#### FORM CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED OMB NO. 0938-0050 payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE PROVIDER CCN: PERIOD WORKSHEET S COMPLEX COST REPORT CERTIFICATION FROM PARTS I, II & III AND SETTLEMENT SUMMARY то PART I - COST REPORT STATUS Provider use only [ ] Electronically filed cost report Date Time: 1. 2. [] Manually submitted cost report 3. [] If this is an amended report enter the number of times the provider resubmitted this cost report 4 [ ] Medicare Utilization. Enter "F" for full or "L" for low. Contractor 5. [ ] Cost Report Status 6. Date Received: 10. NPR Date: use only (1) As Submitted 7. Contractor No.: 11. Contractor's Vendor Code: (2) Settled without audit 8. [ ] Initial Report for this Provider CCN 12. [] If line 5, column 1 is 4: Enter number of (3) Settled with audit 9. [ ] Final Report for this Provider CCN times reopened = 0.9. (4) Reopened (5) Amended

PART II - CERTIFICATION

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

CERTIFICATION BY 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			1
	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						e
7 <i>SNF</i>						7
8 NF, ICF/IID						8
9 HOME HEALTH AGENCY						ç
10 HOSPITAL-BASED - RHC						10
11 HOSPITAL-BASED - 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 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4003.1-4003.3)

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

IOSPITAL	Cont.)		FORM CMS-2552	2-10						11-1
	L AND HOSPITAL HEALTH CARE I IDENTIFICATION DATA				PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I		
	d Hospital Health Care Complex Address:					10				
1 Stre		P.O. Box:								
2 City		State:	Zip Code:	County:						
lospital and	d Hospital-Based Component Identification:	Component	CCN	CBSA	Provider	Date	De	yment System (P, T, O, o	- N)	<u> </u>
	Component	Name	Number	Number	Type	Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	-
3 Hos	spital				· · · · · · · · · · · · · · · · · · ·	5	0	,	0	
	bprovider- IPF									
	bprovider- IRF									
	bprovider- (Other)									
	ing Beds-SNF									
	ing Beds-NF					-				
	spital-Based SNF									
	spital-Based NF			_						_
	spital-Based OLTC spital-Based HHA									
	parately Certified ASC				-					
	spiral-Based Hospice									
	spital-Based Health Clinic-RHC									
	spital-Based Health Clinic-FQHC			<u> </u>						
17 Hos	spital-Based (CMHC, CORF and OPT)									
18 Rer	nal Dialysis									
19 Oth	ner									1
	st Reporting Period (mm/dd/yyyy)	From:	To:							4
	pe of control (see instructions)						1 .	-	-	
	PS Information		at 1 - 1 - 1a	10 CED 110 10 CO			1	2	3	
	es this facility qualify and is it currently receiving payments for column 1, enter "Y" for yes or "N" for no. Is this facility subje				INTE C					
	d this hospital receive interim uncompensated care payments f					ourring prior to October 1				22
	ter in column 2, "Y" for yes or "N" for no for the portion of the				a the cost reporting period of	curring prior to october 1.				
	his a newly merged hospital that requires final uncompensated				mn 1. "Y" for yes or "N" for	no.				22
	the portion of the cost reporting period prior to October 1. Er									
2.03 Did	d this hospital receive a geographic reclassification from urbar	n to rural as a result of the OMB st	andards for delineating statistic	al areas adopted by CMS i	in FY2015? Enter in column	1, "Y" for yes or "N" for no				22
	the portion of the cost reporting period prior to October 1. E					see instructions)				
	es this hospital contain at least 100 but not more than 499 bed									_
	nich method is used to determine Medicaid days on lines 24 an			sus days, or 3 if date of dis						
Is th	he method of identifying the days in this cost reporting period	different from the method used in								
			the prior cost reporting period	? In column 2, enter "Y" f						
			the prior cost reporting period.		for yes or "N" for no.	Out of State	Out of State	Madianid	Other	
			the pror cost reporting period.	In-State	for yes or "N" for no.	Out-of State Medicaid	Out-of State Medicaid eligible	Medicaid HMO	Other Medicaid	
			the prior cost reporting period.	In-State Medicaid	for yes or "N" for no. In-State Medicaid eligible	Medicaid	Medicaid eligible	HMO	Medicaid	T
			the prior cost reporting period.	In-State	for yes or "N" for no.					
24 If th	his provider is an IPPS hospital, enter the in-state Medicaid p	aid days in column 1, in-state Med		In-State Medicaid	for yes or "N" for no. In-State Medicaid eligible unpaid days	Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
	his provider is an IPPS hospital, enter the in-state Medicaid pa gible unpaid days in column 2, out-of-state Medicaid paid day		icaid	In-State Medicaid	for yes or "N" for no. In-State Medicaid eligible unpaid days	Medicaid paid days	Medicaid eligible unpaid days	HMO days	Medicaid days	
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elig in c 25 If th days in c 26 Entu 27 Entu 17 ag 35 If th 36 Entu 37 If th 38 If li 39 Doc	gible unpaid days in column 2, out-of-state Medicaid paid days column 4, Medicaid HMO paid and eligible but unpaid days in his provider is an IRF, enter the in-state Medicaid paid days in sin column 2, out-of-state Medicaid paid days in column 3, o column 4 Medicaid HMO paid and eligible but unpaid days in ter your standard geographic classification (not wage) status a ter your standard geographic Classification (not wage) status a upplicable enter the effective date of the geographic reclassific his is a sole community hospital (SCH), enter the number of p ter applicable beginning and ending dates of SCH status. Sub his is a Medicare dependent hospital (MDH), enter the numbe his hospital a former MDH that is eligible for the MDH transi ine 37 is 1, enter the beginning and ending dates of MDH stat es this facility qualify for the inpatient hospital payment adjus	s in column 3, out-of-state Medicai column 5, and other Medicaid da n column 1, in-state Medicaid eligi uut-of state Medicaid eligible unpai column 5. the beginning of the cost reportin t the end of the cost reporting peri- ation in column 2. veriods SCH status in effect in the 6 script line 36 for number of period r of periods MDH status is in effect titonal payment in accordance with us. If line 37 is greater than 1, sau If line 37 is greater than 1, sau	icaid d eligible unpaid days ys in column 6. ble unpaid d days g period. Enter "1" for urban o od. Enter in column 1, "1" for u tost reporting period. s in excess of one and enter sub t in the cost reporting period. the FY 2016 OPPS final rule? secript this line for the number 4 accordance with 42 CFR 412.10	In-State Medicaid paid days 1 m "2" for rural. urban or "2" for rural. urban or "2" for rural. Enter "Y" for yes or "N" f of periods in excess of one 01(b)(2)(ii)? Enter in colu	for yes or "N" for no.  In-State Medicaid eligible unpaid days 2 2 for no. (see instructions) e and enter subsequent dates. unn 1 "Y" for yes or "N for for yes or "N for the formation of the set of	Medicaid paid days 3 3 Beginning: Beginning:	Medicaid eligible unpaid days	HMO days 5	Medicaid days	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
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FORM CMS-2552-10 (03-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

09-15 FORM CMS-2552-10	0				4090 (	(Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE	PROVIDER CCN:	PERIOD		WORKSHEET S-2		· · · ·
COMPLEX IDENTIFICATION DATA		FROM		PART I (CONT.)		
		то		XVIII		
Prospective Payment System (PPS)-Capital			V	2	XIX	-
45 Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (see instructions)	1		1	2		45
46 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete		Pt. III.				46
47 Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes or "N" for no.						47
48 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						48
The birst Hawled				2		
Teaching Hospitals 56 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.			1	2	3	56
57 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "	"Y" for yes or "N" for no in column 1.					57
If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						
58 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148?						58
If yes, complete Wkst. D-5.						
59 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					L	59
60 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter	"Y" for yes or "N" for no. (see instructions) Y/N			IME	Direct GME	60
	1 I	2	3	1ME 4	5	-
61 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	1 1	2	5			61
	+			IME	Direct GME	
			1	2	3	
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before M						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs add		15)			L	61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see in						61.03 61.04
61.04 Enter the number of unweighted primary care/of surgery allopathic and/or osteopathic r1 is in the current cost reporting period. (see in 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surger		e instructions)			+	61.04
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see in		e instructions)				61.06
				Unweighted	Unweighted	
				IME	Direct GME	
		Program Name	Program Code	FTE Count	FTE Count	
		1	2	3	4	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see inst						61.10
Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter GME FTE unweighted count.	ter in column 4, direct					
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program	m. (see instructions)				-	61.20
Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter GME FTE unweighted count.						
						_
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					-	
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE			1			62
						62 62.01
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE						
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE						
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting per	riod of HRSA THC program. (see instructions)					
62 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting per Teaching Hospitals that Claim Residents in Nonprovider Settings	riod of HRSA THC program. (see instructions)		Unweighted	Unweighted	Ratio	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         7       Teaching Hospitals that Claim Residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions)		FTEs	FTEs	(col. 1/	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         7       Teaching Hospitals that Claim Residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010.					62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin	5 5	FTEs	FTEs	(col. 1/	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period.         7       Teaching Hospitals that Claim Residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin	8	FTEs	FTEs	(col. 1/	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin	8	FTEs	FTEs	(col. 1/	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin	-	FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital.	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin Program Name	Program Code	FTEs Nonprovider Site Unweighted FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs in Hospital	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/ (col. 3 + col. 4))	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in nonprovider Settings         63       Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care in all nonprovider settings. Enter in column 1 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin	-	FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/	62.01 63 64
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         62.03       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care in all nonprovider settings.         65       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin Program Name	Program Code	FTEs Nonprovider Site Unweighted FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs in Hospital	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/ (col. 3 + col. 4))	62.01
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care ris column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)         65       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents.	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin Program Name	Program Code	FTEs Nonprovider Site Unweighted FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs in Hospital	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/ (col. 3 + col. 4))	62.01 63 64
62       Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE         62.01       Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period         63       Has your facility trained residents in Nonprovider Settings         63       Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, con         Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after         64       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care         65       Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name	riod of HRSA THC program. (see instructions) nplete lines 64-67. (see instructions) r July 1, 2009 and before June 30, 2010. e resident FTEs attributable to rotations occurrin Program Name	Program Code	FTEs Nonprovider Site Unweighted FTEs Nonprovider Site	FTEs in Hospital Unweighted FTEs in Hospital	(col. 1/ (col. 1 + col. 2)) Ratio (col. 3/ (col. 3 + col. 4))	62.01 63 64

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1

4090 (Cont.) FORM CMS-2552-1	0					09-15
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings—Effective for cost reporting periods beginning on or after July 1 66 Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider setti unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 1 divided by (column	ings. Enter in column 2, the number of		1	2	3	66
unweigned non-primary care resident PTPS that trained in your hospital. Enter in countin's, the ratio of (column 1 urviced by (column	1 + column 2)). (see instructions)		Unweighted FTEs	Unweighted FTEs	Ratio (col. 3/	
	Program Name	Program Code	Nonprovider Site	in Hospital 4	(col. 3 + col. 4)) 5	4
67 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						67
Inpatient Psychiatric Facility PPS			1	2	3	Т
70 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.						70
71 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 200 Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(ii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		2 CFR 412.424(d)(1)(iii)(C))				
Inpatient Rehabilitation Facility PPS			1	2	3	Т
75 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.						75
76 If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before Nove Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(ii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)		or no.				76
Long Term Care Hospital PPS						
80 Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						80
81 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.						81
TEFRA Providers						
85 Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						85
86 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.						86
87 Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.						87
· · · · ·				V	XIX	
Title V and XIX Services				1	2	
90 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.						90
91 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the						91
92 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the	applicable column.					92
93 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.						93
94 Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.						94
95 If line 94 is "Y", enter the reduction percentage in the applicable column.						95
96 Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.						96
97 If line 96 is "Y", enter the reduction percentage in the applicable column.						97

11-1	6 FORM CMS-2552-	-10				4090 (	(Cont.)
	ITAL AND HOSPITAL HEALTH CARE LEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
Rural	Providers				1	2	$\top$
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	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						107
100	If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 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 n						108
108	Is this a rural nospital qualifying for an exception to the CRNA ree schedule? See 42 CFR 412.113(c). Enter Y for yes of N for h	0.	Physical	0	6 t	Designed	108
100		contract data and	Physical	Occupational	Speech	Respiratory	100
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 n	to for each therapy.				1	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period	od? Enter "Y" for yes or "N" for no.				1	110
		ž				•	
Misco	llaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or	r 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 psychiatr	ic, rehabilitation and long term hospitals					
	providers) based on the definition in CMS Pub.15-1, chapter 22, §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	ence.					118
118.01	List amounts of malpractice premiums and paid losses:			Premiums	Paid losses	Self insurance	118.01
							_
	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit support		ntained therein.				118.02
	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2						119
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see in						120
	rural hospital with $\leq 100$ beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (s	see instructions) Enter in column 2, "Y" for yes	or "N" for no.				1.01
	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.						121
122	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in colu	umn 2 the Worksheet A line number where these	taxes are included.				122
Trans	plant Center Information						
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.						125
126		column 2.					126
127	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in col					1	127
128						1	128
129	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in col						129
130	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in						130
-	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in						131
132	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in colu						132
133	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in co					İ	133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column						134
						•	

4090	) (Cont.) FORM CMS-2552-10						11-16
	ITAL AND HOSPITAL HEALTH CARE LEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM TO		WORKSHEET S-2 PART I (CONT.)		
A11 Dr	oviders						
ЛПП	oviders				1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1.					2	140
110	If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)						110
	in jes, and nome office costs are channed, enter in column 2 the nome office chann number. (see instructions)						
If this	facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor r	name and contractor number					
	Name: Contracto			Contractor's Number:			141
	Street: P. O. Box:	A s Hume.	-	contractor s runnoer.			141
							143
	Are provider based physicians' costs included in Worksheet A?	•					144
	It costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1.						145
145	If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15	5-2 chapter 40 84020)			-	-	146
140	If yes, enter the approval date (mm/dd/yyyy) in column 2.	5-2, enapter 40, §4020)					140
	n yes, enter the approval date (nine do 3333) in column 2.						
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						147
	Was there a change in the statistical basis. Enter "Y" for yes or "N" for no.				-		147
	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				-		149
					+		1.0
Does	this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges?		Title X	VIII			
	"Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR 413.13)		Part A	Part B	Title V	Title XIX	
Linter			1	2	3	4	
155	Hospital		*		5		155
	Subprovider - IPF						156
	Subprovide - IRF						157
	Subprovider - Other						158
							159
	HIA						160
	CMHC						161
							101
Multi	campus						
	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/Ct	ampus in column 5. (see instruction	ons)				166
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	
	L		•				
Health	h Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.						167
168	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets. (see inst	tructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a)(6)(ii)? Enter "Y" for ye	es or "N" for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						169
	Enter in columns 1 and 2, the EHR beginning date and ending date for the reporting period, respectively (mm/dd/yyyy)						170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2,	col. 6? Enter "Y" for yes and "N"	for no in column 1.				171

If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

09-15	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		
Provid	ler Organization and Operation		1/1	2	-	
	Has the provider changed ownership immediately prior to the beginning of the cost reporting period?		1	2		1
1	If yes, enter the date of the change in column 2. (see instructions)					1
	in yes, enter the date of the change in column 2. (see histractions)		Y/N	Date	V/I	
			1	2	3	-
2	Has the provider terminated participation in the Medicare Program?		1	2	5	2
2	If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.					2
3	Is the provider involved in business transactions, including management contracts, with individuals or entiti	95				3
5	(e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, i					5
	staff, management personnel, or members of the board of directors through ownership, control, or family an					
	other similar relationships? (see instructions)	u				
	ould similar relationships: (see instructions)		1			
			Y/N	Туре	Date	T
Financ	cial Data and Reports		1	2	3	-
	Column 1: Were the financial statements prepared by a Certified Public Accountant?		1	2	5	4
4		r ontor				4
	Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy of	l'enter				
5	date available in column 3. (see instructions) If no, see instructions.					5
э	Are the cost report total expenses and total revenues different from those on the filed financial statements?					3
	If yes, submit reconciliation.		1			
				Y/N	Y/N	1
A	ved Educational Activities			1 1	1/N	-1
	Ved Educational Activities			1	2	6
6	Column 1: Are costs claimed for nursing school?					6
	Column 2: If yes, is the provider is the legal operator of the program?					7
7	Are costs claimed for allied health programs? If yes, see instructions.	10				7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting perio	d?				8
	If yes, see instructions.					0
9	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, s					9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting perio		instructions.			10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Wo	rksneet A?				11
	If yes, see instructions.					
D-1D	1214-				V/N	T
Bad D 12					Y/N	12
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If ye	es, submit cop	by.			13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					14
DedC						
<u>веа С</u> 15	omplement				1	15
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.					15
		Da	rt A	Par	D	
			Date	Y/N	Б	1
		V/M			Data	-
DC %D	Depart Date	Y/N	1		Date	-
-	Report Data	Y/N 1	2	3	Date 4	16
PS&R 16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the		1			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)		1			
-	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the		1			16 17
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)		1			
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)		1			
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)		1			
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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation?		1			
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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		1			17
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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been		1			
16 17 18	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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.		1			17
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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other		1			17
16 17 18 19	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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.		1			17 18 19
16 17 18	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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. 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.		1			17
16 17 18 19	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 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. 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.		1			17 18 19

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4004.2) Rev. 8

4090 (Cont.)	FORM CMS-2552-10			09-15
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	or 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.		T	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation			29
	account? If yes, see instructions.			
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
urch	ased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of servic	es?		32
	If yes, see instructions.			
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding?			33
	If no, see instructions.			
Provi	ler-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.			34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost			35
	reporting period? If yes, see instructions.			
		Y/N	Date	<u> </u>
Iome	Office Costs	1	2	-
_	Are home office costs claimed on the cost report?	1	2	36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
	If line 36 is yes, was the fiscal year end of the home office different from that of the provider?			38
50	If yes, enter in column 2 the fiscal year end of the home office.			50
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to other enancemponents. If yes, see instructions.			40
-70	i inc so is yes, an are provider render services to are nonic orned: if yes, see instructions.			
'ost ]	Report Preparer Contact Information			
				4
41	First name: Last name: Title:			1
	First name: 11tte: Employer:			42

11-16					FORM	I CMS-2	552-10			-		-			4090 (C	Joint.
HOSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX									PROVIDE	R CCN:	PERIOD		WORKS	HEET S-3	
STATISTICAL DATA												FROM		PART I		
	-	-			<b>1</b>				1			ТО				
					Inpatier	nt Days / Ou	tpatient Visit	ts / Trips	Full	Time Equiva	lents		Disc	harges	1	-
	Worksheet															
	Α							Total	Total	Employees					Total	
_	Line	No. of	Bed Days	CAH		Title	Title	All	Interns &	On	Nonpaid		Title	Title	All	
Component	No.	Beds	Available	Hours	Title V	XVIII	XIX	Patients	Residents	Payroll	Workers	Title V	XVIII	XIX	Patients	-
	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) (see instructions for col.																
2 for the portion of LDP room available bed	s)															
2 HMO and other (see instructions)																2
3 HMO IPF Subprovider																3
4 HMO IRF Subprovider																4
5 Hospital Adults & Peds. Swing Bed SNF																5
6 Hospital Adults & Peds. Swing Bed NF																6
7 Total Adults and Peds. (exclude																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
19 Skilled Nursing Facility																19
20 Nursing Facility																20
21 Other Long Term Care																21
22 Home Health Agency																22
23 ASC (Distinct Part)																23
24 Hospice (Distinct Part)																24
24.10 Hospice (non-distinct part)																24.1
25 CMHC				_												25
26 RHC/FQHC (specify)							1	1	1							26
27 Total (sum of lines 14-26)																27
28 Observation Bed Days																28
29 Ambulance Trips																29
30 Employee discount days (see instructions)																30
31 Employee discount days (see instructions)																31
32 Labor & delivery (see instructions)																32
32.01 Total ancillary labor & delivery room																32.0
outpatient days (see instructions)																52.0
33 LTCH non-covered days																33

4090	) (Cont.) H ITAL WAGE INDEX INFORMATION	M CMS-2	552-10				11-3		
HOSPIT	TAL WAGE INDEX INFORMATION		PROVIDER CO	CN:	PERIOD FROM TO		WORKSHEET S PART II	5-3	
Part II -	Wage Data								
		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)		
		1	2	3	4	5	6		
	SALARIES								
1	Total salaries (see instructions)							1	
2	Non-physician anesthetist Part A							2	
3	Non-physician anesthetist Part B							3	
4	Physician-Part A - Administrative							4	
4.01	Physician-Part A - Teaching							4.01	
5	Physician and Non Physician -Part B							5	
6	Non-physician-Part B for hospital-based RHC and FQHC services							6	
7	Interns & residents (in an approved program)							7	
7.01	Contracted interns & residents (in an approved program)							7.01	
8	Home office and/or related organization personnel							8	
9	SNF							9	
10	Excluded area salaries (see instructions)							10	
	OTHER WAGES AND RELATED COSTS								
11	Contract labor : Direct Patient Care							11	
12	Contract labor: Top level management and other management and administrative services							12	
13	Contract labor: Physician-Part A - Administrative							13	
14	Home office and/or related orgainzation salaries and wage-related costs							14	
14.01	Home office salaries							14.01	
14.02	Related organization salaries							14.02	
15	Home office: Physician Part A - Administrative							15	
16	Home office & Contract Physicians Part A - Teaching							16	
	WAGE-RELATED COSTS								
17	Wage-related costs (core) (see instructions)							17	
18	Wage-related costs (other) (see instructions)							18	
19	Excluded areas							19	
20	Non-physician anesthetist Part A							20	
21	Non-physician anesthetist Part B							21	
22	Physician Part A - Administrative							22	
22.01	Physician Part A - Teaching							22.01	
23								23	
24	Wage-related costs (RHC/FQHC)							24	
25	Interns & residents (in an approved program)							25	
25.50	Home office wage-related							25.50	
25.51	Related orgainzation wage-related							25.51	
25.52	Home office: Physician Part A - Administrative - wage-related							25.52	
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53	

WAGE INDEX INFORMATION ge Data		PROVIDER CO	CN:	PERIOD		WORKSHEET S	.3
ge Data				FROM TO		PART II & III	
-				10			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
	1	2	3	4	5	6	
VERHEAD COSTS - DIRECT SALARIES							
mployee Benefits Department	4						26
dministrative & General	5						27
							28
	6						29
peration of Plant	7						30
aundry & Linen Service	8						31
ousekeeping	9						32
ousekeeping under contract (see instructions)							33
ietary	10						34
ietary under contract (see instructions)							35
afeteria	11						36
laintenance of Personnel	12						37
ursing Administration	13						38
entral Services and Supply	14						39
harmacy	15						40
Iedical Records & Medical Records Library	16						41
ocial Service	17						42
ther General Service	18						43
enited Wares Index Comments							
							1
							2
· / /							4
			+				
	dministrative & General under contract (see instructions) aintenance & Repairs peration of Plant aundry & Linen Service ousekeeping ousekeeping ideary under contract (see instructions) ietary ietary under contract (see instructions) afeteria aintenance of Personnel ursing Administration entral Services and Supply armacy iedical Records & Medical Records Library ocial Service	dministrative & General under contract (see instructions)       6         iaintenance & Repairs       6         peration of Plant       7         aundry & Linen Service       8         ousekeeping       9         ousekeeping under contract (see instructions)       9         ietary under contract (see instructions)       10         ietary under contract (see instructions)       10         ietary under contract (see instructions)       12         ursing Administration       13         entral Services and Supply       14         narmacy       15         edical Records & Medical Records Library       16         ocial Service       17         ther General Service       18         spital Wage Index Summary       18         spital Wage Index Summary       10         ubtotal salaries (see instructions)       10         ubtotal salaries (line 1 minus line 2)       10         ubtotal wage-related costs (see instructions)       10         ustoral wage-related costs (see instructions)       10         otal (sum of lines 3 through 5)       10	dministrative & General under contract (see instructions)       6         iaintenance & Repairs       6         peration of Plant       7         aundry & Linen Service       8         ousekeeping       9         ousekeeping under contract (see instructions)       10         ietary under contract (see instructions)       10         ietary under contract (see instructions)       11         afteria       11         iaintenance of Personnel       12         ursing Administration       13         entral Services and Supply       14         narmacy       15         edical Records & Medical Records Library       16         cicial Service       17         ther General Service       18         spital Wage Index Summary       1         spital Wage Index Summary       1         ubtotal alaries (see instructions)       1         ubtotal salaries (line 1 minus line 2)       1         ubtotal wage-related costs (see instructions)       1         ursitotal wage-related costs (see instructions)       1         ursitotal subtotal vage-related costs (see instructions)       1	dministrative & General under contract (see instructions)       6         iaintenance & Repairs       6         peration of Plant       7         undry & Linen Service       8         ousekeeping       9         ousekeeping under contract (see instructions)       10         ietary under contract (see instructions)       10         afeteria       11         aintenance of Personnel       12         ursing Administration       13         edical Records & Medical Records Library       16         cial Records & Medical Records Library       16         cial service       17         ther General Service       17         spital Wage Index Summary       18         spital Wage Index Summary       1         spital wage and related costs (see instructions)       1         abotal alaries (ine 1 minus line 2)       1         abotal wage-related costs (see instructions)       1         abotal wage-related costs (see instructions)       1	dministrative & General under contract (see instructions)       6       1         iaintenance & Repairs       6       1         peration of Plant       7       1         undry & Linen Service       8       1         ousekeeping       9       1         ousekeeping under contract (see instructions)       10       1         ietary       10       1       1         ietary under contract (see instructions)       10       1       1         ietary under contract (see instructions)       10       1       1       1         iaintenance of Personnel       12       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1 </td <td>Ininistrative &amp; General under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)aintenance &amp; Repairs6Image: contract (see instructions)Image: contract (see instructions)aundry &amp; Linen Service8Image: contract (see instructions)Image: contract (see instructions)ousekeeping9Image: contract (see instructions)Image: contract (see instructions)ietary10Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and self (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions)<!--</td--><td>Initializative &amp; General under contract (see instructions)         Image: method is an instruction instruction is an instruction instruction is an instruction insen instruction is an instruction is an instruction i</td></td>	Ininistrative & General under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)aintenance & Repairs6Image: contract (see instructions)Image: contract (see instructions)aundry & Linen Service8Image: contract (see instructions)Image: contract (see instructions)ousekeeping9Image: contract (see instructions)Image: contract (see instructions)ietary10Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary under contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary and self (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions)Image: contract (see instructions)ietary contract (see instructions)Image: contract (see instructions) </td <td>Initializative &amp; General under contract (see instructions)         Image: method is an instruction instruction is an instruction instruction is an instruction insen instruction is an instruction is an instruction i</td>	Initializative & General under contract (see instructions)         Image: method is an instruction instruction is an instruction instruction is an instruction insen instruction is an instruction is an instruction i

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

		Amount Reported	
	RETIREMENT COST		
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 through 23)		24

Part B - Other that	n Core Related Cost	
25 Other W	age Related Costs (specify)	25

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

Part V - Contract Labor and Benefit Cost

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

	PITAL-BASED HOME HEALTH AGENCY FISTICAL DATA	PROVIDE HHA CCN		PERIOD: FROM TO		WORKSHE	ET S-4	
	HOME HEALTH AGENCY STATISTICAL DATA			County	:	• 		
			Title V	Title XVIII	Title XIX	Other	Total	Г
1	Description		1	2	3	4	5	╇
2	Home Health Aide Hours Unduplicated Census Count (see instructions)							+
	· ·			1				4
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES				Nur	nber of Emplo	oyees	Т
	Enter the number of hours in					l Time Equiva	alent)	
	your normal work week				Staff	Contract	Total	1
	1				1	2	3	Ļ
	Administrator and Assistant Administrator(s)							Ļ
4								Ļ
5								Ļ
6								Ļ
7							ļ	t
8							ļ	t
9								ł
	Occupational Therapy Service							∔
	Occupational Therapy Supervisor							∔
	Speech Pathology Service							Ļ
	Speech Pathology Supervisor							∔
	Medical Social Service							∔
15	L.							∔
	Home Health Aide							∔
17								╇
18	Other (specify)							1
	HOME HEALTH AGENCY CBSA CODES							
10	Enter the number of CBSAs where you provided services during the cost rep	orting period						т
20		<u> </u>	e)					t
20	• • • • •	ontains the first cod						1
	PPS ACTIVITY		Full E	pisodes			Total	Т
			Without	With	LUPA	PEP only	(columns 1	
			Outliers	Outliers	Episodes	Episodes	through 4)	
			1	2	3	4	5	l
	0							ſ
21	Skilled Nursing Visit Charges							I
								l
22	Physical Therapy Visits							Ĺ
22 23	Physical Therapy Visit Charges							Ĺ
22 23 24 25	Physical Therapy Visit Charges Occupational Therapy Visits							
22 23 24 25 26	Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges							t
22 23 24 25 26 27	Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits							ţ
22 23 24 25 26 27 28	Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges							
22 23 24 25 26 27 28 29	Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits							
22 23 24 25 26 27 28 29 30	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visit Charges							
22 23 24 25 26 27 28 29 30 31	Physical Therapy Visit Charges Occupational Therapy Visits Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits							
27 28 29 30 31 32	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visit Charges         Home Health Aide Visits         Home Health Aide Visit Charges							
22 23 24 25 26 27 28 29 30 31 32 33	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visit Charges         Home Health Aide Visits         Home Health Aide Visit Charges         Total visits (sum of lines 21, 23, 25, 27, 29, and 31)							
22 23 24 25 26 27 28 29 30 31 32 33 34	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visits         Home Health Aide Visits         Home Health Aide Visit Charges         Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         Other Charges							
22 23 24 25 26 27 28 29 30 31 32 33 34 35	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visit Charges         Home Health Aide Visits         Home Health Aide Visit Charges         Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         Other Charges         Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)							
22 23 24 25 26 27 28 29 30 31 32 33 34 35 36	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visits Charges         Home Health Aide Visits         Home Health Aide Visits         Home Health Aide Visits Charges         Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         Other Charges         Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)         Total Number of Episodes (standard/non-outlier)							
22 23 24 25 26 27 28 29 30 31 32 33 34 35	Physical Therapy Visit Charges         Occupational Therapy Visits         Occupational Therapy Visit Charges         Speech Pathology Visits         Speech Pathology Visit Charges         Medical Social Service Visits         Medical Social Service Visits Charges         Home Health Aide Visits         Home Health Aide Visits Charges         Total visits (sum of lines 21, 23, 25, 27, 29, and 31)         Other Charges         Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)         Total Number of Episodes (standard/non-outlier)         Total Number of Outlier Episodes							

