
14	Limit adjustment for mental he	alth services (see inst	tructions)				14		
15	Graduate Medical Education p	ass-through cost (see	instructions)				15		
16	Total Program cost (sum of line	es 11, 14, and 15, col	umns 1, 2 and 3)				16		
16.01	Total program charges (see ins	structions)(from contr	actor's records)				16.01		
16.02	Total program preventive charge	ges (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	s)				16.04		
16.05	Total program cost (see instru-	ctions)					16.05		
17	Primary payer amounts						17		
18			ructions) (from contractor recor	,			18		
19	Less: Beneficiary coinsurance	for RHC/FQHC servi	ices (see instructions) (from co	ntractor records)			19		
20	Net Medicare cost excluding v	accines (see instruction	ons)				20		
21	Program cost of vaccines and t	heir administration (fr	rom Worksheet M-4, line 16)				21		
22	Total reimbursable Program co	(I	1)				22		
23	Reimbursable bad debts (see i	,					23		
24	Reimbursable bad debts for du	<u> </u>	es (see instructions)				24		
25	Other adjustments (specify) (s	,					25		
26	Net reimbursable amount (lines	s 22 plus 23 plus or m	inus line 25)				26		
27	Interim payments						27		
28	Tentative settlement (for contra						28		
29	Balance due component/progra						29		
30	Protested amounts (nonallowal	• ·	in accordance with CMS				30		
	Pub. 15-2, chapter 1, section	115.2			1	1	1		

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

4090	D(Cont.)		FORM CMS-2552-10					
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST			Ą	PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-4		
				COMPONENT CCN:	то			
Check		[] RHC	[] Title V	[] Title XIX		P		
applic	able boxes:	[] FQHC	[] Title XVIII			· · · · · · · · · · · · · · · · · · ·		
					PNEUMOCOCCAL	INFLUENZA	4	
1	Health care staff cost (from Work	schoot M 1. column 7	line 10)		1	2	1	
2	Ratio of pneumococcal and influe	, , ,	/				2	
2	health care staff time	inza vacenie stari time	10 10141				2	
3		vine health care staff c	ost (line 1 x line 2)				3	
4	Medical supplies cost - pneumoco		× /				4	
	(from your records)							
5	Direct cost of pneumococcal and	influenza vaccine (lin	e 3 plus line 4)				5	
6	Total direct cost of the facility (fr	om Worksheet M-1, c	olumn 7, line 22)				6	
7	Total overhead (from Worksheet	M-2, line 16)					7	
8	Ratio of pneumococcal and influe	enza vaccine direct cos	st to total direct				8	
	cost (line 5 divided by line 6)							
9	Overhead cost - pneumococcal an						9	
10	1		eir				10	
	administration costs (sum of lines	/						
11	Total number of pneumococcal and	nd influenza vaccine in	ijections				11	
12	(from your records) Cost per pneumococcal and influe		(line 10/line 11)				12	
12	1 1	5	· · · · · · · · · · · · · · · · · · ·				12	
15	to Program beneficiaries	iuenza vacenie injecti	ons auministereu				15	
14		nd influenza vaccines	and their				14	
• •	administration costs (line 12 x lin							
15		,	their administration costs (sur	m of columns			15	
	1 and 2, line 10) (transfer this an							
16	Total Program cost of pneumocod	ccal and influenza vac	cines and their administration	costs (sum			16	
	of columns 1 and 2, line 14) (tran	nsfer this amount to W	orksheet M-3, line 21)					

ALYSIS OF PAYMENTS TO HOSPITAL-BASED C/FQHC PROVIDER FOR SERVICES RENDERED PROGRAM BENEFICIARIES	PROVIDER		'ERIOD:	WORKSHEET M-5	
			DOM .	WORKSHEET M-5	
PROGRAM BENEFICIARIES	COL (DOL)		ROM	-	
	COMPONEN	NT CCN: 1	0	-	
ck applicable box: [] RHC [] FQHC					
				Part B	
DESCRIPTION			1	2	4
1			mm/dd/yyyy	Amount	-
1 Total interim payments paid to providers					+
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.		01			_
3 List separately each retroactive		.01			3
lump sum adjustment amount	Program	.02			3
based on subsequent revision of	to	.03			3
the interim rate for the	Provider	.04			3
cost reporting period. Also show		.05		_	3
date of each payment.		.50			3
If none, write "NONE",	Provider	.51			3
or enter zero (1).	to	.52			3
	Program	.53			3
		.54			3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3
4 Total interim payments (sum of lines 1, 2, and 3.99)					
(transfer to Worksheet M-3, line 27)					
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative	Program	.01			5
settlement payment after desk review.	to	.02			5
Also show date of each payment.	Provider	.03			5
If none, write "NONE,"	Provider	.50			5
or enter zero (1).	to	.51			5
	Program	.52			5
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5
6 Determine net settlement amount	Program				
(balance due) based on the cost	to				
report (see instructions). (1)	Provider	.01			6
	Provider				
	to				
	Program	.02			6
7 Total Medicare liability (see instructions)					T
8 Name of Contractor		Contrac	ctor Number	Date (Month/Day/Year))

(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.