11-16	FORM C	MS-2552-10	0			4090 (0	Cont.)
HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		PROVIDER O	CCN:	PERIOD: FROM TO		WORKSHEET	Г S-5
RENAL DIALYSIS STATISTICS							
	Outpati	ent	Train	ing	Home	e	
DESCRIPTION	Regular	High Flux	Hemo- dialysis 3	CAPD CCPD 4	Hemo- dialysis 5	CAPD CCPD 6	
1 Number of patients in program at	1	2	5		5	0	1
end of cost reporting period							
2 Number of times per week patient							2
receives dialysis							
3 Average patient dialysis time including setup							3
4 CAPD exchanges per day							4
5 Number of days in year dialysis furnished							5
6 Number of stations							6
7 Treatment capacity per day per station							7
8 Utilization (see instructions)							8
9 Average times dialyzers re-used							9
10 Percentage of patients re-using dialyzers							10
Enter "Y" for yes or "N" for no. (see instructions)           10.02         Did your facility elect 100% PPS effective January 1, (See instructions for "new" providers.)           10.03         If you responded "N" to line 10.02, enter in column 1 enter in column 2 the year of transition for periods after	the year of transition for period	ls prior to Januar	y 1 and				10.02
TRANSPLANT INFORMATION							
11 Number of patients on transplant list							11
12 Number of patients transplanted during the cost report	ting period						12
						-	
EPOETIN							
13 Net costs of Epoetin furnished to all maintenance dia						-	13
<ol> <li>Net costs of Epoetin furnished to all maintenance dial</li> <li>Epoetin amount from Worksheet A for home dialysis</li> </ol>	program						14
<ul> <li>13 Net costs of Epoetin furnished to all maintenance dial</li> <li>14 Epoetin amount from Worksheet A for home dialysis</li> <li>15 Number of EPO units furnished relating to the renal of</li> </ul>	program lialysis department						14 15
<ol> <li>Net costs of Epoetin furnished to all maintenance dial</li> <li>Epoetin amount from Worksheet A for home dialysis</li> </ol>	program lialysis department						14 15
<ul> <li>13 Net costs of Epoetin furnished to all maintenance dial</li> <li>14 Epoetin amount from Worksheet A for home dialysis</li> <li>15 Number of EPO units furnished relating to the renal of</li> </ul>	program lialysis department						14
<ul> <li>13 Net costs of Epoetin furnished to all maintenance dial</li> <li>14 Epoetin amount from Worksheet A for home dialysis</li> <li>15 Number of EPO units furnished relating to the renal of</li> <li>16 Number of EPO units furnished relating to the home of</li> </ul>	program lialysis department dialysis department	г					14 15
<ul> <li>13 Net costs of Epoetin furnished to all maintenance dial</li> <li>14 Epoetin amount from Worksheet A for home dialysis</li> <li>15 Number of EPO units furnished relating to the renal of</li> <li>16 Number of EPO units furnished relating to the home of</li> <li>ARANESP</li> </ul>	program lialysis department dialysis department dialysis patients by the provide	r					14 15 16
<ul> <li>13 Net costs of Epoetin furnished to all maintenance dial</li> <li>14 Epoetin amount from Worksheet A for home dialysis</li> <li>15 Number of EPO units furnished relating to the renal of</li> <li>16 Number of EPO units furnished relating to the home of</li> <li>ARANESP</li> <li>17 Net costs of ARANESP furnished to all maintenance</li> </ul>	program lialysis department dialysis department dialysis patients by the provide ysis program	r					14 15 16 17

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

21	MCP	INITIAL METHOD					21
			Net Cost of	Net Cost of	Number of ESA	Number of ESA	
		ESA	ESAs for	ESAs for	Units - Renal	Units - Home	
		Description	<b>Renal Patients</b>	Home Patients	Dialysis Dept.	Dialysis Dept.	
	Erythropoiesis-Stimulating Agents (ESA) Statistics:	1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net						22
	costs of ESAs furnished to all renal dialysis patients.						
	Enter in column 3 the net cost of ESAs furnished to all home						
	dialysis program patients. Enter in column 4 the number of						
	ESA units furnished to patients in the renal dialysis department.						
	Enter in column 5 the number of units furnished						
	to patients in the home dialysis program. (see instructions)						

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

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4007) Rev.  $10\,$ 

4090 (Cont.)	FORM CMS-2552-10				11-16
HOSPITAL-BASED COMMUNITY MENTAL HEALTH CEI	NTER 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	<u> </u>
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

10-1	2 FO	RM CMS-2552-10		4090 (Cont		
	PECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7		
SIAL	ISTICAL DATA		FROM TO	ī		
			10	- ]		
			Y/N	Date		
			1	2		
1	If this facility contains a hospital-based SNF, were all patients under man				1	
	utilization? Enter "Y" for yes and do not complete the rest of this works Does this hospital have an agreement under either section 1883 or section	heet.				
2	yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/				2	
	yes of 14 10 no in column 1. If yes, ener the agreement date (minude)	yyyy) ii coluini 2.	1		<u> </u>	
		SNF	Swing Bed SNF	TOTAL		
	Group	Days	Days	(sum of col. 2 + 3)		
	1	2	3	4		
3	RUX RUL				3	
5	RVX				5	
6	RVL				6	
7	RHX				7	
8	RHL				8	
9	RMX				9	
10	RML RLX				10 11	
11	RUC				11	
13	RUB				13	
14	RUA			1	14	
15	RVC				15	
16	RVB				16	
17	RVA				17	
18 19	RHC RHB			1	18 19	
20	RHA				20	
21	RMC				21	
22	RMB				22	
23	RMA				23	
24	RLB				24	
25	RLA				25	
26 27	ES3 ES2				26 27	
28	ES1				28	
29	HE2			1	29	
30	HE1				30	
31	HD2				31	
32	HD1				32	
33 34	HC2 HC1				33 34	
35	HB2		1	1	35	
36	HB1				36	
37	LE2				37	
38	LE1				38	
39	LD2				39	
40	LD1 LC2		1	1	40 41	
41	LCI				41	
43	LB2				43	
44	LB1				44	
45	CE2				45	
46	CE1				46	
47	CD2 CD1				47 48	
48	CDI CC2				48	
50	CCI		1	1	50	
51	CB2			1	51	
52	CB1				52	
53	CA2				53	
54	CA1				54	

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4009) Rev.  $3\,$ 

4090	) (Cont.)	FORM CMS-2552-10	FORM CMS-2552-10						
	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. $2 + 3$ )	Γ				
	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	
				Direct Patient Care	
		Expenses	Percentage	and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (Specify)				206
207	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)				207

11-16 FG					FORM	RM CMS-2552-10								4090 (Cont.)		
HOSPITAL-BASED RH	C/FQHC STAT	TISTICAL .	DATA					DER CCN				):		WORK	SHEET S	-8
Check applicable box:	[] Hospit [] Hospit	tal-based 1 tal-based 1														
Clinic Address and Iden	tification:															
1 Street:																1
2 City:	ED FOUG O	State:			Zip Coc				County:					1		2
3 HOSPITAL-BAS	ED FQHCs O	NLY: De	signation	- Enter "	R" for ru	ral or "U"	for urbar	1								3
Source of Federal Funds	3:									1				1		
												Award			ate	
														1	2	
4 Community Hea		,		Act)												4
5 Migrant Health		( ))		BIIG I												5
6 Health Services			n 340(d)	, PHS Ac	t)											6
7 Appalachian Res 8 Look-alikes	gional Commi	ssion														7
																9
9 Other (specify)																9
														1	2	<u> </u>
10 Does this facility If yes, indicate the	*				-	HC? Ente	er "Y" for	yes or "N	" for no i	n column	1.					10
Facility hours of operati	ons (1)															
			nday		nday		esday		nesday		rsday		day		ırday	
Type Op	eration	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
0 11 Clinic		1	2	3	4	5	6	7	8	9	10	11	12	13	14	11
(1) Enter clinic hour		E 11						11 (h - 4		1 f						11
List hours of ope																
r					<b>F</b>		,r		,							
														1	2	
12 Have you receive	ed an approva	l for an exc	cention to	the prod	nctivity	standard?									2	12
13 Is this a consolid							ection 30	8? Enter	"Y" for v	es or "N"	for no in	column 1				13
If yes, enter in co	*											column 1	•			15
14 RHC/FQHC nat			roviders	mended	in uns re	port. List		s of all pi	CCN nu		13 0010 W.					14
·																<u> </u>
													1	1	Total	
											Y/N	v	XVIII	XIX	Visits	
												· ·				4

		Y/N	v	XVIII	XIX	Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1.						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. Enter in column 5 the number of total visits for this provider. (see instructions)						

4090 (Cont.)	FORM CMS-2552-10			11-16
HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		PROVIDER CCN:	PERIOD:	WORKSHEET S-9
			FROM	PARTS I THROUGH IV
		HOSPICE CCN:	то	

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

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

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

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

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

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

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

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

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

11-1	6 FORM CMS-2552	2-10		4090 (Cont.)	
HOSP	PITAL UNCOMPENSATED AND INDIGENT	PROVIDER CCN:	PERIOD:	WORKSHEET S-10	
	EDATA		FROM		
			ТО	-	
			10	-	
Unco	mpensated and indigent care cost computation				
1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3, divided by line 202, co	olumn 8)			1
	Cost to charge ratio (worksheet C, Fart I, mic 202, column 5, divided by mic 202, co	oluliii o)			1
Media	caid (see instructions for each line)				
2	Net revenue from Medicaid				2
3	Did you receive DSH or supplemental payments from Medicaid?				3
	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid	49			4
	If line 4 is no, enter DSH or supplemental payments from Medicaid	u:			5
6					6
7					7
-		2 1 5)			8
8	10	2 and 3).			0
	If line 7 is less than the sum of lines 2 and 5, then enter zero.				
CUL	(CIUD) (as instruction for each line)				
	Iren's Health Insurance Program (CHIP) (see instructions for each line)				0
9					9
10	<u> </u>				10
11	Stand-alone <i>CHIP</i> cost (line 1 times line 10)	0)			11
12	· · · · · · · · · · · · · · · · · · ·	9).			12
	If line 11 is less than line 9, then enter zero.				L
-	state or local government indigent care program (see instructions for each line)				T
13					13
14	Charges for patients covered under state or local indigent care program (not included	d in lines 6 or 10)			14
15					15
16	Difference between net revenue and costs for state or local indigent care program (li	ine 15 minus line 13)			16
	If line 15 is less than line 13, then enter zero.				<u> </u>
-	mpensated 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, CHIP, and state and local indigent care prog	rams (sum of lines 8, 12, and	d 16)		19
				-	
		Uninsured	Insured	Total	
		patients	patients	(col. 1 + col. 2)	_
		1	2	3	
20	Charity care charges for the entire facility (see instructions)				20
21	Cost 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 leng	gth of stay limit imposed on p	patients 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 len	igth of stay limit (see instruct	ions)		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 Medicare bad debt expense (line 26 minus line	e 27)			28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 time	es line 28)			29
30	Cost of uncompensated care (line 23 column 3 plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

4090 (Cont.)			FORM CMS-2	FORM CMS-2552-10					
HOSPITAL-BASED FQI	IC IDENTIFICATION DATA				PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM: TO:	WORKSHEET S-11 PART I		
PART I - HOSPITAL-BA	SED FQHC IDENTIFICATION DATA								
				Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW		
1 Site Name:	1			2	3	4	5	1	
2 Street:	<i>P.O. Box:</i>				1			2	
3 City:	State:	Zip Code:	County:	Designation - Enter "I	R" for rural or "U" for u	·ban:		3	
4 Is this hospital-ba enter the entity's i 5 Name of Entity:	sed FQHC part of an entity that owns, leases or contro nformation below.	ls multiple FQHCs? Ente	r "Y" for yes or "N" for no. If yes,					4	
6 Street:	<i>P.O. Box:</i>		HRSA Award Number:					6	
7 City:	State:		Zip Code:					7	
				1	2	3	4		
Consolidated Cost Report	t			Y/N	Date Requested	Date Approved	Number of FQHCs	1	
	sed FQHC filing a consolidated cost report per CMS P complete columns 2 through 4, and line 9 beginning w			CCN	CBSA	Date Requested	Date Approved	8	
	1			2	3	4	5	9	
<ul> <li>9 List of Consolidat</li> <li>9 Site Name:</li> </ul>	ed Providers:							9	
9 Sile Name: Hospital-Based FQHC O	perations				1	2	3	9	
10 What type of orga	nization is this hospital-based FQHC? If you operate mn 2. (see instructions)	as more than one sub-typ	e of an organization, enter only the applicable alph	a	1			10	
on line 1, column	based FQHC receive a grant under \$330 of the PHS Ac 1, receive a grant under \$330 of the PHS Act during th	is cost reporting period?	Enter "Y" for yes or "N" for no. (complete line 12)	)				11	
column 2, and ent	line 11 is yes, indicate in column 1, the type of HRSA g er the grant award number in column 3. If you receive		· · · · ·	in				12	
Medical Malpractice					1			_	
yes or "N" for no	based FQHC submit an initial deeming or annual redee in column 1. If column 1 is yes, enter the effective date		1 0	RSA? Enter "Y" for				13	
Interns and Residents							-		
	based FQHC receive a THC development grant authori in column 1. If yes, enter in column 2, the number of F			urough your				14	
THC grant in this period. (see instr	cost reporting period and in column 3, enter the total actions)	number of visits performe	ed by residents funded by the THC grant in this cost	t reporting					

11-16				FORM CMS-2552	-10			4090	4090 (Cont.)	
HOSPITAL-BASED	FQHC IDENTIFICATION DAT	ΓΑ				PROVIDER CCN:	PERIOD: FROM	WORKSHEET S-11 PART II		
						COMPONENT CCN:	TO			
						SUBCOMPONENT CCN	2			
PART II - HOSPITAL	BASED FQHC CONSOLIDATE	ED COST REPORT PARTIC	PANT IDENTIFICATION DATA							
				Date Certified	Type of control (see instructions)	Date Decertified	V/I Decertification	Date of CHOW		
		1		2	3	4	5	6		
1 Site Name:	<b>D O D</b>								1	
2 Street: 3 City:	P.O. Box: State:	Zip Code:	County:		Designation Enter "P"	for rural or "U" for urban:		-	2	
Hospital-Based FQHC		Zip Coue.	County.		Designation - Enter K	ווויזענטר ט ווויזענטר. 1	2	3	5	
4 What type of o			more than one sub-type of an or	rganization, enter only the app	plicable	1	2		4	
5 Did this hospit	al-based FQHC receive a grant	under §330 of the PHS Act of	luring this cost reporting period	1? Enter "Y" for yes or "N" fo	r no. (complete line 6)				5	
			t that was awarded (see instructi nore than one grant subscript the		rant award in				6	
Medical Malpractice										
		· · · · · · · · · · · · · · · · · · ·	ing application for medical mal ffective date of coverage in colu	· · · · · · · · · · · · · · · · · · ·	TCA with HRSA?				7	
Interns and Residents										
8 Did this hospit	al-based FQHC receive a THC o	development grant authorize	d under Part C of Title VII of the	e PHS Act from HRSA?					8	
			umber of FTE residents that you							
your THC gran	nt in this cost reporting period as	nd in column 3, enter the tot	al number of visits performed by	residents funded by the THC	grant					
in this cost rep	orting period. (see instructions)									

4090 (Cont.) FORM CMS-2552-10							
HOSPITAL-BASED FQHC IDENTIFICATION DATA				PERIOD: FROM TO		WORKSHEET PART III	T S-11
PART III - HOSPITAL-BASED FQHC STATISTICAL DATA		<u>т —                                   </u>	-	<u>т</u>	1		
	COMPONENT CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
	0	1	2	3	4	5	
1 Medical Visits 2 Total Medical Visits							1
3 Mental Health Visits							3
4 Total Mental Health Visits							4

This page is reserved for future use.

090 (	Cont.	)		FORM CM	AS-2552-10					11-16
ECLAS	SIFICA	TION AND ADJUSTMENT OF TRIAL BALANCE OF I	EXPENSES		PROVIDER CCN:		PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. $3 \pm$ 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 Department								4
5	00500	Administrative and General								5
6	00600									6
7	00700	Operation of Plant								7
8		Laundry and Linen Service								8
9		Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13		Nursing Administration								13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18	01700	Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
20	02100	Intern & Res. Service-Salary & Fringes (Approved)								20
22	02200	Intern & Res. Other Program Costs (Approved)								22
22	02200	Paramedical Ed. Program (specify)								23
25		INPATIENT ROUTINE SERVICE COST CENTERS								23
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35	05400	Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
40	04000	Subprovider - IRF								40
42	04100	Subprovider - IKI								41
42	04300	Nursery					1			42
43		Skilled Nursing Facility		1						43
44	04400	Nursing Facility					1			44
45		Other Long Term Care		<del> </del>	+		+		ł	45

10-12				FORM CM	<b>4</b> S-2552-10				4090 (	Cont.)
RECLAS	SIFICA	TION AND ADJUSTMENT OF TRIAL BALANCE O	FEXPENSES		PROVIDER CCN:		PERIOD: FROM TO	-	WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6)	
			1	2	3	4	5	6	7	<b> </b>
50	05000	ANCILLARY SERVICE COST CENTERS								50
	05000	Operating Room Recovery Room								50
		Labor Room and Delivery Room	_							52
		Anesthesiology	_							53
-		Radiology-Diagnostic	_							54
		Radiology-Diagnostic Radiology-Therapeutic								55
-	05500	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
		17	-							65
		Respiratory Therapy Physical Therapy								66
		Occupational Therapy	_							67
		Speech Pathology	_							68
		Electrocardiology	-							69
-		Electroencephalography								70
		Medical Supplies Charged to Patients								70
		Implantable Devices Charged to Patients								71
	07200	Drugs Charged to Patients								73
		Renal Dialysis								73
		ASC (Non-Distinct Part)	1							74
75	01500	Other Ancillary (specify)	1							76
,0		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
	08900	Federally Qualified Health Center (FQHC)	1		1		1			89
	09000	Clinic	1				1			90
	09100	Emergency	1	1	1		1			90
-	09200	Observation Beds								92
93	.,200	Other Outpatient Service (specify)								93

4090 (	Cont.	)	FORM CM	4S-2552-10					10-12	
RECLAS	SSIFICA	ATION AND ADJUSTMENT OF TRIAL BALANCE OF	FEXPENSES		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. $3 \pm col. 4$ )	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6) 7	
		OTHER REIMBURSABLE COST CENTERS		-	5		5	Ū	,	
94	09400	Home Program Dialysis								94
95		Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97		Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101		Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106		Heart Acquisition								106
107		Liver Acquisition								107
108		Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)		1						112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF		1					- 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	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)				- 0 -				200

LASSIFICATIONS						PROVIDER CCN:	PERIOI FROM_ TO	D:	WORKSHEET	A-6
		INCREASES				DECREASES			Wkst.	
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										1
		-								
		-								
		-								
										<b>_</b>
										<b>_</b>
										┿───
	_					_				┿───
	_						_			<u> </u>
										+
										┿───
	_									
										+
	_									
	_									+
										-
					1	1				1
					1		1 1			1
		-								
Total reclassifications (sum of columns 4 and 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	T BALANCES				;				
				Acquisitions		Disposals		Fully	
Description		Beginning Balances	Purchases	Donation	Total	and Retirements	Ending Balance	Depreciated Assets	
		1	2	3	4	5	6	7	<u> </u>
1 Land									1
2 Land Improvements									2
3 Buildings and Fixtures									3
4 Building Improvements									4
5 Fixed Equipment									5
6 Movable Equipment									6
7 HIT-designated Assets									7
8 Subtotal (sum of lines 1-7)									8
9 Reconciling Items									9
10 Total (line 7 minus line 9)									10
PART II - RECONCILIATION OF AMOUNTS FROM W	VORKSHEET A, COI	LUMN 2, LINES 1 A	AND 2						
					SUMMARY OF CAP	PITAL			I
					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	
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1-2)									3
<ol> <li>The amount in columns 9 through 14 must equal the amo column 2, lines 1 and 2.</li> </ol>			<ol><li>Enter in each colu</li></ol>	mn the appropriate am	ounts including any d	lirectly assigned cost t	hat may have been incl	luded in Worksheet A,	
* All lines numbers are to be consistent with Worksheet A		al cost centers.							
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS								
		COMPUTAT	ION OF RATIOS			ALLOCATION O	F OTHER CAPITAL	-	I
			Gross Assets					Total	J
		Capitalized	for Ratio	Ratio			Other Capital-	(sum of	J
Description	Gross Assets	Leases	(col. 1 - col. 2)	(see instructions)	Insurance	Taxes	Related Costs	cols. 5 through 7)	I
*	1	2	3	4	5	6	7	8	1
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
3 Total (sum of lines 1-2)				1.000000					3
				S	SUMMARY OF CAL	PITAL			1
							Other Capital-	Total (2)	1
					Insurance	Taxes	Related Costs	(sum of	1
Description		Depreciation	Lease	Interest	(see instructions)	(see instructions)	(see instructions)	cols. 9 through 14)	I
*		9	10	11	12	13	14	15	1
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment		l	1		1	1			2
3 Total (sum of lines 1-2)		1			1			1	3
(2) The amounts on lines 1 and 2 must equal the correspond		ant A naturna 7 line	a Land 2 Columna	o theory of 14 should in	aluda ralatad	•	•	•	

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)

IMENTS TO EXPENSES	PROVIDER CCN:		PERIOD: FROM	WORKS	HEET A	-8
			то	WORKSHEET A		
DESCRIPTION (1)	) BASIS/CODE (2) AMOUNT		EXPENSE CLASSIFICAT WORKSHEET A TO/FROM THE AMOUNT IS TO BE A	A WHICH DJUSTED	Wkst. A-7	
	BASIS/CODE (2)	2 AMOUNT	COST CENTER	LINE #	Ref.	
nvestment income - buildings and fixtures (chapter 2)	1	2	Buildings and Fixtures	1	5	1
nvestment income - movable equipment (chapter 2)			Movable Equipment	2		2
nvestment income - other (chapter 2)				_		3
Trade, quantity, and time discounts (chapter 8)						4
Refunds and rebates of expenses (chapter 8)						5
Rental of provider space by suppliers (chapter 8)						6
Celephone services (pay stations excluded) (chapter 21)						7
Television and radio service (chapter 21)						8
Parking lot (chapter 21)						9
Provider-based physician adjustment	Worksheet A-8-2					10
sale of scrap, waste, etc. (chapter 23)	Wollahoot II o 2					11
Related organization transactions (chapter 10)	Worksheet A-8-1					12
aundry and linen service	Worksheet H 0 1					13
Cafeteria-employees and guests						14
Rental of quarters to employee and others						15
ale of medical and surgical						16
upplies to other than patients						10
						17
						18
						19
						20
						20
•						21
						22
						22
						23
	Worksheet A-8-3		Respiratory Therapy	65		25
	Worksheet H 0 5		Respiratory merupy	05		24
	Worksheet A-8-3		Physical Therapy	66		24
	Worksheet 71-0-5					25
						26
			0	-		20
						28
1 7				1/		20
						30
	Worksheet A-8-3		Occupational Therapy	67		50
						30.99
				50		31
	Worksheet A-8-3		Speech Pathology	68		
			Specch r uniology	00		32
and a subscription of population						33
)ther adjustments (specify) <sup>(3)</sup>						
Other adjustments (specify) <sup>(3)</sup> COTAL (sum of lines 1 through 49)						50
Gailand Salahan S	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts rrsing school (tuition, fees, books, etc.) ending machines come from imposition of interest, ance or penalty charges (chapter 21) erest expense on Medicare overpayments and rrowings to repay Medicare overpayments ljustment for respiratory therapy sts in excess of limitation (chapter 14) ljustment for physical therapy costs excess of limitation (chapter 14) ilization review - physicians' compensation (chapter 21) epreciation - buildings and fixtures epreciation - movable equipment m-physician Anesthetist ysicians' assistant ljustment for occupational therapy costs excess of limitation (chapter 14) spice (non-distinct) (see instructions) ljustment for speech pathology costs excess of limitation (chapter 14) AH HIT Adjustment for Depreciation	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts rrsing school (tuition, fees, books, etc.) ending machines come from imposition of interest, ance or penalty charges (chapter 21) erest expense on Medicare overpayments and rrowings to repay Medicare overpayments ljustment for respiratory therapy sts in excess of limitation (chapter 14) Worksheet A-8-3 ljustment for physical therapy costs excess of limitation (chapter 14) worksheet A-8-3 lization review - physicians' compensation (chapter 21) ereciation - buildings and fixtures preciation - movable equipment m-physician Anesthetist ysicians' assistant ljustment for occupational therapy costs excess of limitation (chapter 14) worksheet A-8-3 Spice (non-distinct) (see instructions) ljustment for speech pathology costs excess of limitation (chapter 14) Worksheet A-8-3 AH HIT Adjustment for Depreciation	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts rrsing school (tuition, fees, books, etc.) ending machines come from imposition of interest, ance or penalty charges (chapter 21) erest expense on Medicare overpayments and rrowings to repay Medicare overpayments ljustment for respiratory therapy sts in excess of limitation (chapter 14) lipustment for physical therapy costs excess of limitation (chapter 14) worksheet A-8-3 lilization review - physicians' compensation (chapter 21) preciation - buildings and fixtures preciation - movable equipment m-physician Anesthetist ysicians' assistant ljustment for occupational therapy costs excess of limitation (chapter 14) Worksheet A-8-3 spice (non-distinct) (see instructions) ljustment for speech pathology costs excess of limitation (chapter 14) Worksheet A-8-3 Spice (non-distinct) (see instructions) ljustment for opepeciation HIT Adjustment for Depreciation	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts rrsing school (tuition, fees, books, etc.) ending machines come from imposition of interest, ance or penalty charges (chapter 21) erest expense on Medicare overpayments and rrowings to repay Medicare overpayments ljustment for respiratory therapy ts in excess of limitation (chapter 14) lipustment for physical therapy costs excess of limitation (chapter 14) worksheet A-8-3 Physical Therapy lipustment for physicians' compensation (chapter 21) preciation - buildings and fixtures preciation - movable equipment m-physician Anesthetist ysicians' assistant lipustment for occupational therapy costs excess of limitation (chapter 14) Worksheet A-8-3 Physical Therapy Worksheet A-8-3 Physical Therapy Utilization Review - SNF Buildings and Fixtures preciation - movable equipment m-physician Anesthetist ysicians' assistant lipustment for occupational therapy costs excess of limitation (chapter 14) Worksheet A-8-3 Physical Therapy Movable Equipment Adults and Pediatrics lipustment for speech pathology costs excess of limitation (chapter 14) Worksheet A-8-3 Speech Pathology AH HIT Adjustment for Depreciation	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts rsing school (tuition, fees, books, etc.) rsing sc	le of drugs to other than patients le of drugs to other than patients le of medical records and abstracts sring school (tuition, fees, books, etc.) ending machines come from imposition of interest, ance or penalty charges (chapter 21) erest expense on Medicare overpayments and rrowings to repay Medicare overpayments lijustment for respiratory therapy sts in excess of limitation (chapter 14) Worksheet A-8-3 excess of limitation (chapter 14) Worksheet A-8-3 Physical Therapy 66 lizition review - physicians' compensation (chapter 21) Utilization review - SNF 114 preciation - buildings and fixtures preciation - buildings and fixtures preciation - buildings and fixtures preciation - buildings and fixtures preciation - movable equipment on-physician Anesthetist lijustment for occupational therapy costs excess of limitation (chapter 14) Worksheet A-8-3 Occupational Therapy 67 excess of limitation (chapter 14) Worksheet A-8-3 Speech Pathology costs excess of limitation (chapter 14) Worksheet A-8-3 Worksheet A-8-3 Physician Anesthetist lijustment for occupational therapy costs excess of limitation (chapter 14) Worksheet A-8-3 Worksheet A-8-3 Occupational Therapy 67 Adults and Pediatrics 30 Lijustment for Depreciation Worksheet A-8-3 Speech Pathology 68 Worksheet A-8-3 Speech Pa

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

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined B. Amount Received - if cost cannot be determined

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

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

FORM CMS-2552-10 (09-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4016) Rev. 4

4090 (Cont.) FORM CMS-2552-10					09-13
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 OF 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	TOTALS (s A-8, column	sum of lines 1-4) Transfer column 6, n 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 organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify

10-1			10.	RM CMS-255			PERIOR		4090 (0	
ROV	IDER-BASED PHY	SICIANS 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
_	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.)			FO	RM CMS-2552-	-10				10-12
	EASONABLE COST DETERMINATION FOR THERAPY SERVICES JRNISHED BY OUTSIDE SUPPLIERS						PERIOD: FROM TO	WORKSHEET A-8 PARTS I & II	-3,
Check applicable box:	[] Occupational	[] Physical	[] Respirator	y [] Speech Path	nology				-
PART I - GENERAL INFORMATI		(* )							
1 Total number of weeks worked	· · ·	ctions)							2
<ul><li>2 Line 1 multiplied by 15 hours</li><li>3 Number of unduplicated days i</li></ul>			l						3
4 Number of unduplicated days i	1 1	1			a on provider site (see	instructions)			4
5 Number of unduplicated days				ervisor nor merapist wa	as on provider site (see	liisu ucuolis)			5
6 Number of unduplicated offsite	1 1			v accistant and an whi					6
supervisor and/or therapist wa		•	• •	y assistant and on whit	211				0
7 Standard travel expense rate	is not present during the visit(s	)) (see maruen	0113)						7
8 Optional travel expense rate pe	er mile								8
o optional flavor expense face pe				Supervisors	Therapists	Assistants	Aides	Trainees	
				1	2	3	4	5	
9 Total hours worked				-	_	-		-	9
10 AHSEA (see instructions)									10
11 Standard travel allowance (colu	umns 1 and 2, one-half of colu	ımn 2,							11
line 10; column 3, one-half of	column 3, line 10)								
12 Number of travel hours (see ins	structions)								12
13 Number of miles driven (see in	nstructions)								13
<b>i</b>					•			•	
PART II - SALARY EQUIVALENO									
14 Supervisors (column 1, line 9 t									14
15 Therapists (column 2, line 9 tir	, ,								15
16 Assistants (column 3, line 9 tin	, ,								16
17 Subtotal allowance amount (su	1	ratory therapy of	or lines 14-16 for	all others)					17
	18 Aides (column 4, line 9 times column 4, line 10)								18
19 Trainees (column 5, line 9 time									19
20 Total allowance amount (sum o		11							20
If the sum of columns 1 and 2 f	1 2 12	U	1 2	1,7,1 1 0,	1 1	py, line 9, is greater than 1	line 2,		
make no entries on lines 21 and									
21 Weighted average rate excludin	0	,	ot columns 1 and	12, line 9 for respirato	ry therapy or columns	1 through 3, line 9 for all	others)		21
22 Weighted allowance excluding		es line 21)							22
23 Total salary equivalency (see in	nstructions)								23

03-16		FOI	RM CMS-2552-10			4090	0 (Cont.)
REASONABLE COST DETERMINATION FOR TH FURNISHED BY OUTSIDE SUPPLIERS						WORKSHEET A PARTS III & IV	8-3,
Check applicable box: [] Occ	upational [] Physical	[] Respiratory	[] Speech Pathology		•		
PART III - STANDARD AND OPTIONAL TRAV Standard Travel Allowance	EL ALLOWANCE AND T	RAVEL EXPENSE	COMPUTATION - PROVI	DER SITE			
24 Therapists (line 3 times column 2, line 11)							24
25 Assistants (line 4 times column 3, line 11)							24
26 Subtotal (line 24 for respiratory therapy or sur							25
26 Subtotal (line 24 for respiratory therapy or sur 27 Standard travel expense (line 7 times line 3 for			otham)				26
28 Total standard travel allowance and standard tr	1 1 11						27
Optional Travel Allowance and Optional Travel Exp	1 1	ne (suill of filles 20 a	liu 27)				20
29 Therapists (column 2, line 10 times the sum of							29
30 Assistants (column 3, line 10 times column 3,							30
31 Subtotal (line 29 for respiratory therapy or sur		ers)					31
32 Optional travel expense (line 8 times columns			olumns 1-3 line 13 for all oth	ers)			32
33 Standard travel allowance and standard travel		y incrupy or sum or e	orannis i 3, nice 13 for an our	(15)			33
34 Optional travel allowance and standard travel		31)					34
35 Optional travel allowance and optional travel	1 \	,					35
	······································	-/					
PART IV - STANDARD AND OPTIONAL TRAV	EL ALLOWANCE AND T	RAVEL EXPENSE	COMPUTATION - SERVI	CES OUTSIDE PROVIDER SITI	C		
Standard Travel Expense							
36 Therapists (line 5 times column 2, line 11)							36
37 Assistants (line 6 times column 3, line 11)							37
38 Subtotal (sum of lines 36 and 37)							38
39 Standard travel expense (line 7 times the sum	of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Exp	pense						
40 Therapists (sum of columns 1 and 2, line 12.0	1 times column 2, line 10)						40
41 Assistants (column 3, line 12.01 times column	13, line 10)						41
42 Subtotal (sum of lines 40 and 41)							42
43 Optional travel expense (line 8 times the sum	of columns 1-3, line 13.01)						43
Total Travel Allowance and Travel Expense - Offsit	te Services: Complete one of t	the following					
three lines 44, 45, or 46, as appropriate.							
44 Standard travel allowance and standard travel	1 1	, , , ,					44
45 Optional travel allowance and standard travel		, , ,					45
46 Optional travel allowance and optional travel of	expense (sum of lines 42 and 4	(and instructions)				1	46

4090 (Cont.)	FORM CMS-25	52-10				03-16	
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER CCN:	WORKSHEET A-	/ORKSHEET A-8-3, ARTS V-VI				
Check applicable box: [] Occupational [] Physical	[] Respiratory [] Speech Pat	nology					
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	n 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 ADJUSTMENT					57	
	7 Salary equivalency amount (from line 23)						
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	

09-13	3		FO	RM CMS-255					4090 (Cont.	
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART I	
		NET EXPENSES FOR COST		ITAL D COSTS			то			
	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A col. 7) 0	BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	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	44	5	0	,	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits Department									3
5	Administrative and General									4
	Maintenance and Repairs									5
	Operation of Plant									6
_	Laundry and Linen Service									7
9	Housekeeping									8
10							_			9
11	Cafeteria									10
	Maintenance of Personnel									11 12
13	Nursing Administration Central Services and Supply									12
14	Pharmacy									13
	Medical Records & Medical Records Library									15
17	Social Service									16
										17
19	Nonphysician Anesthetists									18
20	Nursing School									19
21	Intern & Res. Service-Salary & Fringes (Approved)									20
22	Intern & Res. Other Program Costs (Approved)									21
23	Paramedical Education Program (specify)									22
	INPATIENT ROUTINE SERVICE COST CENTERS									
	Adults and Pediatrics (General Routine Care)						+			30
	Intensive Care Unit						+	ļ		31
-	Coronary Care Unit									32
33	Burn Intensive Care Unit Surgical Intensive Care Unit									33 34
	Other Special Care Unit (specify)				1					34
	Subprovider IPF									40
	Subprovider IRF	1 1				1	1	1	1	40
42	Subprovider (specify)	1 1					1	İ		42
43	Nursery								1	43
44	Skilled Nursing Facility	1								44
45	Nursing Facility									45
46	Other Long Term Care									46

4090	(Cont.)	RM CMS-255	2-10					09-13		
COST	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART I	
							то			
		NET EXPENSES		PITAL						
		FOR COST	RELATE	ED COSTS	_					
		ALLOCATION			EMPLOYEE		ADMINIS-	MAIN-		
	COST CENTER DESCRIPTIONS	(from Wkst.	BLDGS. &	MOVABLE	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION	
		A col. 7)	FIXTURES	EQUIPMENT	DEPARTMENT	(cols. 0-4)	GENERAL	REPAIRS	OF PLANT	4
		0	1	2	4	4A	5	6	7	
	ANCILLARY SERVICE COST CENTERS			-						50
	Operating Room									50 51
	Recovery Room						-			51
	Labor Room and Delivery Room			}	1		+		+	52
	Anesthesiology Radiology-Diagnostic			}	1		+		+	53
	Radiology-Diagnostic Radiology-Therapeutic			}	1		+		+	54
										56
	Radioisotope Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catheterization									59
60	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						1			82
	Drugs Charged to Patients	1		1			1	1		73
	Renal Dialysis									74
	ASC (Non-Distinct Part)			l			1	İ		75
	Other Ancillary (specify)			1						76
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)	1		I	1		T			89
90	Clinic	1		I	1		T			90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

09-13	3		FO	RM CMS-255	2-10				4090 (0	Cont.)
COST A	ALLOCATION - GENERAL SERVICE COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART I	
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)		ITAL ED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	4	4A	5	6	7	
	OTHER REIMBURSABLE COST CENTERS									
	Home Program Dialysis									94
	Ambulance Services									95
	Durable Medical Equipment-Rented									96
	Durable Medical Equipment-Sold									97
-	Other Reimbursable (specify)									98
	Outpatient Rehabilitation Provider (specify)									99
	Intern-Resident Service (not appvd. tchng. prgm.)									100
	Home Health Agency									101
_	SPECIAL PURPOSE COST CENTERS									
	Kidney Acquisition									105
	Heart Acquisition									106
	Liver Acquisition									107
	Lung Acquisition									108
	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
-	Hospice									116
-	Other Special Purpose (specify)									117
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

4090	(Cont.)			FOF	RM CMS-25	52-10					C	)9-13.
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	
	GENERAL SERVICE COST CENTERS											1
1	Capital Related Costs-Buildings and Fixtures											1
2	Capital Related Costs-Movable Equipment	7										2
4	Employee Benefits Department											3
5	Administrative and General											4
6	Maintenance and Repairs											5
7	Operation of Plant											6
8	Laundry and Linen Service											7
9	Housekeeping											8
10	Dietary											9
11	Cafeteria											10
12	Maintenance of Personnel											11
13	Nursing Administration											12
14	Central Services and Supply											13
15	Pharmacy											14
16	Medical Records & Medical Records Library											15
17	Social Service											16
18	Other General Service (specify)											17
19	Nonphysician Anesthetists											18
20	Nursing School											19
21												20
	Intern & Res. Other Program Costs (Approved)											21
23												22
	INPATIENT ROUTINE SERVICE COST CENTERS											
	Adults and Pediatrics (General Routine Care)											30
31		_										31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit	_			-							33
34		+	<b> </b>	<b> </b>		<b> </b>		ł		ł	ļ	34
35	Other Special Care Unit (specify)	+				<b> </b>				<b> </b>	ļ	35
40	1	+	<b> </b>	<b> </b>		<b> </b>				ł	[	40
41	Subprovider IRF											41
42	Subprovider (specify)	+	<b> </b>	<b> </b>		<b> </b>				ł		42
43	Nursery	+	<b> </b>	<b> </b>		<b> </b>		ł		ł	ļ	43
44	Skilled Nursing Facility			<del> </del>						<del> </del>		44
45	Nursing Facility	-										45
46	Other Long Term Care											46

10-12	2		FOR	FORM CMS-2552-10						4090 (Cont.		
COST	ALLOCATION - GENERAL SERVICE COSTS	I	PROVIDER CO	CN:		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	
	ANCILLARY SERVICE COST CENTERS	0		10		12	10		10	10	1,	t i
50	Operating Room											50
												51
					1							52
	Anesthesiology							1			1	53
54	Radiology-Diagnostic							1			1	54
55	Radiology-Therapeutic									1		55
56	Radioisotope											56
57										1		57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
	Physical Therapy											66
67	Occupational Therapy											67
												68
	Electrocardiology											69
	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72												82
	Drugs Charged to Patients											73
	Renal Dialysis											74
	ASC (Non-Distinct Part)							ļ			ļ	75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											<b></b>
	Rural Health Clinic (RHC)			ļ				<b> </b>			<b> </b>	88
	Federally Qualified Health Center (FQHC)							ł		<b> </b>	ł	89
90	Clinic							ł		<b> </b>	ł	90
	Emergency	_						-			L	91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93

4090	(Cont.)	FOR	M CMS-25	52-10						10-12		
COST	ALLOCATION - GENERAL SERVICE COSTS			T	PROVIDER CO	CN:		PERIOD: FROM TO		T	WORKSHEET PART I	'B,
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
	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	TOTAL (sum lines 118-201)											202

09-14	4			FO	RM CMS-255	2-10				4090	(Cont.)
COST	ALLOCATION - GENERAL SERVICE COSTS					PROVIDER CCN	[:	PERIOD: FROM TO		WORKSHEET I PART I	3,
	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		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	1									2
4	Employee Benefits Department	1									3
5	Administrative and General	1									4
6	Maintenance and Repairs	1									5
7	Operation of Plant	1									6
8	Laundry and Linen Service	1									7
9	Housekeeping	1									8
10	Dietary	1									9
11	Cafeteria	1									10
12	Maintenance of Personnel	1									11
13	Nursing Administration	4									12
14	Central Services and Supply	1									13
15	Pharmacy	1									14
16	Medical Records & Medical Records Library	1									15
17	Social Service	1									16
18	Other General Service (specify)										17
19	Nonphysician Anesthetists										18
20	Nursing School				1						19
21											20
22	Intern & Res. Other Program Costs (Approved)										21
23	Paramedical Education Program (specify)										22
	INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)										30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery						Ĩ				43
44							Ĩ				44
45	Nursing Facility										45
46	Other Long Term Care										46

4090	(Cont.)	RM CMS-255	2-10					09-14			
COST	ALLOCATION - GENERAL SERVICE COSTS							PERIOD: FROM TO		WORKSHEET B PART I	8,
	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	21			21		20	
50	Operating Room										50
	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology								1		53
									1		54
55	Radiology-Therapeutic										55
	Radioisotope					1		1			56
57	Computed Tomography (CT) Scan					1		1			57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
	Electrocardiology										69
	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										82
-	Drugs Charged to Patients		ļ				ļ				73
-			ļ				ļ				74
_	ASC (Non-Distinct Part)		ļ			ļ	ļ	ļ			75
76	Other Ancillary (specify)	-									76
	OUTPATIENT SERVICE COST CENTERS										
	Rural Health Clinic (RHC)		<b> </b>			ļ	<b> </b>	Į			88
	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds										92
93	Other Outpatient Service (specify)										93

09-13			FO	RM CMS-255	2-10				4090	(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	_
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					1					105
106 Heart Acquisition		1			1					106
107 Liver Acquisition		1			1					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 TOTAL (sum lines 118-201)										202

4090	(Cont.)	RM CMS-255	2-10					09-13		
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED		PITAL ED COSTS			то			
	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of (cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS	0	1	2	ZA	4	5	0	/	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment				1					2
	Employee Benefits Department									3
5	Administrative and General									4
6	Maintenance and Repairs									5
7	Operation of Plant									6
	Laundry and Linen Service									7
	Housekeeping									8
	Dietary									9
11	Cafeteria									10
-	Maintenance of Personnel									11
	Nursing Administration									12
										13
	Pharmacy									14 15
	Medical Records & Medical Records Library Social Service									15
_	Other General Service (specify)									10
19	Nonphysician Anesthetists									18
20	Nursing School									19
	Intern & Res. Service-Salary & Fringes (Approved)									20
	Intern & Res. Other Program Costs (Approved)									21
	Paramedical Education Program (specify)									22
	INPATIENT ROUTINE SERVICE COST CENTERS									
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
	Burn Intensive Care Unit									33
	Surgical Intensive Care Unit									34
	Other Special Care Unit (specify)									36
	Subprovider IPF									40
	Subprovider IRF					ļ		ļ		41
-	1 1 27									42
	Nursery					<b> </b>	1			43
	Skilled Nursing Facility									44
	Nursing Facility									45
46	Other Long Term Care									46

09-13	3		FO	RM CMS-255	2-10				4090 (0	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM		WORKSHEET B, PART II	
							TO		IARTI	
		DIRECTLY		PITAL						
	COST CENTER DESCRIPTIONS	ASSIGNED NEW CAPITAL RELATED COSTS	RELATE BLDGS. & FIXTURES	ED COSTS MOVABLE EQUIPMENT	SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	2A	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells							1		62
	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
	Respiratory Therapy									65
	Physical Therapy									66
	Occupational Therapy									67
68	Speech Pathology									68
	Electrocardiology									69
	Electroencephalography									70
	Medical Supplies Charged to Patients			1		Ī				71
	Implantable Devices Charged to Patients			1						72
	Drugs Charged to Patients			1		Ī				73
	Renal Dialysis			1						74
	ASC (Non-Distinct Part)			1				İ	i i	75
	Other Ancillary (specify)			1	1	1	1			76
	OUTPATIENT SERVICE COST CENTERS									
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
90	Clinic			1						90
91	Emergency			1		Ī				91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

4090	(Cont.)		RM CMS-255	2-10					09-13	
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B, PART II	
		DIRECTLY ASSIGNED NEW CAPITAL		PITAL ED COSTS	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	COST CENTER DESCRIPTIONS	RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	(sum of (cols. 0-2) 2A	BENEFITS DEPARTMENT 4	TRATIVE & GENERAL 5	TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	OTHER REIMBURSABLE COST CENTERS	0	1		211		5	0	,	
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
	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							1		109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)							1		112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									113
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

09-1	3			FOR	M CMS-25	52-10					4090 (0	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER C	CN:		PERIOD: FROM			WORKSHEET I PART II	В,
						_		то				
												T
		LAUNDON				MADY	NUDGDIG			MEDICAL		
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN	HOUSE-			MAIN- TENANCE OF	NURSING ADMINIS-	CENTRAL SERVICES &		MEDICAL RECORDS &	SOCIAL	
	COST CENTER 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
	Employee Benefits Department	4										3
5	Administrative and General	4										4
	Maintenance and Repairs	4										5
	Operation of Plant Laundry and Linen Service	+										6
	Housekeeping			1								8
	Dietary				-							9
11	Cafeteria					1						10
12	Maintenance of Personnel						1					11
13	Nursing Administration											12
14	Central Services and Supply											13
	Pharmacy										1	14
	Medical Records & Medical Records Library											15
17	Social Service											16
18	Other General Service (specify)											17
19	Nonphysician Anesthetists Nursing School	-									-	18 19
	Intern & Res. Service-Salary & Fringes (Approved)											20
	Intern & Res. Other Program Costs (Approved)	1				1						20
	Paramedical Education Program (specify)											22
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
_	Intensive Care Unit											31
	Coronary Care Unit											32
33	Burn Intensive Care Unit					ļ	ļ				<u> </u>	33
	Surgical Intensive Care Unit	+			ł	l	ł				l	34
	Other Special Care Unit (specify)		[									36 40
	Subprovider IPF Subprovider IRF	+										40
	Subprovider IRF Subprovider (specify)	+				<del> </del>					<u> </u>	41 42
	Nursery	1			1	t	<u> </u>				<u> </u>	42
	Skilled Nursing Facility	1				1		1			1	44
45	Nursing Facility											45
46	Other Long Term Care	1		1	1	1	1					46

4090	90 (Cont.) JOCATION OF CAPITAL-RELATED COSTS				M CMS-25	52-10						09-13
ALLO	CATION 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	
	ANCILLARY SERVICE COST CENTERS	0	,	10		12	15	17	15	10	17	
	Operating Room											50
	Recovery Room											51
	Labor Room and Delivery Room											52
	Anesthesiology	1			1	ĺ		1		l	1	53
	Radiology-Diagnostic											54
	Radiology-Therapeutic											55
	Radioisotope											56
	Computed Tomography (CT) Scan											57
	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
	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
90	Clinic											90
	Emergency											91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93

09-13	FOR	M CMS-25	52-10					4090(	Cont.)		
ALLOCATION OF CAPITAL-RELATED COSTS				PROVIDER C	TENANCE OFADMINIS-SERVICES &RECORCAFETERIAPERSONNELTRATIONSUPPLYPHARMACYLIBRA					WORKSHEET	В,
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	TENANCE OF PERSONNEL	ADMINIS- TRATION	SERVICES & SUPPLY		MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
OTHER REIMBURSABLE COST CENTERS											
94 Home Program Dialysis											94
95 Ambulance Services				1							95
96 Durable Medical Equipment-Rented			1		1				1	1	96
97 Durable Medical Equipment-Sold			1		1				1	1	97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchng. prgm.)											100
101 Home Health Agency											101
SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition											106
107 Liver Acquisition											107
108 Lung Acquisition											108
109 Pancreas Acquisition											109
110 Intestinal Acquisition											110
111 Islet Acquisition											111
112 Other Organ Acquisition (specify)											112
115 Ambulatory Surgical Center (Distinct Part)											115
116 Hospice											113
117 Other Special Purpose (specify)											117
118 SUBTOTALS (sum of lines 1-117)											118
NONREIMBURSABLE COST CENTERS											
190 Gift, Flower, Coffee Shop, & Canteen											190
191 Research				1	1					1	191
192 Physicians' Private Offices				1	1					1	192
193 Nonpaid Workers				1	1					1	193
194 Other Nonreimbursable (specify)				1	1					1	194
200 Cross Foot Adjustments											200
201 Negative Cost Centers											201
202 TOTAL (sum lines 118-201)			1								202

4090	(Cont.)		FOF	RM CMS-255	52-10						09-13
ALLO	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	:N:	PERIOD: FROM TO		WORKSHEET 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	
	GENERAL SERVICE COST CENTERS	10	.,	20	21		20	21		20	
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										3
5	Administrative and General										4
6	Maintenance and Repairs										5
7	Operation of Plant										6
	Laundry and Linen Service										7
9	Housekeeping										8
	Dietary										9
11	Cafeteria										10
12	Maintenance of Personnel										11
13		_									12
14	Central Services and Supply	_									13
	Pharmacy	_									14
16	Medical Records & Medical Records Library Social Service										15 16
17	Other General Service (specify)										10
19	Nonphysician Anesthetists										18
	Nursing School				-						19
20	Intern & Res. Service-Salary & Fringes (Approved)					1					20
	Intern & Res. Other Program Costs (Approved)						1				21
	Paramedical Education Program (specify)							1			22
	INPATIENT ROUTINE SERVICE COST CENTERS		1								
30	Adults and Pediatrics (General Routine Care)										30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										36
_	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)	1							ļ	ļ	42
43	Nursery										43
44	Skilled Nursing Facility	+					-	<b> </b>	<b> </b>	<b> </b>	44
45	Nursing Facility										45
46	Other Long Term Care								L		46

10-12	2		FOR	M CMS-255	52-10					4090 (	Cont.)
ALLO	CATION OF CAPITAL-RELATED COSTS				PROVIDER CC	'N:	PERIOD: FROM TO		WORKSHEET PART II	В,	
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS		
	ANCILLARY SERVICE COST CENTERS	18	19	20	21	22	23	24	25	26	-
	Operating Room										50
	A 0										
	Recovery Room										51 52
	Labor Room and Delivery Room Anesthesiology									<u> </u>	52
	Radiology-Diagnostic									ł	54
	Radiology-Diagnostic Radiology-Therapeutic										55
	Radioiogy-Therapeutic Radioisotope										56
	Computed Tomography (CT) Scan										57
	Magnetic Resonance Imaging (MRI)										57
-	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	-			1						67
	Speech Pathology	-			1						68
	Electrocardiology	-			1						69
	Electroencephalography	-			1						70
	Medical Supplies Charged to Patients	-			1						70
-	Implantable Devices Charged to Patients									ł	71
_	Drugs Charged to Patients										72
	Renal Dialysis										73
	ASC (Non-Distinct Part)										74
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										70
	Rural Health Clinic (RHC)										88
	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
_	Emergency										90
92	Observation Beds										91
	Other Outpatient Service (specify)										93

4090	(Cont.)		FOR	RM CMS-255	52-10						10-12
ALLO	CATION OF CAPITAL-RELATED COSTS					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET	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										
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
	SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										113
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)										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

09-13	3	FO	RM CMS-255	2-10				4090 (0	Cont.)
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	l
		-				ТО			
		CAPITAL RE	ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		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	1	2	-	514	5	0	,	<u> </u>
	Capital Related Costs-Buildings and Fixtures								1
_	Capital Related Costs-Movable Equipment								2
	Employee Benefits Department								4
	Administrative and General						1		5
								-	6
	Maintenance and Repairs								6
	Operation of Plant								
	Laundry and Linen Service					_			8
	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								16
17	Social Service								17
18	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)		1						30
_	Intensive Care Unit					1	1	1	31
	Coronary Care Unit								32
	Burn Intensive Care Unit					1	1	1	33
	Surgical Intensive Care Unit					1		1	34
						+	<u> </u>	+	35
	Other Special Care Unit (specify)								_
	Subprovider IPF								40
	Subprovider IRF								41
	Subprovider (specify)							+	42
	Nursery								43
	Skilled Nursing Facility								44
	Nursing Facility								45
46	Other Long Term Care								46

4090	(Cont.)	FO	RM CMS-255	2-10					09-13
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B-1	l
						то			
		CAPITAL RE	ELATED COST	EMPLOYEE		ADMINIS-	MAIN-		
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	
		FIXTURES	EQUIPMENT	DEPARTMENT		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	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
	Recovery Room								51
52	Labor Room and Delivery Room								52
	Anesthesiology								53
	Radiology-Diagnostic	ļ	ļ			1			54
55	Radiology-Therapeutic								55
	Radioisotope								56
	Computed Tomography (CT) Scan								57
	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
	Laboratory								60
	PBP Clinical Laboratory Services-Program Only								61
	Whole Blood & Packed Red Blood Cells								62
	Blood Storing, Processing, & Trans.								63
	Intravenous Therapy								64
65	Respiratory Therapy								65
	Physical Therapy								66
	Occupational Therapy								67
	Speech Pathology								68
	Electrocardiology								69
	Electroencephalography								70
71	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								90
91	Emergency								91
-	Observation Beds								92
93	Other Outpatient Service (specify)								93

09-13	3	FO	RM CMS-255	2-10				4090 (	Cont.)
COST	ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B-	1
	COST CENTER DESCRIPTIONS	CAPITAL RF BLDGS. & FIXTURES (SQUARE FEET)	ELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	4	5A	5	6	7	
	OTHER REIMBURSABLE COST CENTERS								
_	Home Program Dialysis								94
	Ambulance Services								95
	Durable Medical Equipment-Rented								96
	Durable Medical Equipment-Sold								97
	Other Reimbursable (specify)								98
	Outpatient Rehabilitation Provider (specify)								99
	Intern-Resident Service (not appvd. tchng. prgm.)								100
	Home Health Agency								101
	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	(Cont.)			FOR	M CMS-25	52-10					(	09-13
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	
	GENERAL SERVICE COST CENTERS		-	-					-			
1	Capital Related Costs-Buildings and Fixtures											1
2	Capital Related Costs-Movable Equipment											2
4	Employee Benefits Department											4
5	Administrative and General											5
6	Maintenance and Repairs											6
7	Operation of Plant											7
8	Laundry and Linen Service											8
9	Housekeeping	-			-							9
10	Dietary											10
11	Cafeteria	-			-		4					11 12
12	Maintenance of Personnel Nursing Administration				-			4				12
13	Central Services and Supply											13
15	Pharmacy											15
16	Medical Records & Medical Records Library											16
17	Social Service											17
18	Other General Service (specify)											18
19	Nonphysician Anesthetists											19
20	Nursing School											20
21	Intern & Res. Service-Salary & Fringes (Approved)											21
22	Intern & Res. Other Program Costs (Approved)											22
23	Paramedical Education Program (specify)											23
	INPATIENT ROUTINE SERVICE COST CENTERS											<u> </u>
30	Adults and Pediatrics (General Routine Care)					[						30
31	Intensive Care Unit											31
32	Coronary Care Unit Burn Intensive Care Unit											32 33
33	Surgical Intensive Care Unit	+										33
35	Other Special Care Unit (specify)	1			<u> </u>					<u> </u>		35
40	Subprovider IPF	1			<u> </u>					<u> </u>		40
41	Subprovider IRF	1			1	1	1	1	1	1	İ	40
42	Subprovider (specify)	1			1		İ	İ		1		42
43	Nursery	1			l –		l I			l –		43
44	Skilled Nursing Facility	1			1		1	1		1		44
45	Nursing Facility											45
46	Other Long Term Care											46

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

4090	(Cont.)			FOR	M CMS-25	52-10						10-12
COST	ALLOCATION - STATISTICAL BASIS						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET	ſВ-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	0	,	10		12	15	17	15	10	17	<u> </u>
94	Home Program Dialysis											94
	Ambulance Services											95
-	Durable Medical Equipment-Rented						1	1	1		1	96
	Durable Medical Equipment-Sold											97
	Other Reimbursable (specify)				1		1	1	1		1	98
99	Outpatient Rehabilitation Provider (specify)						1	1	1		1	99
	Intern-Resident Service (not appvd. tchng. prgm.)											100
	Home Health Agency											101
	SPECIAL PURPOSE COST CENTERS											101
	Kidney Acquisition											105
	Heart Acquisition											105
	Liver Acquisition											100
	Lung Acquisition											107
100	Pancreas Acquisition											100
	Intestinal Acquisition											110
	Islet Acquisition											111
	Other Organ Acquisition (specify)											112
_	Ambulatory Surgical Center (Distinct Part)											115
_	Hospice											116
	Other Special Purpose (specify)											117
	SUBTOTALS (sum of lines 1-117)						1	1	1		1	118
	NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen											190
	Research				1		1	1	1		1	191
_	Physicians' Private Offices				1		1	1	1		1	192
	Nonpaid Workers				1		1	1	1		1	193
	Other Nonreimbursable (specify)				1		1	1	1		1	194
200	Cross foot adjustments									1		200
201	Negative cost centers											201
	Cost to be allocated (per Worksheet B, Part I)									1		202
	Unit cost multiplier (Worksheet B, Part I)				İ.		1	1			1	202
203	Cost to be allocated (per Worksheet B, Part II)				İ.		1	1			1	203
	Unit cost multiplier (Worksheet B, Part II)				1		t	t	t	1	t	205

09-14	4		FOR	M CMS-255	52-10					4090 (	Cont.)
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET	B-1
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & SALARY AND FRINGES (ASSIGNED TIME)	RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA- MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
	GENERAL SERVICE COST CENTERS										_
1	Capital Related Costs-Buildings and Fixtures	_									1
2	Capital Related Costs-Movable Equipment	_									2
4	Employee Benefits Department	_									4
5	Administrative and General	_									5
6	Maintenance and Repairs	_									6
7	Operation of Plant	-									7
8	Laundry and Linen Service										8
9	Housekeeping	_									9
10	Dietary										10
11		_									11
12	Maintenance of Personnel	_									12
13	*										13
14	Central Services and Supply	_									14
15											15
16	×										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
	Intern & Res. Other Program Costs (Approved)	+						4			22
23	Paramedical Education Program (specify)										23
30	INPATIENT ROUTINE SERVICE COST CENTERS										20
30	Adults and Pediatrics (General Routine Care) Intensive Care Unit						<u> </u>				30
31	Coronary Care Unit	+					ł				32
32	Burn Intensive Care Unit	1	<u> </u>		1		<del> </del>			1	32
34	Surgical Intensive Care Unit										33
35	Other Special Care Unit (specify)										35
40							<del> </del>				40
40	Subprovider IFF Subprovider IRF						<del> </del>				40
41	Subprovider (specify)										41
42	Nursery										42
43	Skilled Nursing Facility										43
44	Nursing Facility						<u> </u>				44
46	Other Long Term Care						<u> </u>				45
-0	ould Long Term Care	1	I		I		1				-10

4090	(Cont.)		FOR	M CMS-255	52-10						09-14
COST	ALLOCATION - STATISTICAL BASIS					PROVIDER CC	J:	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		20			20	2.	20	20	
50	Operating Room										50
-	Recovery Room										51
52	Labor Room and Delivery Room		1								52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
	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
_	Respiratory Therapy										65
_	Physical Therapy										66
67	Occupational Therapy										67
_	Speech Pathology										68
-	Electrocardiology										69
_	Electroencephalography		<b> </b>		<b> </b>	<b> </b>		-			70
	Medical Supplies Charged to Patients		<b> </b>		<b> </b>	<b> </b>		-			71
	Implantable Devices Charged to Patients										72
-	Drugs Charged to Patients										73
	Renal Dialysis										74 75
	ASC (Non-Distinct Part)										75
	Other Ancillary (specify) OUTPATIENT SERVICE COST CENTERS										/0
	Rural Health Clinic (RHC)										8
_	Federally Qualified Health Center (FQHC)	+	<u> </u>		ł	<del> </del>					89
<u>89</u> 90	Clinic		<del> </del>			<del> </del>					<u>89</u> 90
90	Emergency					1					90
91	Observation Beds										91
	Other Outpatient Service (specify)										92
93	Other Outpatient Service (specify)										93

09-13	3		FOR	M CMS-255	52-10					4090 (	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	10	15	20	21	22	23	27	23	20	
9/	Home Program Dialysis										94
95	Ambulance Services									1	95
	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold	1	1		1						97
	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
	Home Health Agency									1	100
	SPECIAL PURPOSE COST CENTERS										101
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition									1	111
112	Other Organ Acquisition (specify)									1	112
115	Ambulatory Surgical Center (Distinct Part)										115
	Hospice								1	1	116
	Other Special Purpose (specify)										117
	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 (C		FORM CMS-2552				09-13
POST STEP	PDOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD: FROM		WORKSHEET B-2	
			то			
			WORKS	SHEET		
	DESCRIPTION		PART	LINE NO.	AMOUNT	
	1		2	3	4	
	ustment for EPO costs in Renal Dialysis cost center		1	74		1
	ustment for EPO costs in Home Program Dialysis cost center		1	94		2
	ustment for ARANESP costs in Renal Dialysis cost center		1	74		3
	ustment for ARANESP costs in Home Program Dialysis cost		1	94		4
	ustment for ESA costs in Renal Dialysis cost center (see instru-		1	74 94		5
6 Adji 7	ustment for ESA costs in Home Program Dialysis cost center	(see instructions)	1	94		7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
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19			+			19
20				-		20
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38						38
39 40					<u> </u>	39 40
40						40
41 42						41 42
42				1	1	42
44			1	1	1	44
45						45
46				1		46
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55			+			55
56			+		<b> </b>	56
57						57
58						58
59					1	59

31       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       Intensive Care Unit       In	10-12	2			FOR	M CMS-25	52-10						4090 (0	Cont.)
COST CENTER DESCRIPTION         Instrume         RCE B, Port I, Colum         RCE Junite         Total Inpatient         RCE Junite         Total Inpatient         Output Inpatient         Total Inpatient         Total Inpatient         Total Inpatient         Total Inpatient         Total Inpatient         Inpatient Inpatient         Inpatient Inpatient         Total Inpatient         Inpatient Inpatient         Inpa	COMP	UTATION OF RATIO OF COSTS TO CHARGES							PROVIDER	CCN:	FROM			ET C
INPATIENT ROUTINE SIRVICE COST CENTERS         Image: Care Uait		COST CENTER DESCRIPTIONS	(from Wkst. B, Part I,	Limit Adj.	Costs	RCE Dis- allowance	Costs	-	Outpatient	(column 6 + column 7)	Other Ratio	Inpatient Ratio	Inpatient Ratio	
30       Adults and Pediutrics (General Routine Care Unit       Image: Second Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second Care Unit       Image: Second C			1	2	3	4	5	6	7	8	9	10	11	<u> </u>
31Intensive Care UnitIntensive														20
31       Coronary Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image: Care Unit       Image:	_													30
33     Burn Intensive Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit     Image: Care Unit														31
34       Surgical Intensive Care Unit       Image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity in the image: Care Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opecity Opeci														32
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40       Subprovider IPF       Image: Constraint of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se														34 35
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58       Magnetic Resonance Imaging (MRI)       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Catheterization       Image: Cardiac Ca														57
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61       PBP Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical Laboratory Services-Prgm. Only       Image: Clinical						-								60
62       Whole Blood & Packed Red Blood Cells       Image: Constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint o														61
63       Blod Storing, Processing, & Trans.       Image: Constraint of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the system of the syst														62
64     Intravenous Therapy       65     Respiratory Therapy       66     Physical Therapy	_													63
65     Respiratory Therapy     66     Physical Therapy     67     68														64
66 Physical Therapy														65
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68     Speech Pathology														68

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COMP	UTATION OF RATIO OF COSTS TO CHARGES							PROVIDER	CCN:	PERIOD: FROM TO		WORKSHE PART I	ET C
		Total Cost			Costs			Charges		10			Π
	COST CENTER DESCRIPTIONS	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
	Г	1	2	3	4	5	6	7	8	9	10	11	
	Electrocardiology				+ +								69
	Electroencephalography				+ +			-				-	70
71	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
													89
90													90
91	Emergency												91
	Observation Beds (see instructions)												92
93	Other Outpatient Service (specify)												93
	OTHER REIMBURSABLE COST CENTERS												
	Home Program Dialysis												94
	Ambulance Services												95
	Durable Medical Equipment-Rented												96
	Durable Medical Equipment-Sold												97
	Other Reimbursable (specify)												98
	Outpatient Rehabilitation Provider (specify)												99
	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
	SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
200	Subtotal (see instructions)												200
201	Less Observation Beds												201
202	Total (see instructions)												202

10-12	2	FOF	RM CMS-25	52-10					4090 (C	lont.)
	ULATION OF OUTPATIENT SERVICE COST TO GE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title V [ ] Title XIX			PROVIDER C	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)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	· · · · · · · · · · · · · · · · · · ·	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	8	<u> </u>
50	Operating Room									50
	Recovery Room									51
	Labor Room and Delivery Room									52
	Anesthesiology									53
	Radiology-Diagnostic									54
	Radiology-Therapeutic									55
	Radioisotope									56
	Computed Tomography (CT) Scan									57
	Magnetic Resonance Imaging (MRI)									58
	Cardiac Catherization				1					59
	Laboratory									60
	PBP Clinical Laboratory Services-Prgm. 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									68
	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76

4090	(Cont.)	FOF	RM CMS-25	52-10					1	0-12
	JLATION OF OUTPATIENT SERVICE COST TO GE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	[ ] Title V [ ] Title XIX			PROVIDER CO	CN:	PERIOD: FROM TO		WORKSHEET C. PART II (CONT.)	
	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)	Capital Reduction	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	1	2	5		5	0	/	0	
	Rural Health Clinic (RHC)									88
	Federally Qualified Health Center (FQHC)									89
	Clinic		1							90
	Emergency		1							91
	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		1							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
	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
	Lung Acquisition									108
109	Pancreas Acquisition									109
	Intestinal Acquisition									110
	Islet Acquisition									111
	Other Organ Acquisition (specify)									112
	Ambulatory Surgical Center (Distinct Part)									115
	Hospice					ļ				116
	Other Special Purpose (specify)									117
	Subtotal (sum of lines 50 through 199)									200
	Less Observation Beds									201
202	Total (line 200 minus line 201)									202

03-1	6	FOR	M CMS-25	52-10				4090 (C	Cont.)
	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	1	2	3	4	5	6	7	
30	INPATIENT ROUTNE SERVICE COST CENTERS Adults & Pediatrics (General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit					ļ			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

4090	) (Cont.)	]	FORM CMS-255	2-10				03-16
APPO	RTIONMENT OF INPATIENT AND	CILLARY	PROVIDER CCN	:	PERIOD:		WORKSHEET D	,
SERV	ICE CAPITAL COSTS				FROM		PART II	
			COMPONENT CO	CN:	ТО			
Check		[] Title V		[] Hospital	[] Subprovider (	Other)	[] PPS	
applic	able	[] Title XVII	I, Part A	[] IPF			[] TEFRA	
boxes:		[] Title XIX		[] IRF				
			Capital					
			Related Cost		Ratio of Cost		Capital	
			(from Wkst.	Total Charges	to Charges	Inpatient	Costs	
			B, Part II,	(from Wkst. C,	(col .1 ÷	Program	(column 3 x	
			col. 26)	Part I, col. 8)	col. 2)	Charges	column 4)	<b>—</b>
(A)	Cost Center Description		1	2	3	4	5	_
	ANCILLARY SERVICE COST CE	NTERS						
50	Operating Room							50
51	Recovery Room							51
52	Labor Room and Delivery Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic				┦────┤			54
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI	)						58
59	Cardiac Catheterization							60
60	Laboratory							60
61	PBP Clinical Laboratory Services-P							61
62	Whole Blood & Packed Red Blood							62
63	Blood Storing, Processing, & Transi	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 Patien							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
00	OUTPATIENT SERVICE COST CH	LINTERS						00
88	Rural Health Clinic (RHC)	SOLIC)						88 89
89	Federally Qualified Health Center (I	rynu)			┥───┤			
90 91	Clinic Emergency				┥───┤			90 91
91	Observation Beds				┥───┤			91
92				+				92
93	Other Outpatient Service (specify) OTHER REIMBURSABLE COST	TENTERS						95
94	Home Program Dialysis							94
94	Ambulance Services							94
95	Durable Medical Equipment-Rented	1						95
90	Durable Medical Equipment-Sold	1		+				90
97	Other Reimbursable (specify)				+			97
200	Total (sum of lines 50 through 199)			1				200

09-1	5			FOR	M CMS-255	52-10					4090 (C	ont.)
	RTIONMENT OF INPATIENT ROUTINE ICE OTHER PASS THROUGH COSTS						PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET D, PART III	
Check applica boxes:	able	[] Title V [] Title XVIII, [] Title XIX	Part A	[] PPS [] TEFRA [] Other								
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description INPATIENT ROUTINE SERVICE COST CEN	TEDÓ	1	2	3	4	5	6	7	8	9	
30	Adults & Pediatrics (General Routine Care)	IEKS										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				0	9-15
APPO	RTIONMENT OF INPAT	ENT/OUTPATIENT ANCILL	ARY	PROVIDER CC	N:	PERIOD:		WORKSHEET I	D,
SERV	ICE OTHER PASS THRO	UGH COSTS				FROM		PART IV	
				COMPONENT (	CCN:	то			
Check		[] Title V	[] Hospital	[] Subprov	vider (Other)	[] ICF/IID	[] PPS		
applic	able	[] Title XVIII, Part A	[] IPF	[] SNF			[] TEFRA		
boxes:		[] Title XIX	[] IRF	[] NF			[] Other		
						All		Total	
			Non			Other		Outpatient	
			Physician			Medical	Total cost	Cost	
			Anesthetist	Nursing	Allied	Education	(sum of col 1	(sum of col. 2,	
			Cost	School	Health	Cost	through col. 4)	3 and 4)	
(A)	Cost Center Descrip		1	2	3	4	5	6	
	ANCILLARY SERVICE	COST CENTERS							
50	Operating Room								50
51	Recovery Room								51
52	Labor room and Delivery	Room							52
53	Anesthesiology			_					53
54	Radiology-Diagnostic			<b> </b>		+	ł		54
55	Radiology-Therapeutic								55
56	Radioisotope			+					56
57	Computed Tomography (								57
58	Magnetic Resonance Imag	ging (MRI)							58
59	Cardiac Catheterization								59
60	Laboratory		_						60
61	PBP Clinical Laboratory								61
62	Whole Blood & Packed R								62
63	Blood Storing, Processing	g, & Transfusing							63
64 65	Intravenous Therapy								64 65
66	Respiratory Therapy Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged	1 To Patients			1				71
72	Implantable Devices Char								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)			1	1		1		75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE	COST CENTERS							
88	Rural Health Clinic (RHC								88
89	Federally Qualified Health	h Center (FQHC)							89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service								93
	OTHER REIMBURSABI	LE COST CENTERS							
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipme								96
97	Durable Medical Equipme			ļ		L	L		97
98	Other Reimbursable (spec								98
200	Total (sum of lines 50 three	ough 199)							200

09-1	5			FORM CM					4090 (C	ont.)
APPO	RTIONMENT OF INPAT	FIENT/OUTPATIEN	IT ANCILLARY		PROVIDER CCN	l:	PERIOD:		WORKSHEET D	),
SERV	ICE OTHER PASS THRO	OUGH COSTS					FROM		PART IV (Cont.)	
					COMPONENT C	CN:	то			
Check		[] Title V		[] Hospital	[] Subprov	ider (Other)	[] ICF/IIR	[] PPS		
applica	able	[] Title XVIII, Pa	art A	[] IPF	[ ] SNF			[] TEFRA		
boxes:		[] Title XIX		[] IRF	[] NF			[] Other		
							Inpatient		Outpatient	
					Outpatient		Program		Program	
			Total	Ratio	Ratio		Pass-		Pass-	
			Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
			(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
			Part I, col. 8)	(col. 5 ÷ col. 7)	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	
(A)	Cost Center Descrip		7	8	9	10	11	12	13	
	ANCILLARY SERVICE	COST CENTERS								
	Operating Room									50
	Recovery Room	D								51
52	Delivery Room and Labo	or Room								52
	Anesthesiology Rediclogy Diagnostic									53
54 55	Radiology-Diagnostic									54 55
55	Radiology-Therapeutic Radioisotope								1	55
57	Computed Tomography (	(CT) Score								57
58	Magnetic Resonance Ima									58
59	Cardiac Catheterization	aging (witci)								59
60	Laboratory									60
61	PBP Clinical Laboratory	Serv Prom Only								61
62	Whole Blood & Packed I									62
63	Blood Storing, Processin									63
64	Intravenous Therapy	6,								64
65	Respiratory Therapy									65
-	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charge	ed To Patients								71
72	Implantable Devices Cha	arged to Patients								72
73	Drugs Charged to Patient	ts								73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76										76
	OUTPATIENT SERVICI									<u> </u>
	Rural Health Clinic (RH									88
89	Federally Qualified Heal	th Center (FQHC)								89
90	Clinic									90
91	Emergency									91
92	Observation Beds	(aposify)								92
93	Other Outpatient Service OTHER REIMBURSAB		c							93
94	Home Program Dialysis	LE COST CENTER	5							94
-	Ambulance Services									94 95
95	Durable Medical Equipm	nent-Rented								95
90	Durable Medical Equipri						1			90
98	Other Reimbursable (spe									98
200	Total (sum of lines 50 th						1		1	200
_00		0						C	1	

(A) Worksheet A line numbers

09-1	5		FORM CM	<b>[S-2552-10</b>				0	9-15
APPO	RTIONMENT OF MEDICAL AND OTHER			PROVIDER CCI	N:	PERIOD:		WORKSHEET I	),
HEAL	TH SERVICES COSTS					FROM		PART V	
				COMPONENT O	CCN:	то			
Check	[ ] Title V - O/P		[] Hospital	[] Subprov	ider (Other)	[] Swing Be	d SNF		
applica	ble [] Title XVIII, Part B		[] IPF	[ ] SNF		[] Swing Be	d NF		
boxes:	[] Title XIX - O/P		[ ] IRF	[] NF		[] ICF/IID			
PART	V - APPORTIONMENT OF MEDICAL A	AND OTHER H	IEALTH SERV	ICES COSTS					
				Program Charges	8		Program Cost	t	
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Worksheet C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Part I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory ServPrgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
	Implantable Devices Charged to Patients								72
73	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				ļ		<b> </b>	88
89	Federally Qualified Health Center (FQHC)					<u> </u>			89
90	Clinic							<b> </b>	90
	Emergency Observation Red								91
92	Observation Bed								92
	Other Outpatient Service (specify)	a							93
	OTHER REIMBURSABLE COST CENTER	3							04
	Home Program Dialysis Ambulance								94 95
	Durable Medical Equipment-Rented								95
96	Durable Medical Equipment-Rented					<u> </u>			96 97
97	Other Reimbursable Cost Center					1		<del> </del>	97
200	Subtotal (see instructions)					<u> </u>			200
200	Less PBP Clinic Lab. Services-Program							<del> </del>	200
201	Only Charges								201
202	Net Charges (line 200 - line 201 )							<del> </del>	202
202	The charges (me 200 - me 201 )					1		1	202

09-15		FORM CMS-25	552-10		4090 (Cor	nt.)
COMPUTATION OF I	INPATIENT	PROVIDER CCN	:	PERIOD:	WORKSHEET D-1,	
OPERATING COST				FROM	PART I	
		COMPONENT CO	CN.:	ТО		
Check	[] Title V - I/P	[] Hospital	[] Subprovider (other)	[] ICF/IID	[] PPS	
applicable	[] Title XVIII, Part A	[] IPF	[] SNF		[] TEFRA	
boxes:	[] Title XIX - I/P	[] IRF	[] NF		[] Other	
PART I - ALL PRO	VIDER COMPONENTS					
		INPATIENT DAY:	5			
1 Inpatient days (	including private room days and swin	g-bed days, excluding ne	wborn)			1
2 Inpatient days (	including private room days, excludin	g swing-bed and newbor	n days)			2
3 Private room da	ays (excluding swing-bed and observa	tion bed days). If you hav	e only private room days, do no	t complete this line.		3
4 Semi-private ro	om days (excluding swing-bed and of	oservation bed days)				4
5 Total swing-bed	d SNF type inpatient days (including J	private room days) throug	h December 31 of the cost repor	ting period		5
6 Total swing-bed	d SNF type inpatient days (including I	orivate room days) after I	December 31 of the cost reporting	g period (if		6
calendar year, e	enter 0 on this line)					
7 Total swing-bed	d NF type inpatient days (including pr	ivate room days) through	December 31 of the cost reporti	ng period		7
	d NF type inpatient days (including pr					8
-	enter 0 on this line)	•	. 0			
9 Total inpatient	days including private room days app	icable to the Program (ex	cluding swing-bed and newborn	days)		9
10 Swing-bed SNF	<sup>7</sup> type inpatient days applicable to title	XVIII only (including p	rivate room days) through Decen	nber 31 of the		10
-	period (see instructions).					
	<sup>7</sup> type inpatient days applicable to title	XVIII only (including p	rivate room days) after December	er 31 of the		11
÷	period (if calendar year, enter 0 on thi					
	type inpatient days applicable to titles		g private room days) through De	cember 31 of		12
the cost reporti			51			
	type inpatient days applicable to titles	V or XIX only (includin	g private room days) after Decen	nber 31 of the		13
-	period (if calendar year, enter 0 on this	-				
	ssary private room days applicable to		wing-bed days)			14
	ays (title V or XIX only)	e · · ·				15
16 Nursery days (t	itle V or XIX only)					16
	•	SWING BED ADJ	USTMENT			
17 Medicare rate f	or swing-bed SNF services applicable	to services through Dece	mber 31 of the cost reporting pe	riod		17
18 Medicare rate f	or swing-bed SNF services applicable	to services after Decemb	er 31 of the cost reporting period	1		18
	or swing-bed NF services applicable t					19
	or swing-bed NF services applicable t					20
21 Total general in	patient routine service cost (see instru	ctions)	1 01			21
	applicable to SNF type services throu		cost reporting period (line 5 x lin	ie 17)		22
	applicable to SNF type services after	-				23
24 Swing-bed cost	applicable to NF type services through	h December 31 of the co	ost reporting period (line 7 x line	19)		24
-	applicable to NF type services after I					25
Ŭ	d cost (see instructions)					26
Ũ	nt routine service cost net of swing-be	d cost (line 21 minus line	26)			27
1 1			DIFFERENTIAL ADJUSTMEN	T		
28 General inpatie	nt routine service charges (excluding s					28
	harges (excluding swing-bed charges)	~	<u>v</u> ,			29
	om charges (excluding swing-bed cha	rges)				30
	nt routine service cost/charge ratio (lir					31
1	e room per diem charge (line 29 ÷ line	•				32
81	private room per diem charge (line 30				1	33
<u> </u>	em private room charge differential (li		e instructions)			34
	em private room cost differential (line		· · · · · · · · · · · · · · · · · · ·			35
	ost differential adjustment (line 3 x lin					36
	nt routine service cost net of swing-be		cost differential (line 27 minus li	ne 36)		37

4090	) (Cont.)		FORM	M CMS-2552-10	)		(	09-15
COM	PUTATION OF INPATIENT			PROVIDER CCN: _		PERIOD:	WORKSHEET D-1	,
OPER	ATING COST					FROM	PART II	
				COMPONENT CCN	:	то		
Check		] Title V - I/P		[] Hospital	[]Subprovider (othe	er)	[] PPS	
applica		[] Title XVIII, Part A		[] IPF	[]===F======(====		[] TEFRA	
boxes:		[] Title XIX - I/P		[] IRF			[] Other	
	II - HOSPITAL AND SUBP							
IANI		ROGRAM INPATIENT O	PERATIN	C COST BEFORE				
	11						1	
20	A disarte di anno and incretionet ann	PASS-THROUGH C					1	20
38	Adjusted general inpatient rou			ons)				38
39	Program general inpatient rou	1						39
40	Medically necessary private ro							40
41	Total Program general inpatie	nt routine service cost (line 3	9 + line  40	)		1		41
					Average			
		To	otal	Total	Per Diem	Program	Program Cost	
		Inpatie	ent Cost	Inpatient Days	$(col. 1 \div col. 2)$	Days	(col. 3 x col. 4)	
			1	2	3	4	5	
42	Nursery (title V & XIX only)							42
	Intensive Care Type Inpatier	nt						
	Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
40		(f)						-
47	Other Special Care Unit (spec	lly)					1	47
10				200			1	10
48	Program inpatient ancillary se							48
49	Total Program inpatient costs	(sum of lines 41 through 48)	(see instruc	ctions)				49
		PASS-THROUGH C						-
50	Pass through costs applicable	8 I						50
51	Pass through costs applicable	to Program inpatient ancillar	y services (	from Worksheet D, sur	n of Parts II and IV)			51
52	Total Program excludable cos							52
53	Total Program inpatient opera	ting cost excluding capital re	lated, nonp	hysician anesthetist, an	d medical education cos	sts		53
	(line 49 minus line 52)							
		TARGET AMOUNT ANI	LIMIT C	OMPUTATION				
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line	55)						56
57	Difference between adjusted i		arget amour	t (line 56 minus line 5	3)		1	57
58	Bonus payment (see instruction	· · · ·	oor amou		- /		1	58
59				ding 1006 undated an	J	aulaat haalaat		59
	Lesser of line $53 \div \text{line } 54 \text{ or}$					arket basket		
60	Lesser of line $53 \div \text{line } 54 \text{ or}$							60
61	If line 53 ÷ line 54 is less than					ng costs		61
	(line 53) are less than expected	d costs (lines 54 x 60), or 1 9	% of the targ	get amount (line 56), of	herwise enter zero.			
	(see instructions)							_
62	Relief payment (see instructio	ns)						62
63	Allowable Inpatient cost plus	incentive payment (see instru	(ctions)					63
	р	ROGRAM INPATIENT R	OUTINE S	WING BED COST				
64	Medicare swing-bed SNF inpa				period (see instructions)			64
	(title XVIII only)							
65	Medicare swing-bed SNF inpa	atient routine costs after Dec	ember 31 of	f the cost reporting peri	od (see instructions)			65
	(title XVIII only)							
66	Total Medicare swing-bed SN	F inpatient routine costs (lin	e 64 plus lir	ne 65) (Title XVIII only	. For CAH, see instruct	ions.)		66
67	Title V or XIX swing-bed NF							67
68	Title V or XIX swing-bed NF						1	68

69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)

69

03-16			FOR	M CMS-2552-10			4090 (C	ont.)
	TATION OF	INPATIENT		PROVIDER CCN: COMPONENT CCN:		PERIOD: FROM TO	WORKSHEET D-1, PARTS III & IV	
Check applicabl boxes:		[] Title V - I/P [] Title XVIII, Part A [] Title XIX - I/P AND ICF/IID ONLY		[] Hospital [] IPF [] IRF	[] Subprovider (other) [] SNF [] NF		[] PPS [] TEFRA [] Other	
		F/IID routine service cost	(line 27)					70
			ce cost per diem (line 70	÷ line 2)				71
72 P	Program routing	e service cost (line 9 x li	ne 71)					72
73 N	Medically nece	ssary private room cost a	pplicable to Program (lin	e 14 x line 35)				73
74 1	Total Program	general inpatient routine	service costs (line 72 + li	ne 73)				74
75 0	Capital-related	cost allocated to inpatier	at routine service costs (fr	om Worksheet B, Part II	, column 26, line 45)			75
76 P	Per diem capita	ll-related costs (line 75 ÷	line 2)					76
77 P	Program capita	l-related costs (line 9 x li	ne 76)					77
78 I	npatient routin	e service cost (line 74 m	inus line 77)					78
79 A	Aggregate char	ges to beneficiaries for e	xcess costs (from provide	er records)				79
80 T	Fotal Program	routine service costs for	comparison to the cost lir	nitation (line 78 minus li	ne 79)			80
		e service cost per diem l						81
		e service cost limitation						82
		atient routine service cos						83
84 F	Program inpatie	ent ancillary services (se	e instructions)					84
85 U	Utilization revi	ew - physician compensa	tion (see instructions)					85
86 T	Total Program	inpatient operating costs	(sum of lines 83 through	85)				86
PART I	V - COMPUT	TATION OF OBSERV	ATION BED PASS-TH	ROUGH COST				<u> </u>
87 T	Fotal observation	on bed days (see instruct	tions)					87
88 A	Adjusted gener	al inpatient routine cost j	per diem (line 27 ÷ line 2	)				88
89 C	Observation be	d cost (line 87 x line 88)	(see instructions)					89
		COMPUTATION OF	OBSERVATION BED	PASS THROUGH CO	ST			
			Cost 1	Routine Cost (from line 21) 2	column 1 ÷ column 2 3	Total Observation Bed Cost (from line 89) 4	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions) 5	
00 5	7		1	2	3	4	2	
90 C	Capital-related	cost						90

90	Capital-related cost			90
91	Nursing School cost			91
92	Allied Health cost			92
93	All other Medical Education			93

APPO	RTIONMENT OF COST OF	PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
ERV	CES RENDERED BY		FROM	PARTS I-III	
	INS AND RESIDENTS		ТО		_
ART	I - NOT IN APPROVED TEACHING PROGRAM		-		-
	Cost Centers	Percent of Assigned Time	Expense Allocation 2	Total Inpatient Days All Patients 3	_
1	Total cost of services rendered	100.00	2	5	t
-	Hospital Inpatient Routine Services:				Ē
2	Adults & pediatrics (general routine care)				Т
3	Intensive care unit				
4	Coronary care unit				_
5	Burn Intensive Care Unit				_
6 7	Surgical Intensive Care Unit				+
8	Other Special Care (specify) 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				Τ
13	Skilled Nursing Facility				I
14	Nursing Facility				Ŧ
15	Other Long Term Care				4
16	Home Health Agency Outputient Bahabilitation Providers				╉
17 18	Outpatient Rehabilitation Providers Ambulatory Surgical Center	<u> </u>			ł
18 19	Hospice				t
20	Subtotal (sum of lines 9 through 19)				t
				Total Charges	T
				(from Worksheet C,	
				Part I, column 8,	
	Hospital Outpatient Services:			lines 88 through 93)	
21	Rural Health Clinic (RHC)				∔
22	Federally Qualified Health Center (FQHC)				╇
23 24	Clinic Emergency				╋
24 25	Observation beds				+
26	Other Outpatient Service (specify)				t
27	Subtotal (sum of lines 21 through 26)				t
28	Total (sum of lines 20 and 27)	100.00			
RT	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPA		STS ONLY)		_
		Expenses Allocated			
		to cost centers on Worksheet B, Part I	Swing Dod	Net Cost	
		columns 21 and 22	Swing Bed Amount	(column 1 plus column 2)	
	Hospital Inpatient Routine Services:	1	2	3	-
29	Adults & Pediatrics (general routine care)				Ť
30	Swing Bed - SNF				T
31	Swing Bed - NF				ſ
32	Intensive care unit				1
33	Coronary care unit	<b> </b>			╀
34	Burn Intensive Care Unit				+
35 36	Surgical Intensive Care Unit Other Special Care (specify)	<u> </u>			+
30 37	Subtotal (sum of lines 29, and 32 through 36)	İ			t
38	IPF - Inpatient routine service	İ			t
39	IRF - Inpatient routine service				ţ
40	Subprovider (Other)- Inpatient routine service				Ι
41	Skilled Nursing Facility				Ţ
42	Total (sum of lines 37 through 41)				L
RT	III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH P.	AKTS I AND II ARE U		177 1 5	т
				1 Teaching Program	+
	Hospital		(from Part I)	Amount 2	+
43	Inpatient		column 9, line 9	2	$^{+}$
44	Outpatient		column 9, line 27		t
45	Total Hospital (sum of lines 43 and 44)				ţ
46	IPF - Inpatient routine service		column 9, line 10		T
47	IRF - Inpatient routine service		column 9, line 11		T
48	Subprovider (Other)- Inpatient routine service		column 9, line 12		∔
49	Skilled Nursing Facility		column 9, line 13	1	

FORM CMS-2552-10 (03-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4026) 40-576

49 Skilled Nursing Facility

49

03-1	6			FORM CMS-2			4090 (0	Cont.)
APPOI	RTIONMENT OF CO	ST OF			PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
SERVI	ICES RENDERED BY	<i>I</i>				FROM	PARTS I-III (Cont.)	
	RNS AND RESIDENT					то	_	
PART	I - NOT IN APPRO	VED TEACHING P	ROGRAM		•	-		
	Average Cost		h Care Program Inpatie		Title V	Title XVIII	Title XIX	
	Per Day	Title V	Title XVIII, Part B	Title XIX	(col. 4 x col. 5)	(col. 4 x col. 6)	(col. 4 x col. 7)	
	4	5	6	7	8	9	10	
1								1
								-
2								2
3								3
4								4
5							-	5
7								7
8								8
9								9
10								10
11								11
12								12
13			1	1		1		13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
	Ratio of Cost		es V and XIX Outpatier		Ti	tles V and XIX Outpatie		
	to Charges		Fitle XVIII Part B Char			Title XVIII Part B Co		_
	(column 2 ÷	Title	Title XVIII	Title	Title	Title XVIII	Title	
1	column 3)	V	Part B	XIX	V	Part B	XIX	21
21 22						-		21 22
22								22
23								23
24								24
26								26
27								27
28								28
PART	II - IN AN APPROV	ED TEACHING PR	ROGRAM (TITLE XV	'III, PART B INPAT	IENT ROUTINE COS	TS ONLY)		
		Average Cost		Expenses				
	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				<u> </u>				31
33			+	<del> </del>				33
34				1				34
35			1	1				35
36		1	1	ł				36
37								37
38				1				38
39			1	1				39
40								40
4.1								41
41								42
42		OR TITLE XVIII (T			RTS I AND II ARE US	ED)		
42			Total Title	XVIII Costs				
42	In Approved Te	eaching Program						
42	In Approved Te (from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				
42 <b>PART</b>	In Approved Te (from Part II, col. 7) 3			(col. 2 + col. 4) 6				_
42 <b>PART</b> 43	In Approved Te (from Part II, col. 7)	Amount	(to Wkst. E, Part B)					43
42 PART 43 44	In Approved Te (from Part II, col. 7) 3	Amount	(to Wkst. E, Part B) 5					44
42 <b>PART</b> 43 44 45	In Approved To (from Part II, col. 7) 3 line 37	Amount	(to Wkst. E, Part B) 5 line 22					44
42 <b>PART</b> 43 44 45 46	In Approved To (from Part II, col. 7) 3 line 37 line 38	Amount	(to Wkst. E, Part B) 5 line 22 line 22					44 45 46
42 PART 43 44 45 46 47	In Approved To (from Part II, col. 7) 3 line 37 line 38 line 39	Amount	(to Wkst. E, Part B) 5 line 22 line 22 line 22					44 45 46 47
42 PART 43 44 45 46	In Approved To (from Part II, col. 7) 3 line 37 line 38	Amount	(to Wkst. E, Part B) 5 line 22 line 22					44 45 46

_	) (Cont.)			S-2552-10			03-16
	TENT ANCILLAR	Y SERVICE		PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST	APPORTIONMEN	T			FROM		
				COMPONENT CCN:	то		
Check		[] Title V	[] Hospital	[] Subprovider (other)	[] Swing-Bed SNF	[] PPS	
applica	ible	[] Title XVIII, Part A	[] IPF	[] SNF	[] Swing-Bed NF	[] TEFRA	
boxes:		[] Title XIX	[] IRF	[] NF	[] ICF/IID	[] Other	
	COST CENTER	DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Cost (col. 1 x col. 2)	IS
(A)	CODT CLIMILIA			1	2	3	
		TINE SERVICE COST CEN	TERS				
	Adults and Pediatr Intensive Care Uni	rics (General Routine Care)			_		30 31
	Coronary Care Un				_		31
	Burn Intensive Ca						33
	Surgical Intensive						34
	Other Special Care	e (specify)			_		35
	Subprovider IPF Subprovider IRF						40
	Subprovider (Spec	cify)					41
	Nursery	•					43
-		RVICE COST CENTERS					
	Operating Room						50
	Recovery Room Labor Room and I	Delivery Room			+		51 52
	Anesthesiology	Benvery Room					53
	Radiology-Diagno	ostic					54
	Radiology-Therap	eutic					55
	Radioisotope						56
	Computed Tomog Magnetic Resonan						57 58
	Cardiac Catheteriz	0 0 0					59
60	Laboratory						60
		oratory Services-Prgm. Only					61
		acked Red Blood Cells					62 63
	Blood Storing, Pro Intravenous Therap	-					64
	Respiratory Therap						65
66	Physical Therapy						66
	Occupational Ther	rapy					67
	Speech Pathology Electrocardiology						68 69
	Electroencephalog	raphy					70
		Charged to Patients					71
		es Charged to Patients					72
	Drugs Charged to	Patients					73
	Renal Dialysis ASC (Non-Distinc	rt Part)					74
	Other Ancillary (s						76
		RVICE COST CENTERS					
	Rural Health Clini						88
		d Health Center (FQHC)					89
	Clinic Emergency						90 91
	Observation Beds	(see instructions)					92
93	Other Outpatient S	Service (specify)					93
		RSABLE COST CENTERS					
	Home Program Di Ambulance Servic						94 95
	Durable Medical H						95
	Durable Medical H						97
	Other Reimbursab	* *					98
		s 50-94 and 96-98)			_		200
		aboratory Services-Program o 200 minus line 201)	only charges (line 61)				201 202

(A) Worksheet A line numbers

COM	PUTATION OF ORGAN A	COLUSITION COSTS AN		emb	-2552-10 PROVIDER CCN:	PERIOD:	4090 (C WORKSHEET D-4,	.)
	HOSPITALS WHICH ARE				PROVIDER CCN:	FROM	PART I	
					OPO CCN:	то		
Check	5	[] HEART	[] LIVER	[] PA	NCREAS	[] ISLET	- A	
applic	able box:	[] KIDNEY	[] LUNG	[ ] IN7	ESTINE			
PART	FI-COMPUTATION OF	F ORGAN ACQUISITIO	N COSTS (INPATIENT I	OUTIN	E AND ANCILLARY SI			-
0	CT.		Inpatient			Organ	<u> </u>	
	omputation of Inpatient		Routine Organ		Per Diem Costs (from Wkst. D-1, Part II)	Acquisition	Cost (col. 2 x col. 3)	
	outine Service Costs oplicable to Organ Acquisition	0.0	Charges 1	D	(Irom wkst. D-1, Part II) 2	Days 3	(col. 2 x col. 3) 4	-
1 AP	Adults and Pediatrics	oli	1	38	2	3	4	1
2				43				2
3	Coronary Care			44				3
4	Burn Intensive Care Unit			45				4
5	Surgical Intensive Care U	nit		46				5
6	Other Special Care (special			47				6
7	TOTAL (sum of lines 1-6						1	7
					Ratio of Cost	Organ	Organ	
					to Charges	Acquisition	Acquisition	1
Cor	mputation of Ancillary				(from	Ancillary	Ancillary	
	vice Costs Applicable				Wkst. C)	Charges	Costs	
to C	Organ Acquisition			С	1	2	3	
8	Operating Room			50				8
9	Recovery Room			51				9
10	Labor Room & Delivery I	Room		52				10
11	Anesthesiology			53				11
12	Radiology-Diagnostic			54				12
13	Radiology-Therapeutic			55				13
14	Radioisotope			56				14
15	Computed Tomography (			57				15
16	Magnetic Resonance Imag	ging (MRI)		58				16
17	Cardiac Catheterization			59				17
18	Laboratory			60				18
19	PBP Clinical Laboratory S			61				19
20	Whole Blood & Packed R			62				20
21	Blood Storage, Processing	g, & Transfusing		63				21
22	IV Therapy			64				22
23	Respiratory Therapy			65 66				23 24
24 25	Physical Therapy Occupational Therapy			67				24
23	Speech Pathology			68				25
20	Electrocardiology			69				20
27	Electroencephalography			70				27
28	Medical Supplies Charged	d to Patients		70				28
30	Implantable Devices Char	rged to Patients		72	ł			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	<u>C</u> )		88				35
36	Federally Qualified Health			89				36
37	Clinic			90				37
38	Emergency Room			91	1			38
39	Observation Beds			92				39
40	Other Outpatient Service (	(specify)		93	1			40
41	TOTAL (sum of lines 8-4			_	1			41

C = Worksheet C line numbers

D = Worksheet D-1 line numbers

## 4090 (Cont.) FORM CMS-2552-10 09 COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS PROVIDER CCN: PERIOD: WORKSHEET D-4, PART II FROM PART II PART II PART II

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

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

			Average Cost		Organ	
	Computation of the Cost of Inpatient		Per Day		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

				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

09-14

09-14		FORM CMS-	-2552-10		4090 (Cont.)
COMPUTATION OF ORGAN A	ARGES	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,	
FOR HOSPITALS WHICH ARE	CERTIFIED TRANSPLANT CE	NTERS		FROM	PARTS III & IV
			OPO CCN:	то	_
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE		

## PART III - SUMMARY OF COSTS AND CHARGES

		(	Cost	Cha	rges	
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and Ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct Organ Acquisition (see instructions)					59
60	Cost of physicians' services in a teaching					60
	hospital (see instructions)					
61	Total (sum of lines 56 through 60)					61
62	Total Usable Organs (see instructions)					62
63	Medicare Usable Organs (see instructions)					63
64	Ratio of Medicare Usable Organs to Total Usable					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 through 73)				74
75	Organs Transplanted				75
76	Organs Sold to Other Hospitals				76
77	Organs Sold to OPOs				77
78	Organs Sold to Transplant Hospitals				78
79	Organs Sold to Military or VA Hospitals				79
80	Organs Sold Outside the U.S.				80
81	Organs Sent Outside the U.S. (no revenue received)				81
82	Organs Used for Research				82
83	Unusable/Discarded Organs				83
84	Total (sum of lines 75 through 83 should equal line 74)				84

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

(2) Organs procured outside your center by a procurement team from your center are included in the count.

4090	O (Cont.)	F	ORM CMS-2552-	-10				09-14
APPO	RTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HO	DSPITAL			PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART I	
Check	applicable box: [] Hospital Staff [] Medica	al Staff						
PART	I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION FOR	COST REPORTING PE	RIODS ENDING BEFOI	RE JUNE 30, 2014	Physician/		5 Percent	<b>—</b>
Line	Specialty	Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
No.	Description/Physician Identifier	Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	
1	2	3	4	5	6	7	8	-
1	General Practitioner Family Practice	3	4	5	0	/	0	1
- 1	Internal Medicine							2
2	Surgery							3
3	Pediatrics							4
5	Obstetrics-Gynecology							5
6								6
7	Psychiatry							7
	Anesthesiology							8
9								9
	All Other							10
11	Total							11
- 11	10141							11
		Cost of		Cost of			Adjust Cost	Т
		Membership	Professional	Physician	Professional		of Physician's	
Line	Specialty	& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
No.	Description/Physician Identifier	Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	
9	10	11	12	13	14	15	16	1
1	General Practitioner Family Practice							1
2	Internal Medicine							2
3								3
4	Pediatrics							4
5								5
6	, , , , , , , , , , , , , , , , , , , ,							6
7	Psychiatry							7
8	Anesthesiology							8
9	Pathology							9
10	All Other	1	1					10

11 Total (transfer the amount in column 16, line 11, to

Part II, line 1, column 1 or 2, as appropriate)

11

09-	14
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## FORM CMS-2552-10

4090 (Cont.)

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

applica	able box:	[ ] IRF				
PART	II - APPORTIONMENT OF COST FOR PHY	SICIANS' SERVICES IN A TEAC	CHING HOSPITAL FOR COST R	EPORTING PERIODS E	ENDING BEFORE JUN	E 30, 20
				Medical School	Total	Т
			Hospital Staff	Faculty	$(col \ 1 + col \ 2)$	
			1	2	3	
1	Adjusted Cost of Physician's Direct Medical and	nd Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days	8				2
3	Average Per Diem (line 1 ÷ line 2)					3
	HEALTH CARE PROGRAM REIMBURSAE	BLE DAYS				
4	Title V - Inpatient					4
5	Title V - Outpatient					5
6	Title XVIII - Part A					6
_	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon					

6	Title XVIII - Part A		6
7	Title XVIII - Part B		7
8	Title XIX - Inpatient		8
9	Title XIX - Outpatient		9
10	Inpatient and Outpatient Kidney Acquisition		10
11	Inpatient and Outpatient Liver Acquisition		11
12	Inpatient and Outpatient Heart Acquisition		12
13	Inpatient and Outpatient Lung Acquisition		13
14	Inpatient and Outpatient Pancreas Acquisition		14
15	Inpatient and Outpatient Intestine Acquisition		15
16	Inpatient and Outpatient Islet Acquisition		16
17	Other Organ Acquisition		17

#### HEALTH CARE PROGRAM REIMBURSABLE COST

18	Title V - Inpatient (line 3 x line 4)		18
19	Title V - Outpatient (line 3 x line 5)		19
20	Title XVIII - Part A (line 3 x line 6)		20
21	Title XVIII - Part B (line 3 x line 7)		21
22	Title XIX - Inpatient (line 3 x line 8)		22
23	Title XIX - Outpatient (line 3 x line 9)		23
24	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)		24
25	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)		25
26	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)		26
27	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)		27
28	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)		28
29	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)		29
30	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)		30
31	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)		31

Transfer the amounts in column 3 as follows: Add lines 18 and 19, and transfer to Worksheet E-3, Part VII Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate Line 21 to Worksheet E, Part B

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate

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

## 4090 (Cont.)

## FORM CMS-2552-10

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

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

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

11-16	6 FORM CMS-2552-10				
APPORTIONMENT OF COST FOR PHYSICIANS' SE	RVICES IN A TEACHING HOSPITAL	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, PART IV	
Check applicable box: [] Hospital	[] IPF [] IRF		-		
PART IV - APPORTIONMENT OF COST FOR PHYSI		SPITAL FOR COST REPORT	ING PERIODS EN		
1 Adjusted cost of physicians' direct medical and su	urgical services			1	
2 Total inpatient days and outpatient visit days				2	
3 Average per diem (line 1 ÷ line 2)				3	
HEALTH CARE PROGRAM REIMBURSABL	EDAVS				
4 Title V - Inpatient	E DATS			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 hver acquisition				11	
13 Inpatient and outpatient lung acquisition				12	
14 Inpatient and outpatient rang acquisition				113	
15 Inpatient and outpatient panereas acquisition				15	
16 Inpatient and autpatient islet acquisition				10	
10 Inpatient and adipatient isiet acquisition				10	
1)				17	
HEALTH CARE PROGRAM REIMBURSABL	E 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)				20	
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	3 x line 10)			24	
25 Inpatient and outpatient liver acquisition (line 3 x	,			25	
26 Inpatient and outpatient heart acquisition (line 3 x				26	
27 Inpatient and outpatient lung acquisition (line 3 x				27	
28 Inpatient and outpatient pancreas acquisition (line				28	
29 Inpatient and outpatient intestine acquisition (line				29	
30 Inpatient and outpatient islet acquisition (line 3 x				30	
31				31	
				<i>.</i>	

Transfer amounts as follows:

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

Line 20 to Worksheet E, Part A, line 56 (Medicare IPPS); Worksheet E-3, Part I, line 3 (TEFRA); Worksheet E-3, Part II, line 15 (IPF); Worksheet E-3, Part III, line 16 (IRF); Worksheet E-3, Part IV, line 6 (LTCH); or, Worksheet E-3, Part V, line 17 (Cost reimbursement)

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

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

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

4090 (Cont.)	FORM CMS-2552-10			11-16
CALCULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
SETTLEMENT		FROM	PART A	
	COMPONENT CCN	то		

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

	DRG amounts other than outlier payments	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1.
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1.
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	1.
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	1.
2	Outlier payments for discharges (see instructions)	
2.01	Outlier reconciliation amount	2.
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	2.
3	Managed care simulated payments	
4	Bed days available divided by number of days in the cost reporting period (see instructions)	
	Indirect Medical Education Adjustment Calculation for Hospitals	
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or	
	before 12/31/1996 (see instructions)	
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in	
	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)	
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)	7.
	If the cost report straddles July 1, 2011 then see instructions.	
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance	
0	with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA.	8.
0.01		8.
0.02	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.
	section 5506 of ACA. (see instructions)	
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	
10	FTE count for allopathic and osteopathic programs in the current year from your records	
11	FTE count for residents in dental and podiatric programs	
12	Current year allowable FTE (see instructions)	
13	Total allowable FTE count for the prior year	
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	
15	Sum of lines 12 through 14 divided by 3	
16	Adjustment for residents in initial years of the program	
17	Adjustment for residents displaced by program or hospital closure	
18	Adjusted rolling average FTE count	
19	Current year resident to bed ratio (line 18 divided by line 4)	
20	Prior year resident to bed ratio (see instructions)	
21	Enter the lesser of lines 19 or 20 (see instructions)	
22	IME payment adjustment (see instructions)	
22.01	IME payment adjustment - Managed Care (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).	
24	IME FTE resident count over cap (see instructions)	
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	
26	Resident to bed ratio (divide line 25 by line 4)	
27	IME payments adjustment factor (see instructions)	
28	IME add-on adjustment amount (see instructions)	
28.01	IME add-on adjustment amount - Managed Care (see instructions)	28
29	Total IME payment (sum of lines 22 and 28)	
9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	29
	Disproportionate Share Adjustment	
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	
31	Percentage of Medicaid patient days to total patient days (see instructions)	
32	Sum of lines 30 and 31	
33	Allowable disproportionate share percentage (see instructions)	
34	Disproportionate share adjustment (see instructions)	
	Uncompensated Care Adjustment Prior to October	
35	Total uncompensated care amount (see instructions)	
5.01	Factor 3 (see instructions)	35
5.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	35
5.02	Pro rata share of the hospital uncompensated care payment amount (see instructions)	35
	Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions)	35
5.04	The run share of the hospital ancompensated care payment amount (MD11) (see instructions)	
5.04 5.05	Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions)	35.

11-16	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF REIMBURSEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,
SETTLEMENT		FROM	PART A (Cont.)
	COMPONENT CCN:	то	

## PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)			
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40
40	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			40
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see ins	tructions)		41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	<i>'</i>		42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)			44
45	Average weekly cost for dialysis treatments (see instructions)			45
46	Total additional payment (line 45 times line 44 times line 41.01)			46
47	Subtotal (see instructions)			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)			48
49	Total payment for inpatient operating costs (see instructions)			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)			51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).			52
53	Nursing and allied health managed care payment			53
54 54.01	Special add-on payments for new technologies			54
	Islet isolation add-on payment			54.01
55 56	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions)		1	55 56
57	Routine service other pass through costs (from Wkst .D, Pt. III, col. 9, lines 30 through 35).		+	57
58	Ancillary service other pass through costs (from Wkst. D, Pt. III, col. 9, inter 50 through 55).			58
59	Total (sum of amounts on lines 49 through 58)			59
60	Primary payer payments		1	60
61	Total amount payable for program beneficiaries (line 59 minus line 60)		1	61
62	Deductibles billed to program beneficiaries			62
63	Coinsurance billed to program beneficiaries			63
64	Allowable bad debts (see instructions)			64
65	Adjusted reimbursable bad debts (see instructions)			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)			68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)			69
70	Other adjustments (specify) (see instructions)			70
70.88	SCH or MDH volume decrease adjustment			70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			70.91
70.92	Bundled Model 1 discount amount (see instructions)			70.92
70.93	HVBP payment adjustment amount (see instructions)			70.93
70.94	HRR adjustment amount (see instructions)			70.94
70.95	Recovery of accelerated depreciation			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)			70.96 70.97
70.97	Low volume adjustment for federal fiscal year (yyyy) HAC adjustment amount (see instructions)			70.97
70.55	Amount due provider (see instructions)			70.55
71.01	Sequestration adjustment (see instructions)			71.01
72	Interim payments			71.01
73	Tentative settlement (for contractor use only)			73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			75
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			90
91	Capital outlier from Wkst. L, Pt. I, line 2			91
92	Operating outlier reconciliation adjustment amount (see instructions)			92
93	Capital outlier reconciliation adjustment amount (see instructions)			93
94	The rate used to calculate the fime value of money (see instructions)			94
95	Time value of money for operating expenses (see instructions)			95
96	Time value of money for capital related expenses (see instructions)			96
				-
	HSP Bonus Payment Amount	Prior to 10/1	On or After 10/1	100
100	HSP bonus amount (see instructions)		I	100
	UVBD Adjustment for USD Penus Perment	Drion to 10/1	On or After 10/1	Ъ
	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	Prior to 10/1	On or After 10/1	101
101	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)		1	101
102	11.22 adjustices anount for fist bonds payment (see instructions)		1	102
	HRR Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1	٦
103	HRR adjustment factor (see instructions)			103
103	HRR adjustment amount for HSP bonus payment (see instructions)			103
-				

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4030.1)

	JLATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E,	
REIMB	BURSEMENT SETTLEMENT		FROM	PART B	
		COMPONENT CCN:	то		
Check a	applicable box: [] Hospital [] IPF [] IRF [] Subprov	vider (Other) [ ] SNF			
	B - MEDICAL AND OTHER HEALTH SERVICES	. ,			
1	Medical and other services (see instructions)				
2	Medical and other services reimbursed under OPPS (see instructions).				1
	PPS payments				3
4					4
5					:
	Line 2 times line 5				(
7	· · · · · · · · · · · · · · · · · · ·				7
8	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line	200			8
	Organ acquisition	200			10
	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12					12
13					13
14	Total reasonable charges (sum of lines 12 and 13)				14
	Customary charges				
15	Aggregate amount actually collected from patients liable for payment for serv	rices on a charge basis			15
16	Amounts that would have been realized from patients liable for payment for s	services on a charge			16
	basis had such payment been made in accordance with 42 CFR §413.13(e)				
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
	Total customary charges (see instructions)				18
	Excess of customary charges over reasonable cost (complete only if line 18 e				19
20					20
21					21
22					22
23					23
24	Total prospective payment (sum of lines 3, 4, 8, and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT				24
25	Deductibles and coinsurance (see instructions)				25
25					26
27					27
28					28
29					29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSION	AL SERVICES)			
33					33
34	Allowable bad debts (see instructions)				34
35					35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				30
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
	Other adjustments (specify) (see instructions)				39
	Pioneer ACO demonstration payment adjustment (see instructions)	netructions)			39.5 39.9
	Partial or full credits received from manufacturers for replaced devices (see in Recovery of Accelerated depreciation	instructions)			39.9
39.99 40					39.9
40.01					40.0
40.01					40.0
41	Tentative settlement (for contractors use only)				4/
42	Balance due provider/program (see instructions)				43
т.)	Protested amounts (nonallowable cost report items) in accordance with CMS				4

03-15		FORM CMS-2552-10	4090 (Cont.)			
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: 	PERIOD: FROM	WORKSHEET E, PART B (Cont.)		
Check ap	pplicable box [] Hospital [] IPF [] IRF	[] Subprovider(Other) [] SNF	. 10	-		
	- MEDICAL AND OTHER HEALTH SERVICES					
	Original outlier amount (see instructions)			90		
91	Outlier reconciliation adjustment amount (see instructi	91				
92						

93Time Value of Money (see instructions)94Total (sum of lines 91 and 93)

92 93 94

4090 (Cont.)				FORM	FORM CMS-2552-10					
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			PROVIDER CCN:  COMPONENT CCN	PROVIDER CCN:			PERIOD: FROM TO			
Check		[] Hospital	[] Subprovider (Other)			In	patient			
applic	able	[] IPF	[ ] SNF			F	Part A		Part B	
box:		[] IRF	[] Swing-Bed SNF			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description					1	2	3	4	
1		payments paid to p								1
2	1 2	1 2	ividual bills, either submitted or to be s reporting period. If none, write "NONI							2
3	List separately	y each retroactive			.01					3.01
		ustment amount ba	sed		.02					3.02
	on subsequent	t revision of the		Program to	.03					3.03
	interim rate for	or the cost reporting	g period.	Provider	.04					3.04
		te of each payment			.05					3.05
	If none, write	"NONE" or enter a	a zero. (1)		.50					3.50
					.51					3.51
				Provider to	.52					3.52
				Program	.53					3.53
					.54					3.54
			minus sum of lines 3.50-3.98)		.99					3.99
4			lines 1, 2, and 3.99)							4
		kst. E or Wkst. E-3	3, line							
	and column as									
		PLETED BY CON			-			1	-	
5		y each tentative sett		Program to	.01					5.01
		desk review. Also	show	Provider	.02					5.02
	date of each p	•			.03					5.03
	If none, write	"NONE" or enter a	a zero. (1)		.50					5.50
				Provider to	.51					5.51
				Program	.52					5.52
	<u>`</u>		minus sum of lines 5.50 -5.98)	- · · ·	.99					5.99
6		et settlement amou		Program to provider	.01					6.01
_		the cost report (1)		Provider to program	.02					6.02
7		re program liability	(see instructions)			a				7
8	Name of Cor	ntractor				Contractor Number		NPR Date (Month/Day	y/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.

09-15		FORM CMS-2552	FORM CMS-2552-10		
CALCULATION OF REIMBURS	EMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-1,
SETTLEMENT FOR HIT				FROM	PART II
			COMPONENT CCN:	то	
Check	[] Hospital	[] CAH			
Applicable box:					

#### HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

#### INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4031.2) Rev. 8

4090	O(Cont.)		FORM CMS-	2552-10			09-15
		OF REIMBURSEMENT SWING BEDS		PROVIDER CCN:	PERIOD: FROM	WORKSHEET E-2	
				COMPONENT CCN	то		
Check		[] Title V	[] Swing Bed - S				
applica boxes:		[ ] Title XVIII [ ] Title XIX	[ ] Swing Bed - 1	٩F			
					PART A	PART B	
	COMPUTA	TION OF NET COST OF COVER	ED SERVICES		1	2	
1	Inpatient ro	utine services - swing bed-SNF (s	ee instructions)				1
2	Inpatient ro	utine services - swing bed-NF (se	e instructions)				2
3	Ancillary se	ervices (from Wkst. D-3, col. 3, lin	e 200, for Part A, and sum of	Wkst. D, Pt. V,			3
	cols. 6 and	7, line 202, for Part B) (For CAH	, see instructions)				
4	Per diem co	ost for interns and residents not in a	approved teaching program (s	ee instructions)			4
5	Program da	ys					5
6	Interns and	residents not in approved teaching	program (see instructions)				6
7	Utilization	review - physician compensation -	SNF optional method only				7
8		um of lines 1 through 3 plus lines 6	and 7)				8
9		ver payments (see instructions)					9
10		ne 8 minus line 9)					10
11	Deductible	s billed to program patients (exclud	le amounts applicable to physi	cian professional			11
	services)						
-		ne 10 minus line 11)					12
13		e billed to program patients (from	provider records) (exclude coi	nsurance for			13
	physician p	rofessional services)			1		

14 80% of Part B costs (line 12 x 80%)

17 Allowable bad debts (see instructions)

19.01 Sequestration adjustment (see instructions)

21 Tentative settlement (for contractor use only)

19 Total (see instructions)

chapter 1, §115.2

20 Interim payments

16 Other adjustments (specify) (see instructions)

17.01 Adjusted reimbursable bad debts (see instructions)

15 Subtotal (enter the lesser of line 12 minus line 13, or line 14)

16.50 Pioneer ACO demonstration payment adjustment (see instructions)

18 Allowable bad debts for dual eligible beneficiaries (see instructions)

22 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)

23 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,

14 15

16 16.50

17

17.01 <u>18</u>

19

19.01

20 21

22

23

11-16	FORM CMS-2552-10			4090 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART I
			то	

## PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA

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

## 4090 (Cont.)

Check applicable

box:

## FORM CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

#### PROVIDER CCN: PERIOD: \_\_\_\_\_ FROM

11-16 WORKSHEET E-3,

	COMPONENT CCN:	FROM TO	PART II
[] Hospital			

[] Subprovider IPF

#### PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

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

#### TO BE COMPLETED BY CONTRACTOR

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

11-1	6
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## FORM CMS-2552-10

4090 (Cont.)

WORKSHEET E-3,

CALCULATION OF REIMBURSEMENT SETTLEMENT

## PROVIDER CCN: PERIOD:

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

#### TO BE COMPLETED BY CONTRACTOR

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

4090 (Cont.)	FORM CMS-2552-10		11-16
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET E-3, PART IV

## PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

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

	TO BE COMPLETED BY CONTRACTOR	
50	Original PPS payment and outlier amount from Wkst. E-3, Pt. 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

09-15	FORM CMS-2552-10	_		4090 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
			FROM	PART V
			то	

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

1	Inpatient services	1
2	Nursing and allied health managed care payment (see instructions)	2
3	Organ acquisition	3
4	Subtotal (sum of lines 1 through 3)	4
5	Primary payer payments	5
6	Total cost (see instructions)	6
	COMPUTATION OF LESSER OF COST OR CHARGES	
	Reasonable charges	
7	Routine service charges	7
8	Ancillary service charges	8
9	Organ acquisition charges, net of revenue	9
10	Total reasonable charges	10
	Customary charges	
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis	11
12	Amounts that would have been realized from patients liable for payment for services on	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 physicians' services in a teaching hospital (see instructions)	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	Direct graduate medical education payments	18
19	Cost of covered services (sum of lines 6 and 17)	19
20	Deductibles (exclude professional component)	20
21	Excess reasonable cost (from line 16)	21
22	Subtotal (line 19 minus lines 20 and 21)	22
23	Coinsurance	23
24	Subtotal (line 22 minus line 23)	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	25
26	Adjusted reimbursable bad debts (see instructions)	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	27
28	Subtotal (sum of lines 24 and 25 or 26)	28
29	Other adjustments (specify) (see instructions)	29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	29.50
30	Subtotal (see instructions)	30
30.01	Sequestration adjustment (see instructions)	30.01
31	Interim payments [10]	31
32	Tentative settlement (for contractor use only)	32
33	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	34

4090	(Cont.)
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CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E-3,
		FROM	PART VI
	COMPONENT CCN .:	то	

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

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

11-16		FORM CMS-2552-1	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/IID	[] TEFRA	
boxes:		[ ] 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	<u> </u>
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
1	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES	1		
8	Reasonable Charges Routine service charges			8
- 0	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			10
12	Total reasonable charges (sum of lines 8 through 11)			11
12	CUSTOMARY CHARGES			12
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amount actuary concrete from patients habe for payment for services on a charge basis			13
14	on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)			15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16			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 physicians' service in a teaching hospital (see instructions)			20
	Cost of covered services (enter the lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (title V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	Other adjustments (specify) (see instructions)			37
38	Subtotal (line $36 \pm line 37$ )			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

4090	(Cont.) FORM CMS-2552	2-10			11-16
DIRECT	Γ GRADUATE MEDICAL EDUCATION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRE	O OUTPATIENT DIRECT MEDICAL		FROM		
EDUCA	ATION COSTS		то		
Check	[] Title V				
applicab	[] Title XVIII				
box:	[] Title XIX				
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost	reporting periods ending on	or before December 31,	1996	1
2	Unweighted FTE-resident cap add-on for new programs per 42 CFR 413.79(e) (s	see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CF	R §413.79 (m). (see instruct	ions		3.01
	for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic progra				
4	Adjustment (plus or minus) to the FIE cap for allopathic and osteopathic progra	ms due to a Medicare GME			4
	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost report	ing periods straddling 7/1/20	11)		4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for	or cost reporting periods strad	dling 7/1/2011)		4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 p	lus lines 4.01 and 4.02 plus a	pplicable subscripts		5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the	current year from your record	ls (see instructions)		6
7	Enter the lesser of line 5 or line 6		-		7
		Primary Care	Other	Total	_
		1	2	3	_
8	Weighted FTE count for physicians in an allopathic and osteopathic program for				8
	the current year		_		_
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 tin	nes			9
	the result of line 5 divided by the amount on line 6		_		_
	Weighted dental and podiatric resident FTE count for the current year		_		10
10	Unweighted dental and podiatric resident FTE count for the current year		_		10
	Total weighted FTE count		_		11
-	Total weighted resident FTE count for the prior cost reporting year (see instruct		_		12
-	Total weighted resident FTE count for the penultimate cost reporting year (see i	nstr.)	_		13
-	Rolling average FTE count (sum of lines 11 through 13 divided by 3)		_		14
15	Adjustment for residents in initial years of new programs				15
15	Unweighted adjustment for residents in initial years of new programs				15
16	Adjustment for residents displaced by program or hospital closure				16
16	Unweighted adjustment for residents displaced by program or hospital closure				16
-	Adjusted rolling average FTE count				17
	Per resident amount				18
-	Approved amount for resident costs	1	704 3443	-	19
	Additional unweighted allopathic and osteopathic direct GME FTE resident cap	slots received under 42 §413	./9(c)(4)		20
	Direct GME FTE unweighted resident count over cap (see instructions)				21
	Allowable additional direct GME FTE resident count (see instructions)	<b>on</b> ()			_
	Enter the locality adjustment national average per resident amount (see instructi Multiply line 22 time line 23	0115)			23
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				24
23	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		23
26		inpatient r ait A	manageu Cale		26
	Total inpatient days (see instructions)		1		20
	Ratio of inpatient days to total inpatient days		1		27
	Program direct GME amount		1		20
	Reduction for direct GME payments for Medicare Advantage				30
	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE -	TITLE XVIII ONLY (NURS	ING SCHOOL AND		51
	PARAMEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE -				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20	) and 23. lines 74 and 94)			32
	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, sum of con 20			1	33
	Ratio of direct medical education costs to total charges (wise C, 1 L1, on 8, sum of me			1	34
	Medicare outpatient ESRD charges (see instructions)			1	35
				1	36
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				

09-14	4 FORM CMS-2552-10			4090 (Cor	nt.)	
DIREC	T GRADUATE MEDICAL EDUCAT	ION (GME)	PROVIDER CCN:	PERIOD:	WORKSHEET E-4	
& ESRI	O OUTPATIENT DIRECT MEDICAL	_		FROM	(Cont.)	
EDUCA	ATION COSTS			то	_	
Check	[] Title V					
applical	ble [] Title X	VIII				
box:	[] Title X	IX				
	APPORTIONMENT OF MEDICARI	E REASONABLE COST OF GME				
	Part A Reasonable Cost					
37	Reasonable cost (see instructions)					37
38	Organ acquisition costs Wkst. D-4, H	Pt. III, col. 1, line 69)				38
39	Cost of physicians' services in a teac	hing hospital (see instructions)				39
40	Primary payer payments (see instruct	tions)				40
41	Total Part A reasonable cost (sum of	lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost					
42	Reasonable cost (see instructions)					42
43	Primary payer payments (see instruct	tions)				43
44	Total Part B reasonable cost (line 42	minus line 43)				44
45	Total reasonable cost (sum of lines 4	1 and 44)				45
46	Ratio of Part A reasonable cost to to	tal reasonable cost (line 41 ÷ line 45)				46
47	7 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47	
	ALLOCATION OF MEDICARE DIF	RECT GME COSTS BETWEEN PART A ANI	D PART B			
48	Total program GME payment (line 3	1)				48
49	Part A Medicare GME payment (lin	e 46 x 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (lin	e 47 x 48) (title XVIII only) (see instructions)				50

4090	O (Cont.)	FORM CMS-2552-10			09-14		
BALA	NCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G		
(If you	are nonproprietary and do not maintain fund-type			FROM			
accour	nting records, complete the General Fund column only)			то	_		
			Specific				
		General	Purpose	Endowment	Plant		
	Assets	Fund	Fund	Fund	Fund		
	(Omit cents)	1	2	3	4		
	CURRENT ASSETS			-			
1	Cash on hand and in banks				1		
2	Temporary investments				2		
3					3		
4	Accounts receivable				4		
5	Other receivables				5		
6					6		
	accounts receivable						
7	Inventory				7		
8				_	8		
9	Other current assets			_	9		
10				_	10		
11	Total current assets (sum of lines 1-10)				11		
10	FIXED ASSETS		1	1	12		
12					12		
13	Land improvements				13		
14 15	Accumulated depreciation				14		
15	Buildings Accumulated depreciation		-		15		
10	*		-		10		
17	Accumulated depreciation				17		
18	Fixed equipment		-		18		
20	Accumulated depreciation				20		
20	Automobiles and trucks				20		
21	Accumulated depreciation				21		
22	Major movable equipment				23		
23	Accumulated depreciation				23		
24	Minor equipment depreciable				25		
26	Accumulated depreciation				25		
20	HIT designated Assets				20		
28	Accumulated depreciation				28		
29	Minor equipment-nondepreciable				29		
30	Total fixed assets (sum of lines 12-29)			1	30		
	OTHER ASSETS				50		
31	Investments				31		
32	Deposits on leases				32		
33					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-2	2552-10		4090 (Co	ont.)
BALANCE SHEET		PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type			FROM	(CONT.)	
accounting records, complete the General Fund column of	nly)		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 47 Notes payable					46 47
48 Unsecured loans					48
49 Other long term liabilities					49
50 Total long term liabilities (sum of lines 46 thru 49)					50
51 Total liabilities (sum of lines 45 and 50)					51
CAPITAL ACCOUNTS					
52 General fund balance					52
53 Specific purpose fund					53
54 Donor created - endowment fund					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 Plant fund balance - reserve for plant					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 CCN	I:	PERIOD: FROM TO		WORKSHEE	T G-1
	GENER	AL FUND	SPECIFIC PU	JRPOSE FUND	ENDOW	MENT FUND	PLANT	FUND	
	1	2	3	4	5	6	7	8	
1 Fund balances at beginning of period									1
2 Net income (loss) (from Worksheet G-3, line 29)							I		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		1							16
17		1							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	
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	PROVIDER CCN: 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 other miscellaneous communication services	8
9	Revenue from television and radio service	9
10	Purchase discounts	10
11	Rebates and refunds of expenses	11
12	Parking lot receipts	12
13	Revenue from laundry and linen service	13
14	Revenue from meals sold to employees and guests	14
15	Revenue from rental of living quarters	15
16	Revenue from sale of medical and surgical supplies to other than patients	16
17	Revenue from sale of drugs to other than patients	17
18	Revenue from sale of medical records and abstracts	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)	19
20	Revenue from gifts, flowers, coffee shops, and canteen	20
21	Rental of vending machines	21
22	Rental of hospital space	22
23	Governmental appropriations	23
24	Other (specify)	24
25	Total other income (sum of lines 6-24)	25
26	Total (line 5 plus line 25)	26
27	Other expenses (specify)	27
28	Total other expenses (sum of line 27 and subscripts)	28
29	Net income (or loss) for the period (line 26 minus line 28)	29

11-16			FO	RM CMS-255	2-10					4090 (Co	ont.)
ANALYSIS OF <i>HOSPITAL</i> -BASED HOME HEALTH AGENCY COSTS						PROVIDER CO	'N:	PERIOD: FROM		WORKSHEET H	
						HHA CCN:		ТО			
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
	1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS											
1 Capital Related-Bldgs. and Fixtures											1
2 Capital Related-Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General											5
HHA REIMBURSABLE SERVICES											
6 Skilled Nursing Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech Pathology											9
10 Medical Social Services											10
11 Home Health Aide											11
12 Supplies (see instructions)											12
13 Drugs											13
14 DME											14
HHA NONREIMBURSABLE SERVICES											
15 Home Dialysis Aide Services											15
16 Respiratory Therapy											16
17 Private Duty Nursing											17
18 Clinic											18
19 Health Promotion Activities											19
20 Day Care Program											20
21 Home Delivered Meals Program											21
22 Homemaker Service											22
23 All Others											23
24 Total (sum of lines 1-23)											24

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

4090 (Cont.)		FO	RM CMS-255	2-10				1	1-16
COST ALLOCATION - HHA GENERAL SERVICE COST				PROVIDER CCN:		PERIOD:		WORKSHEET H-1	1
						FROM		PART I	
				HHA CCN:		ТО			
	NET EXPENSES		ITAL						
	FOR COST	RELATE	D 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	<u> </u>
GENERAL SERVICE COST CENTERS									<u> </u>
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

09-13	3	FORM CM	IS-2552	-10				4090 (C	Cont.)
COST	ALLOCATION - HHA STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET H-	1,
						FROM		PART II	
				HHA CCN:		то			
			CAPI	TAL					
			RELATE	O COSTS	PLANT			ADMINIS-	
		BLDO	GS. &	MOVABLE	OPERATION &			TRATIVE	
		FIXTU	URES	EQUIPMENT	MAINTENANCE	TRANS-		& GENERAL	
		(SQU	ARE	(DOLLAR	(SQUARE	PORTATION	RECONCIL-	(ACCUM.	
		FEE	ET)	VALUE)	FEET)	(MILEAGE)	IATION	COST)	
		1		2	3	4	5a	5	
	GENERAL SERVICE COST CENTERS								
	Capital Related-Bldgs. and Fixtures								1
	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								
	Home Dialysis Aide Services								15
16	Respiratory Therapy								16
17	Private Duty Nursing								17
18	Clinic								18
19	Health Promotion Activities								19
20	Day Care Program								20
21	Home Delivered Meals Program								21
22	Homemaker Service								22
23	All Others								23
24	Total (sum of lines 1-23)								24
25	Cost To Be Allocated (per Worksheet H-1, Part I)								25
	Unit Cost Multiplier								26

409	0 (Cont.)			FORM CI	MS-2552-10						(	09-13
	OCATION OF GENERAL SERVICE IS TO HHA COST CENTERS				PROVIDER CC	2N:	_	PERIOD: FROM TO		WORKSHEET H- PART I	2,	
	HHA COST CENTER (omit cents)	From Wkst. H-1 Part I, col. 6, line	HHA TRIAL BALANCE (1) 0	-	PITAL ED COSTS MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	
1	Administrative and General	5										1
2	Skilled Nursing Care	6										2
3	Physical Therapy	7										3
4	Occupational Therapy	8										4
5	Speech Pathology	9										5
6	Medical Social Services	10										6
7	Home Health Aide	11										7
8	Supplies	12										8
9	Drugs	13										9
	DME	14										10
	Home Dialysis Aide Services	15										11
	Respiratory Therapy	16										12
	Private Duty Nursing	17										13
-	Clinic	18										14
	Health Promotion Activities	19										15
	Day Care Program	20										16
	Home Delivered Meals Program	21										17
	Homemaker Service	22										18
	All Others	23										19
	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1 divided by minus column 26, line 1, rounded to 6 decimal pla		6, line 20									21
	minus column 20, mie 1, founded to 6 decimal pla	1008.										

(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	IS-2552-10						4090 (C	ont.)
	CATION OF GENERAL SERVICE IS TO HHA COST CENTERS	HHA COST CENTER (omit cents) HOUSE (omit cents) HOUSE KEEPING DIETARY CAF 9 10 10 10 10 10 10 10 10 10 10 10 10 10 1					2CN:		PERIOD: FROM TO		WORKSHEET PART I (CON		
		KEEPING		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
11	Home Dialysis Aide Services												11
12	Respiratory Therapy												12
13	Private Duty Nursing												13
14	Clinic												14
15	Health Promotion Activities												15
16	Day Care Program												16
17	Home Delivered Meals Program												17
18	Homemaker Service												18
19	All Others												19
20	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 26, line 1 divided	by the sum of colum	n 26, line 20										21
	minus column 26, line 1, rounded to 6 decimal p	places.											

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

4090	) (Cont.)		FOI	RM CMS-255	2-10					1	0-12
	CATION OF GENERAL SERVICE S TO HHA COST CENTERS			PROVIDER CCN	:		PERIOD: FROM TO		WORKSHEET H- PART I (CONT.)	2,	
	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
	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 minus column 26, line 1, rounded to 6 decimal place		n 26, line 20								21

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

09-1	3	FOF	RM CMS-2552-10				4090 ( <b>C</b>	Cont.)
COST	CATION OF GENERAL SERVICE 'S TO HHA COST CENTERS ISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET H-2, PART II	
	HHA COST CENTER	ITAL ED COST EQUIPMENT (DOLLAR VALUE) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 4	RECONCIL- IATION 4A	ADMINIS- TRATIVE & GENERAL (ACCUM. COST) 5	MAIN- TENANCE & REPAIRS (SQUARE FEET) 6	OPERATION OF PLANT (SQUARE FEET) 7	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							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								13
14	Clinic							14
15	Health Promotion Activities							15
	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

409	0 (Cont.)		FOF	RM CMS-255	2-10					0	9-13
COST	OCATION OF GENERAL SERVICE 'S TO HHA COST CENTERS 'ISTICAL BASIS					PROVIDER CCN		PERIOD: FROM TO		WORKSHEET H PART II (CONT.	
	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	-
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
9	Drugs										9
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
13	Private Duty Nursing										13
14	Clinic										14
15	Health Promotion Activities										15
16	Day Care Program										16
17	Home Delivered Meals Program										17
18	Homemaker Service										18
19	All Others										19
20	Totals (sum of lines 1-19)										20
21	Total cost to be allocated										21
22	Unit Cost Multiplier										22

03-15		FOI	RM CMS-2552-10				4090 (0	Cont.)
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET H-2, PART II (CONT.)	
HHA COST CENTER	SOCIAL SERVICE (TIME SPENT) 17	OTHER GENERAL SERVICE (SPECIFY) 18	IMACEAN NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME) 19	NURSING SCHOOL (ASSIGNED TIME) 20		RESIDENTS PROGRAM COSTS (ASSIGNED TIME) 22	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	
1 Administrative and General	17	10	17	20	21	22	25	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

4090 (Cont.)			FORM	[ CMS-2552-10	_		03-15
APPORTIONMENT OF PATIEN	T SERVICE COS	TS		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 Services	s		
	From,	Facility	Shared	Total		Average		Pai	t B		Par	t B		
	Wkst.	Costs	Ancillary	HHA		Cost		Not			Not		Total	
	Н-2,	(from	Costs	Costs		Per Visit		Subject to	Subject to		Subject to	Subject to	Program Cost	
Patient Services	Part I,	Wkst. H-2,	(from	(cols. 1	Total	(col. 3		Deductibles	Deductibles		Deductibles	Deductibles	(sum of	
	col. 28,	Part I)	Part II)	+ 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													
3 Occupational Therapy	4													
4 Speech Pathology	5													
5 Medical Social Service	6													
6 Home Health Aide	7													
7 Total (sum of lines 1-6	)													Γ

	Limitation Cost Computation			Program Visits		
				Pai	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							Prog	gram Covered Cl	narges	Cost of Services		s					
Computations		Facility	Shared	Total	Total			Part B		Part B		Part B			Pa	rt B	
	From	Costs	Ancillary	HHA	Charges			Not			Not						
	Wkst. H-2	(from	Costs	Costs	(from	Ratio		Subject to	Subject to		Subject to	Subject to					
Other Patient Services	Part I,	Wkst. H-2,	(from	(cols. 1	HHA	(col. 3		Deductibles	Deductibles		Deductibles	Deductibles					
	col. 28,	Part I)	Part II)	+ 2)	Records)	$\div$ 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

11-16	FORM CMS-2552-10		4090 (Cont.)
CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROM	WORKSHEET H-4, 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	t B	
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment				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 (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)			31
31.01	Sequestration adjustment (see instructions)			31.01
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with			35
	CMS Pub. 15-2, chapter 1, §115.2			

4090	) (Cont.)		FC	ORM CMS-2552-	-10			11-16
ANAI	LYSIS OF PAYMENTS TO HOSPITAL -				PROVIDER CCN:	PERIOD:	WORKSHEET H-5	
BASE	D HHAs FOR SERVICES					FROM		
REND	DERED TO PROGRAM BENEFICIARIES				HHA CCN:	то	_	
	Description				rt A		art 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 eith							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	I	.01					3.01
	adjustment amount based on subsequent revisior of the interim rate for the cost reporting period.		.02					3.02
	Also show date of each payment. If none, write	to	.03				-	3.03
	"NONE" or enter a zero.(1)	Provider	.04				1	3.04
	"NONE" or enter a zero.(1)		.03				-	3.50
			.50				1	3.50
		Provider	.51					3.52
		to	.52				-	3.53
		Program	.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum	riogram						5.5 .
	of lines 3.50-3.98) .99							3.99
4								4
	(transfer to Wkst. H-4, Part II, column as approp		2)					
	TO BE COMPLETED BY IN	TERMEDI	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							
	of lines 5.50-5.98)	1	.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							7
0	(see instructions)	Cant			NDD Datas Marida D			<u> </u>
8	Name of Contractor	Contrac	tor N	umber	NPR Date: Month, Da	iy, rear		8
								1
					1			1

(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.

11-1	6	FO	IS-2552-10 4090 (Cont.				
ANAI	LYSIS OF RENAL DIALYSIS	DEPARTMENT COSTS		PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET I-1	
Check	applicable box:	[] Renal Dialysis Department	[] Home Progra				
			TOTAL			FTEs per	
			COSTS	BASIS	STATISTICS	2080 Hours	
		Γ	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. H			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. H			Percentage of Time			19
20	Employee Benefits Departme			Salary			20
21	Administrative and General			Accumulated Cost			21
22	Maint./Repairs-Operation-Ho	usekeeping		Square Feet			22
23	Medical Education Program						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 ins	tructions)		Charges			29
30	Other (see instructions)	,		Charges			30
31	Total costs (sum of lines 27-3	0)					31

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

4090 (Cont.) FORM CMS-2552-10 11-16												
ALLOCATION OF RENAL DEPARTMENT COS	STS TO TREATMEN	IT MODALITIES				PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET I-2		
Check applicable box:	[] Renal Dial	ysis Department	[] Home	Program Dialysi	is	-		-		-		
OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS		MEDICAL	ROUTINE ANCILLARY	SUBTOTAL (sum of		TOTAL (col. 9 +	
	BUILDING	EQUIPMENT	RNs	OTHER	DEPARTMENT	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												<u> </u>
2 Hemodialysis												2
3 Intermittent Peritoneal												3
TRAINING												
4 Hemodialysis												4
5 Intermittent Peritoneal												5
6 CAPD												6
7 CCPD												7
HOME												
8 Hemodialysis												8
9 Intermittent Peritoneal												9
10 CAPD												10
11 CCPD												11
OTHER BILLABLE SERVICES												
12 Inpatient Dialysis												12
13 Method II Home Patient												13
14 ESAs (included in Renal Department) 15 ARANESP (see instructions)												14
15												15
16 Other												16
17 Total (sum of lines 2 through 16)							ļ					17
18 Medical Educational Program Costs												18
19 Total Renal Costs (line 17 + line 18)												19

11-16	16 FORM CMS-2552-10 4090 (Cont.)											
DIRECT AND INDIRECT RENAL DIALYSIS CO STATISTICAL BASIS	ST ALLOCATION	1 -				PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEET I-3		
Check applicable box:	[] Renal Dia	alysis Department	[] Home I	Program Dialysi	s			8				
COMPOSITE PAYMENT SERVICES		RELATE	AL AND ED COSTS EQUIPMENT (% OF TIME) 2	-	PATIENT SALARY OTHERS (HOURS) 4	EMPLOYEE BENEFITS DEPARTMENT (SALARY) 5	DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUB- TOTAL 9	OVERHEAD (ACCUM. COST) 10	
1 Total Renal Department Costs			2	5	·	5		,	0	-	10	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 ESAs 15 ARANESP (see instructions)												14
												15
16 Other		-	ļ			<b>I</b>	ļ		ļ			16
17 Total Statistical Basis		<b>I</b>										17
18 Unit Cost Multiplier (line 1 ÷ line 17)		1										18

409	O (Cont.)	FORM	A CMS-25	552-10										1	1-16
	PUTATION OF AVERAGE COST PER TREATMENT DUTPATIENT RENAL DIALYSIS					PROVIDER CO	CN:			PERIOD: FROM TO				WORKSHEET	[-4
Check	applicable box: [] Renal Dialysis Depart	ment [] Ho	ome Program I	Dialysis					-	-	-	-		-	
		Number of Total Treatments		(col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments	Number of Program Treatments	Total Program Expenses (see instructions)	Total Program Payment	Total Program Payment	-	Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02)	
1	Maintenance - Hemodialysis	l	2	3	4	4.01	4.02	5	6	6.01	6.02	7	7.01	7.02	1
2	Maintenance - Peritoneal Dialysis														2
3	Training - Hemodialysis														3
4	Training - Peritoneal Dialysis														4
5	Training - Continuous Ambulatory Peritoneal Dialysis														5
6	Training - Continuous Cycling Peritoneal Dialysis														6
7	Home Program - Hemodialysis														7
8	Home Program - Peritoneal Dialysis														8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis	Patient Weeks			Patient Weeks	Patient Weeks	Patient Weeks								9
10	Home Program - Continuous Cycling Peritoneal Dialysis														10
11	Totals (sum of lines 1 through 8, columns 1 and 4) (sum of lines 1-10, columns 2, 5 and 6) (see instructions)														11
12	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instructions)														12

03-14	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	2
2 Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)		
01 Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)		
02 Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)		
03 Total payment due (see instructions)		
04 Outlier payments		
3 Deductibles billed to Medicare (Part B) patients (see instructions)		
01 Deductibles billed to Medicare (Part B) patients (see instructions)		
02 Deductibles billed to Medicare (Part B) patients (see instructions)		
03 Total deductibles billed to Medicare (Part B) patients (see instructions)		
4 Coinsurance billed to Medicare (Part B) patients (see instructions)		
01 Coinsurance billed to Medicare (Part B) patients (see instructions)		
02 Coinsurance billed to Medicare (Part B) patients (see instructions)		
03 Total coinsurance billed to Medicare (Part B) patients (see instructions)		
5 Bad debts for deductibles and coinsurance, net of bad debt recoveries		
01 Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recov	eries for	
services rendered on or after 1/1/2011 but before 1/1/2012		
02 Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recov	eries for	
services rendered on or after 1/1/2012 but before 1/1/2013		
03 Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recov	eries for	
services rendered on or after 1/1/2013 but before 1/1/2014		
04 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for		
services rendered on or after 1/1/2014		
05 Total bad debts (sum of line 5 through line 5.04)		
6 Allowable bad debts (see instructions)		
7 Reimbursable bad debts for dual eligible beneficiaries (see instructions)		
8 Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)		
9 Program payment (see instructions)		
Unrecovered from Medicare (Part B) patients (see instructions)		
11 Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)		

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

4090	O (Cont.)	FORM CMS-2552-10								0	3-14
	CATION OF GENERAL SERVICE COSTS TO MUNITY MENTAL HEALTH CENTERS			PROVIDER			PERIOD: FROM TO		WORKSHEET J-1, PART I		
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNIT	IY MENTAL HEALTH CEN	NTER COST (								
	COMPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.) 0	CAP RELATE BLDGS. &	ITAL D COSTS MOVABLE	EMPLOYEE BENEFITS DEPARTMENT 4		ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 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
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

10-1	2			FOF	RM CMS-25	552-10						4090 (Cont.)		
	OCATION OF GENERAL SERVICE COSTS TO MUNITY MENTAL HEALTH CENTERS					PROVIDER C	CN:		PERIOD: FROM		WORKSHEE PART I (CON			
						COMPONENT			то					
PAR	<b>I - ALLOCATION OF GENERAL SERVICE (</b>	COSTS TO CON	MMUNITY MI	ENTAL HEAL	TH CENTER C	OST CENTER	s							
	COMPONENT 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	Respiratory Therapy												7	
8	Psychiatric/Psychological Services												8	
9	Individual Therapy												9	
10	Group Therapy												10	
11	Individualized Activity Therapies												11	
12	Family Counseling												12	
13	Diagnostic Services												13	
14	Approved Patient Training & Education												14	
15	Prosthetic and Orthotic Devices												15	
16	Drugs and Biologicals												16	
17	Medical Supplies												17	
18	Medical Appliances												18	
19	Durable Medical Equipment-Rented												19	
20	Durable Medical Equipment-Sold												20	
21	All Others												21	
22	Totals (sum of lines 1-21)(1)												22	
23	Unit Cost Multiplier (see instructions)												23	

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

4090	0 (Cont.) FORM CMS-2552-10 10-12										
ALLO	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CO	:N:		PERIOD:		WORKSHEET .	-1,	
COM	IUNITY MENTAL HEALTH CENTERS						FROM		PART I (CONT.)		
				COMPONENT	CCN:		то				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMU	NITY MENTAL	HEALTH CENT	ER COST CEN	TERS						
							INTERN &				
					PARA-		RESIDENT		ALLOCATED		
	COMPONENT COST CENTER		INTERNS &	RESIDENTS	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)	
		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
	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	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.

09-1	3	FORM CM	FORM CMS-2552-10								
ALLO	CATION OF GENERAL SERVICE COSTS TO			PROVIDER C	CN:		PERIOD:		WORKSHEET	J-1,	
COM	MUNITY MENTAL HEALTH CENTERS						FROM		PART II		
				COMPONENT	Г ССN:		ТО				
PART	II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY	MENTAL HEAL	TH CENTER (	COST CENTER	S - STATISTIC	CAL BASIS					
			CAP	ITAL							
			RELAT	ED COST	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	ł
			BLDGS &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION	& LINEN	l
	CMHC COST CENTER		FIXTURES	EQUIPMENT	DEPARTMENT	ſ	GENERAL	REPAIRS	OF PLANT	SERVICE	l
	(omit cents)		(SQUARE	(SQUARE	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE	(POUNDS OF	l
			FEET)	FEET)	SALARIES)	IATION	COST)	FEET)	FEET)	LAUNDRY)	l
		0	1	2	4	4A	5	6	7	8	l
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
	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	O (Cont.)	MS-2552-10 09-1							9-13				
ALLO	CATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEET	Г J-1,	
COM	MUNITY MENTAL HEALTH CENTERS								FROM		PART II (CON	NT.)	
						COMPONENT	CCN:		ТО				
PART	II - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY M	ENTAL HEAL	TH CENTER O	COST CENTER	S - STATISTIC	CAL BASIS					
					MAIN-							NON-	
					TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
		HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
	CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
	(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
		SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
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

10-12								4090 (Cont.)			
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS			PROVIDER CC		_	PERIOD: FROM TO		WORKSHEET PART II (CON			
PART II - ALLOCATION OF GENERAL SERVICE COS	TS TO COMMUNITY	MENTAL HEA	LTH CENTER C	OST CENTERS -	STATISTICAL	BASIS					
CORF COST CENTER (omit cents)	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & SALARY & FRINGES (ASSIGNED TIME)	RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)	24	25	26	27	28		
1 Administrative and General	20	21	22	23	24	25	26	27	28	- 1	
2 Skilled Nursing Care						-		-	-	2	
2 Skilled Nursing Care 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	1									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	0 (Cont.)		FOI	RM CMS-255	52-10		10-12				
COMI	PUTATION OF COMMUNITY MENTAL HEALTH CENTE	ER PROVIDER CO	STS		PROVIDER CCI	N:	_	PERIOD:		WORKSHEET J	-2,
					COMPONENT O	CCN:		FROM TO		PART I	
PART	I - APPORTIONMENT OF CMHC COST CENTERS										
		(From		Ratio of		Title V		Title XVIII		Title XIX	
		Wkst. J-1,	Total	Costs to	Title V	Component	Title XVIII	Component	Title XIX	Component	
		Pt. I,	Component	Charges	Component	Costs (col. 3	Component	Costs (col. 3	Component	Costs (col. 3	
		col. 28)	Charges	$(col. 1 \div col. 2)$	Charges	x col. 4)	Charges	x col. 6)	Charges	x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
	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
	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	All Others (1)										19
20	Totals (sum of lines 1 through19)										20

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

09-15	FORM CMS-2552-10				
COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS			WORKSHEET J-2,		
		FROM	PART II		
	COMPONENT CCN:	ТО			

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

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

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

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

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

4090	) (Cont.)		FORM CMS-25:	-					
	ULATION OF REIMBURSEMENT SE AL HEALTH CENTER PROVIDER SF		MUNITY	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET J-3			
Check		[] Title V	[] Title XVIII	[ ] Title XIX					
boxes:									
						PROGRAM COST			
1	Cost of component services (from Wkst	t. J-2, Pt. II, line 29	)				1		
2	PPS payments received excluding outlie	ers					2		
3	Outlier payments						3		
4	Primary payer payments						4		
5	Total reasonable cost (see instructions)						5		
6	Total charges for program services						6		
	CUSTOMARY CHARGES								
7	Aggregate amount actually collected from	om patients liable fo	or services on a charge bas	is			7		
8	Amount that would have been realized	from patients liable	for payment for services of	on a charge			8		
	basis had such payment been made in a	ccordance with 42	CFR 413.13(e)				8		
9	Ratio of line 7 to line 8 (not to exceed 1	1.000000) (see inst	ructions)				9		

10 Total customary charges (see instructions)

14 Part B deductible billed to program patients

24 Net reimbursable amount (see instructions)

26.01 Sequestration adjustment (see instructions)

28 Tentative settlement (for contractor use only)

Interim payments (see instructions)

Other adjustments (see instructions) (specify)

13 Total reasonable cost (from line 5)

Net cost (line 13 minus line 14)

17 Subtotal (line 15 minus line 16)

26 Total cost (see instructions)

15

19

22

25

27

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)

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

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

25.50 Pioneer ACO demonstration payment adjustment (see instructions)

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

29 Balance due component/program (line 26 minus lines 26.01, 27, and 28)

30 Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)

Actual coinsurance billed to program patients (from provider records)

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

Adjusted reimbursable bad debts (see instructions)

10

11 12

13

14

15 16

17 18

19

20 21

22 23

24

25

26 26.01

27

28 29

30

25.50

11-1	6	FORM CMS-255	52-10			4090	(Cont.)
		PITAL-BASED COMMUNITY MENTAL HEALTH D TO PROGRAM BENEFICIARIES	PROVIDER	CCN:	PERIOD: FROM	WORKSHEET J-4	
			COMPONE	NT CCN:	то		
Check							
applic		Title XVIII					
boxes	:						
					-	Part B	
	DESCRIPTION				1 mm/dd/yyyy	2 Amount	_
1	Total interim payments paid to p	roviders			mm/dd/yyyy	Amount	1
2	Interim payments payable on ind						2
-	submitted or to be submitted to t						-
	services rendered in the cost repo	-					
	none, write "NONE", or enter ze						
3	List separately each retroactive			.01			3.01
	lump sum adjustment amount		Program	.02			3.02
	based on subsequent revision of		to	.03			3.03
	the interim rate for the		Provider	.04			3.04
	cost reporting period. Also show	,		.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 3.01-3.49						
	minus sum of lines 3.50-3.98)			.99			3.99
4	Total interim payments (sum of l						4
	(transfer to Worksheet J-3, line 2	27)					
O BE	COMPLETED BY INTERMEDI	ARY					
5	List separately each tentative		Program	.01			5.01
	settlement payment after desk re-	view.	to	.02			5.02
	Also show date of each payment		Provider	.03			5.03
	If none, write "NONE,"		Provider	.50			5.50
	or enter zero (1).		to	.51			5.51
			Program	.52			5.52
	Subtotal (sum of lines 5.01-5.49	minus					
	sum of lines 5.50-5.98)			.99			5.99
6	Determine net settlement amount	t	Program				
	(balance due) based on the cost		to				
	report (see instructions). (1)		Provider	.01		_	6.01
			to				
			Program	.02		_	6.02
7	Total Medicare liability (see inst	ructions)					7
8		ontractor Number		NPR	Date (Month, Day, Ye	ar)	8
0		Surfactor (Vullio)		INI K	Dure (monui, Day, 16		0
	I I						

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

4090 (Cont.)		FORM CMS-2552-10										
ANALYSIS OF HOSP	ITAL -BASED	PROVIDER CCN:							PERIOD:		WORKSHEET	K
HOSPICE COSTS									FROM			
						HOSPICE CCN:			то			
			EMPLOYEE	TRANSPOR	CONTRACTED				ave more a		TOTAL	
CONT	ENTER DESCRIPTIONS	SALARIES	BENEFITS	TRANSPOR-	SERVICES		TOTAL	DECLASSI	SUBTOTAL	ADUIGT	TOTAL	
COSTC	ENTER DESCRIPTIONS	(from	(from	TATION	(from	OTUED	TOTAL	RECLASSI-	(col. 6	ADJUST-	(col. 8	
		Wkst. K-1) 1	Wkst. K-2) 2	(see inst.) 3	Wkst. K-3) 4	OTHER 5	(cols. 1-5) 6	FICATION 7	± col. 7) 8	MENTS 9	± col. 9) 10	-
GENERAL SE	RVICE COST CENTERS	1	2	3	4	5	0	/	0	9	10	-
	Costs-Bldg and Fixt.											1
	Costs-Movable Equip.											2
	and Maintenance											3
4 Transportation												4
	ice Coordination											5
6 Administrative												6
INPATIENT C	ARE SERVICE											
7 Inpatient - Gen	eral Care										1	7
8 Inpatient - Resp												8
VISITING SER	VICES											
9 Physician Servi	ices											9
10 Nursing Care												10
11 Nursing Care-C	Continuous Home Care											11
12 Physical Thera	ру											12
13 Occupational T	herapy											13
14 Speech/ Langua	age Pathology											14
15 Medical Social	Services											15
16 Spiritual Couns	seling											16
17 Dietary Counse	ling											17
18 Counseling - O	ther											18
19 Home Health A	ide and Homemaker											19
20 HH Aide & Ho	memaker - Cont. Home Care											20
21 Other												21
	ICE SERVICE COSTS											
	cal and Infusion Therapy											22
23 Analgesics												23
24 Sedatives / Hyp												25
25 Other - Specify												25
	al Equipment/Oxygen											26
27 Patient Transpo												27
28 Imaging Servic		ļ			ļ							28
29 Labs and Diagr		ļ			ļ							29
30 Medical Suppli												30
	vices (including E/R Dept.)	ł		ļ	ł	ļ		ļ			+	31
32 Radiation Ther	ару											32
33 Chemotherapy												33
34 Other												34
	NREIMBURSABLE SERVICE											- 25
35 Bereavement P		<del> </del>			<del> </del>							35
36 Volunteer Prog	ram Costs											36
37 Fundraising	Čt-											37
38 Other Program												38
39 Total (sum of li	nes 1 thru 38)	I			1		1				1	39

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

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

4090 (Cont.)	FORM CMS-2552-10									
HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)				PROVIDER CCN	N:		PERIOD: FROM		WORKSHEET K-2	
BENEFITS (IMIROLE REEATED)				HOSPICE CCN:			то			
COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
GENERAL SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	<u> </u>
1 Capital Related Costs-Bldg and Fixt.										<u> </u>
Capital Related Costs-Bidg and Fixt.     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										0
7 Inpatient - General Care										7
8 Inpatient - Respite Care										8
VISITING SERVICES										0
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care-Continuous Home Care										10
12 Physical Therapy										11
13 Occupational Therapy										12
14 Speech/Language Pathology		-								13
14 Speech Language Pathology 15 Medical Social Services								_		14
		-								15
16         Spiritual Counseling           17         Dietary Counseling										10
17 Dietary Counseing 18 Counseling - Other										17
										18
19 Home Health Aide and Homemaker										20
20 HH Aide & Homemaker - Cont. Home Care 21 Other										20
OTHER HOSPICE SERVICE COSTS 22 Drugs, Biological and Infusion Therapy										22
										22
23 Analgesics										23
24 Sedatives / Hypnotics										24
25 Other - Specify										
26 Durable Medical Equipment/Oxygen										26
27 Patient Transportation								+		27 28
28 Imaging Services										
29 Labs and Diagnostics										29
30 Medical Supplies								+		30
31 Outpatient Services (including E/R Dept.)										31 32
32     Radiation Therapy       33     Chemotherapy										32
										33
34 Other HOSPICE NONREIMBURSABLE SERVICE										54
										25
35 Bereavement Program Costs										35
36 Volunteer Program Costs										36
37 Fundraising								+		37
38 Other Program Costs								+		38
39 Total (sum of lines 1 thru 38) (1) Transfer the amount in column 9 to Wkst K, column 2										39

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

09-13		FORM CMS			4090 (Cont.)					
HOSPICE COMPENSATION ANALYSIS				PROVIDER CC	N:		PERIOD:	WORKSHEET K-3		
CONTRACTED SERVICES/PURCHASED SERVICES				HOSPICE CCN:			FROM TO			
		I	MEDICAL	HOSFICE CCN.	1	T	10	T		Т
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										4
7 Inpatient - General Care										7
8 Inpatient - Respite Care										8
VISITING SERVICES										<b>-</b>
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care-Continuous Home Care										11
12         Physical Therapy           13         Occupational Therapy						-		-	-	12
14 Speech/ Language Pathology										13
14 Speech Language Famology 15 Medical Social Services										14
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								1	1	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				ļ	ļ			ļ	ļ	28
29 Labs and Diagnostics				ļ	ļ					29
30 Medical Supplies				<b> </b>	<b> </b>			+	+	30
31 Outpatient Services (including E/R Dept.)										31
32 Radiation Therapy										32
33 Chemotherapy 34 Other				<u> </u>						33
34 Other HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs								1	1	35
36 Volunteer Program Costs				<u> </u>	<u> </u>			1	1	36
37 Fundraising										37
38 Other Program Costs				<u> </u>	<u> </u>			1	1	38
39 Total (sum of lines 1 thru 38)				1	1			1	1	39

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

4090	0 (Cont.)	FORM CMS	8-2552-10		09-13						
COST	ALLOCATION - HOSPICE GENERAL SERVICE COST				PROVIDER CC	N:		PERIOD: FROM		WORKSHEET PART I	K-4,
					HOSPICE CCN:			ТО		TAKTI	
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	LATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICES COORDI- NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	CENED AL GERMACE COST OF NITERS	0	1	2	3	4	5	5A	6	7	<u> </u>
1	GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt.										1
	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	· · · · · · · · · · · · · · · · · · ·										5
											6
0	INPATIENT CARE SERVICE										0
7	Inpatient - General Care										7
8	· · · ·										8
0	VISITING SERVICES										0
0	Physician Services										9
10	Nursing Care										10
	Nursing Care-Continuous Home Care										10
12											12
13	Occupational Therapy										13
	Speech/ Language Pathology										13
	Medical Social Services										15
16											16
17	Dietary Counseling										17
18	Counseling - Other										18
19											19
20	HH Aide & Homemaker - Cont. Home Care										20
20											20
	OTHER HOSPICE SERVICE COSTS										
22											22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26											26
27	Patient Transportation										27
28	Imaging Services	i						i			28
29		i						i			29
	Medical Supplies	1						1			30
31	Outpatient Services (including E/R Dept.)										31
32											32
33	* *	1						1		1	33
	Other	1						1		1	34
	HOSPICE NONREIMBURSABLE SERVICE										
35	Bereavement Program Costs										35
36		1						1		1	36
37	Fundraising	1						1			37
38	Other Program Costs										38
	Total (sum of lines 1 thru 38)										39

09-1	13		FORM CMS		4090 (Cont.)				
COST	ALLOCATION - HOSPICE STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET K- PART II	4,
				HOSPICE CCN:		то			
		CAPITAL RE	LATED COST	PLANT		VOLUNTEER		ADMINIS-	T
		BUILDINGS	MOVABLE	OPERATION	TRANS-	SERVICES		TRATIVE &	
	COST CENTER DESCRIPTIONS	& FIXTURES	EQUIPMENT	& MAINT.	PORTATION	COORDINATOR	RECONCIL-	GENERAL	
		(SQ. FT.)	(\$ VALUE)	(SQ. FT.)	(MILEAGE)	(HOURS)	IATION	(ACC. COST)	
	GENERAL SERVICE COST CENTERS	1	2	3	4	5	6A	6	<u> </u>
1									1
2	Capital Related Costs-Bidg and Fixt.								2
3	Plant Operation and Maintenance								3
4	· · · · · · · · · · · · · · · · · · ·								5
5									5
6									6
0	INPATIENT CARE SERVICE								0
	Inpatient - General Care								7
	Inpatient - General Care								8
8	1 I								8
9	VISITING SERVICES								9
									_
10	5								10
11									11
12									12
13	1 17								13
	Speech/ Language Pathology								14
15									15
16	· · · · · · · · · · · · · · · · · · ·								16
17									17
18	5								18
19									19
20									20
21									21
	OTHER HOSPICE SERVICE COSTS								<u> </u>
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29						ļ			29
30	11								30
31									31
32									32
33									33
34				-					34
	HOSPICE NONREIMBURSABLE SERVICE								
	Bereavement Program Costs								35
36									36
37									37
38	с С								38
39									39
40	Unit Cost Multiplier								40

	) (Cont.)		FC	ORM CMS-2				•		09-13		
	CATION OF GENERAL SERVICE				PROVIDER CO	CN:		PERIOD:		WORKSHEET K-5		
COST	S TO HOSPICE COST CENTERS							FROM		PART I		
					HOSPICE CCN	l:		ТО				
PAR	<b>1 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSP</b>	ICE COST CENT	TERS	1				r		1	-	
		E.	HOSPICE	GAT								
	LIOSDICE COST CENTED	From Wkst. K-4	HOSPICE		PITAL ED COSTS	EMPLOYEE		ADMINIS-	MAIN-			
	HOSPICE COST CENTER		TRIAL BALANCE	BLDGS. &	MOVABLE	EMPLOYEE BENEFITS	SUBTOTAL	TRATIVE &	TENANCE &	OPERATION		
	(omit cents)	Part I,										
		col. 7,	(1)	FIXTURES	2	DEPARTMENT	(cols. 0-4) 4A	GENERAL 5	REPAIRS	OF PLANT 7		
1	Administrative and General	line 6	0	1	2	4	4A	5	6	/	1	
2		7									2	
3	Inpatient - General Care	8									3	
	Inpatient - Respite Care										-	
4	Physician Services	9									4	
5	Nursing Care	10									5	
6	Nursing Care-Continuous Home Care	11									6	
7	Physical Therapy	12	<b> </b>					<b> </b>	<b> </b>		7	
8	Occupational Therapy	13									8	
9	Speech/ Language Pathology	14									9	
10	Medical Social Services	15									10	
11	Spiritual Counseling	16									11	
12	Dietary Counseling	17									12	
	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		23									18	
19	Sedatives / Hypnotics	24									19	
20	Other - Specify	25									20	
21	Durable Medical Equipment/Oxygen	26									21	
22	Patient Transportation	27									22	
23	Imaging Services	28									23	
24	Labs and Diagnostics	29									24	
25	Medical Supplies	30									25	
26	Outpatient Services (including E/R Dept.)	31									26	
27	Radiation Therapy	32									27	
28	Chemotherapy	33									28	
29	Other	34									29	
30	Bereavement Program Costs	35									30	
31	Volunteer Program Costs	36			Ĩ			1			31	
32	Fundraising	37			Ĩ			1			32	
	Other Program Costs	38						1			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.

10-1	2			ORM CMS-2	552-10		4090 (Cont.)					
	CATION OF GENERAL SERVICE S TO HOSPICE COST CENTERS					PROVIDER CO	N:		PERIOD: FROM TO		WORKSHEET K-5, PART I (Cont.)	
PART	I - ALLOCATION OF GENERAL SERVICE O	COSTS TO HOSPIC	CE COST CENT	ERS		HOSTICE CCN	•		10			<u> </u>
	HOSPICE COST CENTER (omit cents)	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	
1	Administrative and General			10	11	12	15	14	15	10	17	1
2	Inpatient - General Care											2
3	Inpatient - Respite Care											3
4	Physician Services	_										4
5	Nursing Care											5
6	Nursing Care-Continuous Home Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech/ Language Pathology											9
10	Medical Social Services											10
10	Spiritual Counseling											10
	-											11
12	Dietary Counseling											12
<u>13</u> 14	Counseling - Other Home Health Aide and Homemaker											13
14												14
-	HH Aide & Homemaker - Cont. Home Care											
16	Other											16
17	Drugs, Biological and Infusion Therapy											17
18	Analgesics											18
19	Sedatives / Hypnotics											19
20	1 2											20
	Durable Medical Equipment/Oxygen											21
	Patient Transportation											22
23	Imaging Services											23
24	Labs and Diagnostics											24
	Medical Supplies				L			L	L		ļ	25
26	Outpatient Services (including E/R Dept.)				L			L	L		ļ	26
27	Radiation Therapy				ļ			ļ	ļ	ļ	ļ	27
28	Chemotherapy											28
29	Other				L			L	L		ļ	29
30	Bereavement Program Costs				ļ			ļ	ļ	ļ	ļ	30
31	Volunteer Program Costs				ļ			ļ	ļ		ļ	31
32	Fundraising										ļ	32
33	Other Program Costs											33
34	Totals (sum of lines 1-33) (2)											34
35	Unit Cost Multiplier (see instructions)											35

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

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

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

4090	) (Cont.)				FO	RM CMS-2	2552-10	10-12					
	CATION OF GENERAL SERVICE						PROVIDER C	CN:		PERIOD:		WORKSHEET	· · · ·
COST	'S TO HOSPICE COST CENTERS									FROM		PART I (Cont.	)
							HOSPICE CC	N:		TO			
PAR	<b>TI - ALLOCATION OF GENERAL SERVICE</b>	COSTS TO HO	SPICE COST	CENTERS	1		1			1			—
									INTERN &				
			NON-				PARA-		RESIDENT	l	ALLOCATED	TOTAL	Í
	HOSPICE COST CENTER	OTHER	PHYSICIAN			RESIDENTS	MEDICAL		COST & POST		HOSPICE	HOSPICE	
	(omit cents)	GENERAL	ANES-	NURSING	SALARY &			SUBTOTAL		SUBTOTAL	A&G (see	COSTS	1
		SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	(cols. 4a-23)	ADJUST.	$(cols. 24 \pm 25)$		(cols. 26 ± 27)	4
		`8	19	20	21	22	23	24	25	26	27	28	<u> </u>
	Administrative and General												1
2	Inpatient - General Care												2
3	Inpatient - Respite Care												3
4	Physician Services												4
5	Nursing Care	+	<b> </b>		ļ	ł	ł		ł	<b> </b>			5
6	Nursing Care-Continuous Home Care	_											6
7	Physical Therapy	_											7
	Occupational Therapy												8
	Speech/ Language Pathology												9
	Medical Social Services												10
11	Spiritual Counseling												11
12	Dietary Counseling												12
13	Counseling - Other												13
14	Home Health Aide and Homemaker												14
	HH Aide & Homemaker - Cont. Home Care												15
16													16
17	Drugs, Biological and Infusion Therapy												17
18													18
19	Sedatives / Hypnotics												19
20	Other - Specify												20
	Durable Medical Equipment/Oxygen												21
	Patient Transportation												22
	~ ~												23
	Labs and Diagnostics						L						24
	Medical Supplies						L						25
26		_											26
27	Radiation Therapy												27
28	Chemotherapy						L						28
29	Other	_											29
30	Bereavement Program Costs	_											30
31	Volunteer Program Costs	1	ļ			ļ	L		ļ	ļ			31
32	Fundraising												32
33	Other Program Costs												33
34	Totals (sum of lines 1-33) (2)												34
35	Unit Cost Multiplier (see instructions)												35

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

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

09-1	3	RM CMS-255	2-10		4090 (Cont.)					
ALLO	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CCN		PERIOD:		WORKSHEET K-5,		
HOSP	CE COST CENTERS STATISTICAL BASIS					FROM		PART II		
				HOSPICE CCN: _		то				
PART	<b>II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPIC</b>	E COST CENTERS - STATISTI	CAL BASIS	-						
		CAF	PITAL							
		RELAT	ED COST	EMPLOYEE		ADMINIS-	MAIN-			
		BLDGS. &	MOVABLE	BENEFITS		TRATIVE &	TENANCE &	OPERATION		
	HOSPICE COST CENTER	FIXTURES	EQUIPMENT	DEPARTMENT		GENERAL	REPAIRS	OF PLANT		
		(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(SQUARE		
		FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	FEET)		
		1	2	4	5A	5	6	7		
1	Administrative and General								1	
2	Inpatient - General Care								2	
3	Inpatient - Respite Care								3	
4	Physician Services								4	
	Nursing Care								5	
	Nursing Care-Continuous Home Care								6	
7	Physical Therapy								7	
8	Occupational Therapy								8	
9	Speech/ Language Pathology								9	
10	Medical Social Services								10	
11	Spiritual Counseling								11	
12	Dietary Counseling								12	
13	Counseling - Other								13	
14	Home Health Aide and Homemaker								14	
15	HH Aide & Homemaker - Cont. Home Care								15	
16	Other								16	
17	Drugs, Biological and Infusion Therapy								17	
	Analgesics								18	
19	Sedatives / Hypnotics								19	
	Other - Specify								20	
	Durable Medical Equipment/Oxygen								21	
	Patient Transportation								22	
	Imaging Services								23	
_	Labs and Diagnostics								24	
	Medical Supplies								25	
	Outpatient Services (including E/R Dept.)								26	
	Radiation Therapy								27	
	Chemotherapy								28	
	Other								29	
	Bereavement Program Costs								30	
31	Volunteer Program Costs								31	
	Fundraising								32	
	Other Program Costs								33	
	Totals (sum of lines 1-33) (2)		ļ	ļ		ļ	ļ	ļ	34	
	Total cost to be allocated		ļ	ļ		ļ	ļ	ļ	35	
36	Unit Cost Multiplier (see instructions)								36	

4090 (C	Cont.)			FO	RM CMS-255	2-10				C	9-13
	OCATION OF GENERAL SERVICE COSTS T         SPICE COST CENTERS STATISTICAL BASIS         RT II - ALLOCATION OF GENERAL SERV         HOSPICE COST CENTER         1       Administrative and General         2       Inpatient - General Care         3       Inpatient - Respite Care         4       Physician Services         5       Nursing Care         6       Nursing Care         7       Physical Therapy         9       Speech/Language Pathology         0       Medical Social Services         1       Spiritual Counseling         2       Dietary Counseling         3       Counseling - Other         4       Home Health Aide and Homemaker					PROVIDER CCN HOSPICE CCN:	:	PERIOD: FROM TO		WORKSHEET K-5, PART II (Cont.)	
PART II -	ALLOCATION OF GENERAL SERVIC	E COSTS TO HOS	PICE COST CEN	TERS - STATISTI	CAL BASIS	HOSTICE CEIV.		10		1	
	HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8	HOUSE- KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	CAFETERIA (MEALS SERVED) 11	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED) 12	NURSING ADMINIS- TRATION (DIRECT NURS. HRS) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14	PHARMACY (COSTED REQUIS.) 15	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16	-
1 Adr	ministrative and General										1
											2
											3
-	*										4
					l				İ		5
	ž – – – – – – – – – – – – – – – – – – –				1						6
									1		7
											8
									1		9
									1		10
11 Spin	ritual Counseling										11
12 Die	tary Counseling										12
	· · · · · · · · · · · · · · · · · · ·								1		13
14 Hor	me Health Aide and Homemaker								1		14
15 HH	Aide & Homemaker - Cont. Home Care										15
16 Oth	er										16
17 Dru	gs, Biological and Infusion Therapy										17
18 Ana	algesics										18
19 Sed	atives / Hypnotics										19
20 Oth	er - Specify										20
21 Dur	able Medical Equipment/Oxygen										21
22 Pati	ient Transportation										22
23 Ima	iging Services										23
24 Lab	s and Diagnostics										24
25 Mee	dical Supplies										25
	patient Services (including E/R Dept.)										26
	liation Therapy										27
28 Che	emotherapy										28
29 Oth	er										29
	eavement Program Costs										30
	unteer Program Costs										31
	draising										32
33 Oth	er Program Costs										33
34 Tota	als (sum of lines 1-33) (2)										34
35 Tota	al cost to be allocated										35
36 Uni	t Cost Multiplier (see instructions)										36

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

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

09-1	15	FORM	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	TITLE XIX	OTHER 3	TOTAL 4	
1	Total cost (see instructions)						1
2	Total unduplicated days (Worksheet S-9, column	6, line 5)					2
3	Average cost per diem (line 1 divided by line 2)						3
4	Unduplicated Medicare days (Worksheet S-9, co	lumn 1, line 5)					4
5	Aggregate Medicare cost (line 3 times line 4)						5
6	Unduplicated Medicaid days (Worksheet S-9, col	lumn 2, line 5)					6
7	Aggregate Medicaid cost (line 3 times line 6)						7
8	Unduplicated SNF days (Worksheet S-9, column	3, line 5)					8
9	Aggregate SNF cost (line 3 times line 8)						9
10	Unduplicated NF days (Worksheet S-9, column 4	, line 5)					10
11	11 Aggregate NF cost (line 3 times line 10)						11
12	Other Unduplicated days (Worksheet S-9, colum	n 5, line 5)					12
13	Aggregate cost for other days (line 3 times line 1	2)					13

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

4090	(Cont.)
1020	(Cont.)

# FORM CMS-2552-10

09-15

CALCULATION OF CAPITAL PAYMENT		PROVIDER CC	PROVIDER CCN: PERIOD: FROM			WORKSHEET L				
		COMPONENT	LCN:	то						
Check	[] Title V		[] Hospit	al	[] PPS					
applicable	[] Title XVIII	, Part A	[] Subpro	ovider (other)	[] Cost Meth	nod				
boxes:	[] Title XIX									
PART I - FULLY PROSPEC	TIVE METHOD									
CAPITAL FEDERAL A										
1 Capital DRG other than							1			
1.01 Model 4 BPCI Capital D		er					1.01			
2 Capital DRG outlier pay	ments						2			
2.01 Model 4 BPCI Capital D							2.01			
3 Total inpatient days divi	tal inpatient days divided by number of days in the cost reporting period (see instructions)									
4 Number of interns & res	idents (see instruction	ons)					4			
5 Indirect medical education	on percentage (see i	nstructions)					5			
6 Indirect medical education	on adjustment (see i	nstructions)					6			
7 Percentage of SSI recipie	ent patient days to M	ledicare Part A patient	days (Worksheet	E, Part A line 30) (see in	structions)		7			
8 Percentage of Medicaid	patient days to total	days (see instructions)					8			
9 Sum of lines 7 and 8							9			
10 Allowable disproportion	ate share percentage	(see instructions)					10			
11 Disproportionate share a	djustment (see instr	uctions)					11			
12 Total prospective capital	payments (see inst	ructions)					12			
PART II - PAYMENT UNDE	R REASONABLE	COST								
1 Program inpatient routin	e capital cost (see in	nstructions)					1			
2 Program inpatient ancilla	ary capital cost (see	instructions)					2			
3 Total inpatient program	capital cost (line 1 p	lus line 2)					3			
4 Capital cost payment fac	ctor (see instructions	s)					4			
5 Total inpatient program	capital cost (line 3 x	line 4)					5			
PART III - COMPUTATION	OF EXCEPTION	PAYMENTS								
1 Program inpatient capita	l costs (see instructi	ons)					1			
2 Program inpatient capita	l costs for extraordir	ary circumstances (se	e instructions)				2			
3 Net program inpatient ca	apital costs (line 1 m	inus line 2)					3			
4 Applicable exception pe	rcentage (see instrue	ctions)					4			
5 Capital cost for compari	son to payments (lin	e 3 x line 4)					5			
6 Percentage adjustment for	or extraordinary circ	umstances (see instruc	tions)				6			
7 Adjustment to capital mi	inimum payment lev	el for extraordinary cir	cumstances (line	2 x line 6)			7			
8 Capital minimum payme	ent level (line 5 plus	line 7)					8			
9 Current year capital pays	ments (from Part I, li	ne 12 as applicable)					9			
10 Current year comparison	of capital minimum	payment level to capit	al payments (line	e 8 less line 9)			10			
11 Carryover of accumulate	d capital minimum p	bayment level over cap	ital payment				11			
(from prior year Worksh	eet L, Part III, line	14)								
12 Net comparison of capita	al minimum paymen	t level to capital payme	ents (line 10 plus	line 11)			12			
13 Current year exception p							13			
14 Carryover of accumulate		÷					14			
for the following period	(if line 12 is negativ	e, enter the amount on	this line)							
15 Current year allowable							15			
16 Current year operating a							16			
17 Current year exception of							17			

09-13 FORM CMS-2552-1											
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET L PART I	1,	
		EXTRA- ORDINARY		ITAL ED COSTS							
	Cost Center Descriptions	CAPITAL RELATED COSTS 0	BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2	SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7		
	GENERAL SERVICE COST CENTERS	0	1	2	20	7	5	0	,		
1	Capital Related Costs-Buildings and Fixtures									1	
2	Capital Related Costs-Movable Equipment									2	
4	Employee Benefits Department									4	
5	Administrative and General							<u> </u>		5	
6	Maintenance and Repairs									6	
7	Operation of Plant									7	
8	Laundry and Linen Service									8	
9	Housekeeping									9	
10	Dietary									10	
11	Cafeteria									11	
	Maintenance of Personnel									12	
	Nursing Administration									13	
14	Central Services and Supply									14	
15	Pharmacy									15	
	Medical Records & Medical Records Library									16	
17										17	
18	Other General Service (specify)									18	
19	Nonphysician Anesthetists									19	
20	Nursing School									20	
	Intern & Res. Service-Salary & Fringes (Approved)									21	
	Intern & Res. Other Program Costs (Approved)									22	
23	Paramedical Ed. Program (specify)									23	
	INPATIENT ROUTINE SERVICE COST CENTERS										
	Adults and Pediatrics (General Routine Care)									30	
31	Intensive Care Unit									31	
32	Coronary Care Unit									32	
33	Burn Intensive Care Unit									33 34	
34 35	Surgical Intensive Care Unit									34	
				<u> </u>	ł	<u> </u>	<del> </del>	<u> </u>	<del> </del>	40	
40	Subprovider IPF Subprovider IRF			ł	ł	ł	ł	ł	ł	40	
41	Subprovider IRF			<del> </del>		<del> </del>	<u> </u>	<del> </del>	<u> </u>	41	
42	Subprovider						1		1	42	
43	Skilled Nursing Facility			1		1	1	1	1	43	
44	Nursing Facility			<del> </del>		<del> </del>	<u> </u>	<del> </del>	<u> </u>	44	
43	Other Long Term Care			<del> </del>		<del> </del>	<u> </u>	<del> </del>	<u> </u>	43	
40	Outer Long Territ Cale	I		L	1	L	L	L	L	40	

4690	) (Cont.)	8-2552-10			09-13					
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET L PART I (Cont.)	1,
		EXTRA- ORDINARY CAPITAL		PITAL ED COSTS	SUBTOTAL	EMPLOYEE	ADMINIS-	MAIN-		
	Cost Center Descriptions	RELATED COSTS 0	BLDGS. & FIXTURES	MOVABLE EQUIPMENT 2	(sum of cols. 0-2) 2A	BENEFITS DEPARTMENT 4	TRATIVE & GENERAL 5	TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	ANCILLARY SERVICE COST CENTERS	0	1	2	ZA	4	3	0	/	<u> </u>
	Operating Room									50
-										51
-	Labor Room and Delivery Room									52
53	Anesthesiology			1	1					53
	Radiology-Diagnostic			1	1					54
-	Radiology-Therapeutic			Ì	1					55
	Radioisotope			İ	Ì				Ì	56
	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catherization									59
60	Laboratory									60
61	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
	Renal Dialysis									74
	ASC (Non-Distinct Part)									75
	Other Ancillary (specify)								ļ	76
	OUTPATIENT SERVICE COST CENTERS									
-	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient (specify)									93

09-13 FORM CMS-2552-10											
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES				PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET L-1, PART I (Cont.)		
		EXTRA- ORDINARY		PITAL ED COSTS							
	Cost Center Descriptions	CAPITAL RELATED COSTS	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS DEPARTMENT		MAIN- TENANCE & REPAIRS	OPERATION OF PLANT		
		0	1	2	2A	4	5	6	7	_	
	OTHER REIMBURSABLE COST CENTERS										
	<u> </u>									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 SPECIAL PURPOSE COST CENTERS	_								101	
105										105	
105	Kidney Acquisition									105	
106	Heart Acquisition									106	
107	Liver Acquisition									107	
108	Lung Acquisition									108	
109	Pancreas Acquisition									109	
110	Intestinal Acquisition									110	
111	Islet Acquisition									111	
112	Other Organ Acquisition (specify)									112	
115	Ambulatory Surgical Center (Distinct Part)									115	
116										116	
	Other Special Purpose (specify)									117	
118	SUBTOTALS (sum of lines 1-117)									118	
	NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen				1					190	
191	Research				1	1	1	1	1	191	
192	Physicians' Private Offices			1	†	1	1	1	1	192	
193	Nonpaid Workers			1	†	1	1	1	1	193	
194	Other Nonreimbursable (specify)						1		1	194	
200	Cross Foot Adjustments									200	
201	Negative Cost Centers									200	
202	Total (sum of line 118 and lines190-201)						1		1	202	
203	Total Statistical Basis						Ì		1	203	
203	Unit Cost Multiplier						1		1	203	

4090	) (Cont.)			FORM CM	AS-2552-10						(	09-13
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES						PROVIDER O	CCN:	PERIOD: FROM TO		WORKSHEE PART I (Cont	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS	8	2	10	- 11	12	13	14	15	10	17	
1	Capital Related Costs-Buildings and Fixtures											1
2	Capital Related Costs-Movable Equipment											2
4	Employee Benefits Department											4
5	Administrative and General											5
6	Maintenance and Repairs											6
7	Operation of Plant		J									7
8	Laundry and Linen Service											8
9	Housekeeping											9
10	Dietary											10
11	Cafeteria											11
12	Maintenance of Personnel											12
13	Nursing Administration											13
14	Central Services and Supply											14
15	Pharmacy											15
	Medical Records & Medical Records Library											16
17	Social Service											17
18	Other General Service (specify)											18
19	Nonphysician Anesthetists											19
	Nursing School											20
21	Intern & Res. Service-Salary & Fringes (Approved)											21
	Intern & Res. Other Program Costs (Approved)											22
23	Paramedical Ed. Program (specify)	_										23
	INPATIENT ROUTINE SERVICE COST CENTERS											_
	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
41	Subprovider IRF							1				41
42	Subprovider	_										42
43	Nursery	_										43
44	Skilled Nursing Facility											44
45	Nursing Facility							1				45
46	Other Long Term Care											46

10-12 FORM CMS-2552-10										4090 (Cont.		
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES							CCN:	PERIOD: FROM TO		WORKSHEE' PART I (Cont	
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	ANCILLARY SERVICE COST CENTERS	0	,	10	11	12	15	14	15	10	17	
50	Operating Room											50
	Recovery Room											51
52	Labor Room and Delivery Room						1					52
	Anesthesiology						1	1			1	53
	Radiology-Diagnostic						1	1			1	54
												55
56												56
												57
58	Magnetic Resonance Imaging (MRI)											58
59												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												64
65	Respiratory Therapy											65
												66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology											69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											72
73	Drugs Charged to Patients											73
74	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
	OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)						ļ	ļ				88
89	Federally Qualified Health Center (FQHC)											89
90	Clinic						ļ	ļ				90
91	Emergency							L				91
92	Observation Beds											92
93	Other Outpatient (specify)											93

4090	FORM CMS-2552-10							1	10-12			
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES						PROVIDER C	CN:	PERIOD: FROM TO		WORKSHEE PART I (Cont	,
	Cost Center Descriptions	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING	DIETARY 10	CAFETERIA	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	9	10	11	12	13	14	15	10	17	<u> </u>
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
101	SPECIAL PURPOSE COST CENTERS											101
105	Kidney Acquisition											105
106	Heart Acquisition							1				106
107	Liver Acquisition							1				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	Total (sum of line 118 and lines190-201)											202
203	Total Statistical Basis											203
204	Unit Cost Multiplier											204

4090	) (Cont.)			FORM CM	S-2552-10					(	09-13
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES					PROVIDER CCI	N:	PERIOD: FROM TO		WORKSHEET PART I (Cont.)	L-1,
	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	7									2
4	Employee Benefits Department	7									4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant	]									7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy	4									15
16	Medical Records & Medical Records Library	4									16
17	Social Service										17
	Other General Service (specify)										18
19	Nonphysician Anesthetists	_									19
20	Nursing School	_				-					20
	Intern & Res. Service-Salary & Fringes (Approved)	_					4				21
	Intern & Res. Other Program Costs (Approved)							4			22
23	Paramedical Ed. Program (specify)										23
30	INPATIENT ROUTINE SERVICE COST CENTERS Adults and Pediatrics (General Routine Care)										30
30	Adults and Pediatrics (General Routine Care) Intensive Care Unit	+							1	<del> </del>	30
31	Coronary Care Unit	+						ł		<u> </u>	31
33	Burn Intensive Care Unit	+								<u> </u>	32
34	Surgical Intensive Care Unit	+									34
35	Other Special Care Unit (specify)	1								l	35
40	Subprovider IPF	1								1	40
40	Subprovider IRF	1						1		1	40
42	Subprovider	1								1	42
43	Nursery									1	43
44	Skilled Nursing Facility							1		İ	44
45	Nursing Facility										45
46	Other Long Term Care									1	46
-									L		

4690	) (Cont.)			FORM CM	S-2552-10					(	09-13
	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	PARA- MEDICAL EDUCATION (SPECIFY) 23	SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	TOTAL 26	
	ANCILLARY SERVICE COST CENTERS	10	17	20	21		25	24	25	20	
	Operating Room										50
51	Recovery Room										51
	Labor Room and Delivery Room										52
	Anesthesiology									1	53
	Radiology-Diagnostic										54
	Radiology-Therapeutic										55
	Radioisotope										56
	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catherization										59
60	Laboratory										60
61	PBP Clinical Laboratory Service-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
	Medical Supplies Charged to Patients										71
	Implantable Devices Charged to Patients										72
	Drugs Charged to Patients										73
	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
	Other Ancillary (specify)										76
	OUTPATIENT SERVICE COST CENTERS										4
	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency										91
92	Observation Beds										92
93	Other Outpatient (specify)										93

10-1	2			FORM CM	IS-2552-10					4090 (0	Cont.)
	CATION OF ALLOWABLE COSTS FOR AORDINARY CIRCUMSTANCES					PROVIDER CC	N:	PERIOD: FROM TO		WORKSHEET L-1, PART I (Cont.)	
	Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	<b>_</b>
	OTHER REIMBURSABLE COST CENTERS										<b></b>
	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
	SPECIAL PURPOSE COST CENTERS										
	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
	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	Total (sum of line 118 and lines190-201)										202
203	Total Statistical Basis										203
204	Unit Cost Multiplier										204

4090	) (Cont.)			FORM CMS-2552-10							
	PUTATION OF PROGRAM INF FAL COSTS FOR EXTRAORD				PROVIDER CCN:		PERIOD: FROM TO	ROM			
Check applica box:	ble	[] Title V [] Title XVIII, Part A [] Title XIX									
	Cost Center Description		Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Swing Bed Adjustment	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)		
(A)	INPATIENT ROUTINE SERV COST CENTERS	ICE	1	2	3	4	5	6	7		
30	Adults & Pediatrics (General R	outine 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 (specif	y)								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

10-12

# FORM CMS-2552-10

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: PERIOD: WORKSHEET L-1, \_\_\_\_\_\_ FROM \_\_\_\_\_ PART III
COMPONENT CCN: TO \_\_\_\_\_

Check		[] Hospital	[] Title V						
applical	ble	[] Subprovider	[] Title XVIII, Part A						
boxes:			[] Title XIX						
				Capital Cost for					
				Extraordinary				Program	
				Circumstances	Total Charges	Ratio of Cost		Extraordinary	
	Cost Center Description			(from Wkst. L-1,	(from Wkst. C,	to Charges	Inpatient	Capital Cost	
				Part I, col. 26)	Part I, col. 6)	(col. 1 ÷ col. 2)	Program Charges	(col. 3 x col. 4)	
(A)				1	2	3	4	5	
	ANCILLARY SERVICE C	COST CENTERS							
50	Operating Room								50
	Recovery Room								51
	Labor Room and Delivery	Room							52
	Anesthesiology								53
54	Radiology-Diagnostic								54
	Radiology-Therapeutic								55
	Radioisotope								56
57	Computed Tomography (C	CT) Scan							57
	Magnetic Resonance Imagi	ing (MRI)							58
59	Cardiac Catherization								59
	Laboratory								60
	PBP Clinical Laboratory S								61
-	Whole Blood & Packed Re								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								71
	Implantable Devices Charg	ged to Patients							72
	Drugs Charged to Patients								73
	Renal Dialysis								74
	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76

(A) Worksheet A line numbers

### 4090 (Cont.)

#### FORM CMS-2552-10

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN:	PERIOD:	WORKSHEET L-1,
	FROM	PART III (CONT.)
COMPONENT CCN:	то	

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

(A) Worksheet A line numbers

11-16			FOR	M CMS-2552-10				4090	(Cont.)
ANALYS	SIS OF HOSPITAL- BASED RHC/FQHC COSTS					PROVIDER CCN:	PERIOD:	WORKSHEET M-1	
							FROM		
						COMPONENT CCN:	то		
Chook on	plicable box: [] Hospital-based RHG	C [] Hospital-ba	EOHC						
спеск ар	[] Hospital-based Kit	c [] 110spilai-ba				RECLASSIFIED		NET EXPENSES	1
						TRIAL		FOR	
		COMPEN-		TOTAL	RECLASS-	BALANCE		ALLOCATION	
		SATION	OTHER COSTS	(col. 1 + col. 2)	IFICATIONS	(col. 3 + col. 4)	ADJUSTMENTS	(col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services								22
	(sum of lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
-	Dental								24
	Optometry								25
25.01	Telehealth								25.01
	Chronic Care Management								25.02
-	All other nonreimbursable costs								26
	Nonallowable GME costs								27
	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
	Facility Costs								29
	Administrative Costs								30
	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

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

409	0 (Cont.)	FOR	M CMS-2	552-10			11-16
	OCATION OF OVERHEAD OSPTIAL-BASED RHC/FOHC SERVICES			PROVIDER CCN:	PERIOD: FROM	WORKSHEET M-2	
10 11	USI HAL-BASED KIICI QIIC SEKVICES			COMPONENT CCN:	то	-	
Check	applicable box:	[] Hospital-bas	ed RHC	[] Hospital-based FQHC			
_	IS 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 APPLIC	ABLE TO HOSPI	ITAL-BASED	RHC/FQHC SERVICE	s		
10	Total costs of health care services (from Worksheet M	I-1, column 7, line	22)				10
11	Total nonreimbursable costs (from Worksheet M-1, c	olumn 7, line 28)					11
12	Cost of all services (excluding overhead) (sum of line	s 10 and 11)					12
13	Ratio of hospital-based RHC/FQHC services (line 10	divided by line 12	!)				13
14	Total hospital-based RHC/FQHC overhead (from W	orksheet M-1, colu	mn 7, line 31)				14
15	Parent provider overhead allocated to facility (see ins	tructions)					15
16	Total overhead (sum of lines 14 and 15)						16
17	Allowable Direct GME overhead (see instructions)						17
18	Enter the amount from line 16						18
19	Overhead applicable to hospital-based RHC/FQHC s	ervices (line 13 x l	ine 18)				19
20	Total allowable cost of hospital-based RHC/FQHC s	ervices (sum of lin	es 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.

1	1	-1	6
- 1	1	- 1	υ.

### FORM CMS-2552-10

4090(Cont.)

CALCULATION OF REIM	BURSEMENT		PROVIDER CCN:	PERIOD:	WORKSHEET M-3	
SETTLEMENT FOR HOSE	PITAL-BASED RHC/FQHC SERVICES			FROM	-	
			COMPONENT CCN:	то		
Check	[] Hospital-based RHC	[] Title V	[] Title XIX			
applicable boxes:	[] Hospital-based FQHC	[] Title XVIII				
DETERMINATION OF R	ATE FOR HOSPITAL-BASED RHC/FQHC	C SERVICES				
1 Total allowable cost	of hospital-based RHC/FQHC services (from W	Worksheet M-2, line 20)				1
2 Cost of vaccines and	their administration (from Worksheet M-4, line	15)				2
3 Total allowable cost	excluding vaccine (line 1 minus line 2)					3
4 Total visits (from We	orksheet M-2, column 5, line 8)					4
5 Physicians visits und	er agreement (from Worksheet M-2, column 5, 1	line 9)				5
6 Total adjusted visits	(line 4 plus line 5)					6
7 Adjusted cost per vis	it (line 3 divided by line 6)					7

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

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

4090	)(Cont.)	F	0			11-16	
	PUTATION OF <i>HOSPITAL-BASEI</i> ZINE COST	D RHC/FQHC PNEUMOCO	CCAL AND INFLUENZA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET M-4	
Check		[] Hospital-based RHC	[] Title V	[] Title XIX			
applic	able boxes:	[] Hospital-based FQHC	[] Title XVIII		PNEUMOCOCCAL	INFLUENZA	
					PNEUMOCOCCAL	INFLUENZA 2	_
1	Health care staff cost (from Work	(sheet M-1, column 7, line 10)	)		1	2	1
2	Ratio of pneumococcal and influe						2
	health care staff time						
3	Pneumococcal and influenza vaca	cine health care staff cost (line	e 1 x line 2)				3
4	Medical supplies cost - pneumoco	occal and influenza vaccine					4
	(from your records)						
5	Direct cost of pneumococcal and	influenza vaccine (line 3 plus	line 4)				5
6	Total direct cost of the hospital-b	ě ì	ksheet M-1, column 7, line	22)			6
7	Total overhead (from Worksheet	, ,					7
8	Ratio of pneumococcal and influe	enza vaccine direct cost to tota	d direct				8
	cost (line 5 divided by line 6)						
9	Overhead cost - pneumococcal an		line 8)				9
10	Total pneumococcal and influenz						10
	administration costs (sum of lines	,					<b>_</b>
11	Total number of pneumococcal a	nd influenza vaccine injection	S				11
	(from your records)						<u> </u>
12	Cost per pneumococcal and influ-						12
13	Number of pneumococcal and int	fluenza vaccine injections adn	ninistered				13
	to Program beneficiaries						
14	Program cost of pneumococcal and		r				14
15	administration costs (line 12 x lin	,	I	- 1			15
15	Total cost of pneumococcal and i 1 and 2, line 10) (transfer this an		· ·	columns			15
16	Total Program cost of pneumoco	,	/	(			16
16	of columns 1 and 2, line 14) (trai			(sum			16
	or columns 1 and 2, line 14) (trai	inster uns amount to worksnee	et IVI-3, IIIle 21)			1	

11-1	6 FORM CMS-25			4090 (C	Cont.)	
RHC/	YSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERED ROGRAM BENEFICIARIES	PROVIDER C		PERIOD: FROM TO	WORKSHEET M-5	
Check	applicable box: [] Hospital-based RHC [] Hospital-base	ed FQHC			•	
					Part B	
	DESCRIPTION			1	2	_
				mm/did/ivy	Amount	
1	Total interim payments paid to hospital-based RHC/FQHC					1
2	Interim payments payable on individual bills, either					2
	submitted or to be submitted to the intermediary, for					
	services rendered in the cost reporting periods. If					
	none, write "NONE", or enter zero.					
3	List separately each retroactive		.01		_	3.01
	lump sum adjustment amount	Program	.02			3.02
	based on subsequent revision of	to	.03			3.03
	the interim rate for the	Provider	.04		_	3.04
	cost reporting period. Also show		.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 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)					4
	TO BE COMPLETED BY CONTRACTOR					
5		Program	.01			5.01
	settlement payment after desk review.	to	.02			5.02
	Also show date of each payment.	Provider	.03			5.03
	If none, write "NONE,"	Provider	.50			5.50
	or enter zero (1).	to	.51			5.51
		Program	.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount	Program				
	(balance due) based on the cost	to				
	report (see instructions). (1)	Provider	.01			6.01
	Ī	Provider				
		to				
		Program	.02			6.02
7	Total Medicare liability (see instructions)		1			7
8	Name of Contractor		Con	tractor Number	NPR Date (Month/Day/Year)	_
-	•					•

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

4090	(Cont.)		FO	FORM CMS-2552-10						
	ASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSE IOSPITAL-BASED FQHC	PROVIDER CCN:  COMPONENT CCN:		PERIOD: FROM: TO:	WORKSHEET N-1					
	COST CENTER DESCRIPTIONS (omit cents)	SALARIES I	OTHER 2	TOTAL $(col. 1 + col. 2)$ $3$	RECLASSIFI- CATIONS 4	$\begin{array}{c} RECLASSIFIED\\ TRIAL BALANCE\\ (col. 3 \pm col. 4)\\ 5 \end{array}$	ADJUSTMENTS 6	$NET$ $EXPENSES FOR$ $ALLOCATION$ $(col. 5 \pm col. 6)$ $7$		
GENE	RAL SERVICE COST CENTERS									
1	Cap Rel Costs-Bldg and Fix								1	
2	Cap Rel Costs-Mvble Equip								2	
3	Employee Benefits								3	
4	Administrative and General								4	
5	Plant Operation and Maintenance								5	
6	Janitorial								6	
7	Medical Records								7	
8	Subtotal - Administrative Overhead								8	
9	Pharmacy								9	
10	Medical Supplies								10	
11	Transportation								11	
12	Other General Service								12	
	Subtotal - Total Overhead								13	
-	CT CARE COST CENTERS									
23	Physician								23	
24	Physician Services Under Agreement								24	
	Physician Assistant								25	
	Nurse Practitioner								26	
	Visiting Registered Nurse								27	
	Visiting Licensed Practical Nurse								28	
	Certified Nurse Midwife								29	
	Clinical Psychologist								30	
	Clinical Social Worker								31	
	Laboratory Technician								32	
	Reg Dietician/Cert DSMT/MNT Educator								33	
	Physical Therapist								34	
	Occupational Therapist								35	
	Other Allied Health Personnel								36	
37	Subtotal - Direct Patient Care Services								37	

11-16	ORM CMS-2552-10	4090 (Cont.)						
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPL	ENSES		PROVIDER CCN:		PERIOD:	WORKSHEET N-1		
FOR HOSPITAL-BASED FQHC			COMPONENT CCN:		FROM			
COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	$\begin{array}{c} RECLASSIFIED\\ TRIAL BALANCE\\ (col. 3 \pm col. 4)\\ 5 \end{array}$	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
REIMBURSABLE PASS THROUGH COSTS								
47 Pneumococcal Vaccines & Med Supplies								47
48 Influenza Vaccines & Med Supplies								48
49 Subtotal - Reimbursable Pass through Costs								49
OTHER FQHC SERVICES								
60 Medicare Excluded Services								60
61 Diagnostic & Screening Lab Tests								61
62 Radiology - Diagnostic								62
63 Prosthetic Devices								63
64 Durable Medical Equipment								64
65 Ambulance Services								65
66 Telehealth								66
67 Drugs Charged to Patients								67
68 Chronic Care Management								68
69 Other								69
70 Subtotal - Other FQHC Services								70
NONREIMBURSABLE COST CENTERS								
77 Retail Pharmacy								77
78 Other Nonreimbursable								78
79 Subtotal - Non-Reimbursable Costs								79
100 TOTAL (sum of lines 13, 37, 49, 70, and 79)								100

4090 (Cont.)					FORM CM	AS-2552-10							1	1-16
CALCULATION OF HOSPITAL-BASED FQHC COS	HC COST PER VISIT						PROVIDER CCN: COMPONENT CCN:		PERIOD: FROM: TO:		WORKSHEET N	√-2		
								Total	Visits	Title XV	/III Visits	Title XV	/III Costs	<b>r</b>
	From Wkst. N-1, col. 7.	Practitioner	Total Medical & Mental Health Visits by Practitioner	Pharmacy Costs (see	(see	Total Costs by Practitioner		Medical Visits by Practitioner		Medical Visits by Practitioner			Mental Health Cost by Practitioner	
Positions	line:	1	2	3	4	5	6	7	8	9	10	11	12	
1 Physician	23												1 1	1
2 Physician Services Under Agreement	24													2
3 Physician Assistant	25													3
4 Nurse Practitioner	26													- 4
5 Visiting Registered Nurse	27												1	5
6 Visiting Licensed Practical Nurse	28												1	6
7 Certified Nurse Midwife	29												1	7
8 Clinical Psychologist	30												1	8
9 Clinical Social Worker	31												1	9
10 Reg Dietician/Cert DSMT/MNT Educator	33												1	10
11 Totals														- 11
12 Unit Cost Multiplier														12
13 Total Cost Per Visit														13

11-1	6 FORM CM	FORM CMS-2552-10					
	PUTATION OF HOSPITAL-BASED FQHC PNEUMOCOCCAL INFLUENZA VACCINE COST	PROVIDER CCN: 	PERIOD: FROM: TO:	WORKSHEET N-3			
			PNEUMOCOCCAL	INFLUENZA			
			1	2			
1	Health care staff cost (from Worksheet N-1, column 7, sum of lines 23, and 25 through 36)				1		
2	Ratio of pneumococcal and influenza vaccine staff time to total				2		
	health care staff time						
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)				3		
4	Vaccines and related medical supplies cost (from Worksheet N-1, column 7, lines 47 and 4	(8, respectively)			4		
5	Direct cost of pneumococcal and influenza vaccine (line 3 + line 4)				5		
6	Total direct cost of the hospital-based FQHC (from Worksheet N-1, column 7, line 100, mi	inus			6		
	Worksheet N-1, column 7, line 8)						
7	Total administrative overhead (from Worksheet N-1, column 7, line 8)				7		
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct				8		
	cost (line 5 / line 6)						
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)				9		
10	Total cost of pneumococcal and influenza vaccine and their				10		
	administration (sum of lines 5 and 9)						
11	Total number of pneumococcal and influenza vaccine injections				- 11		
	(from your records)						
-	Cost per pneumococcal and influenza vaccine injection (line 10 / line 11)				12		
13	Number of pneumococcal and influenza vaccine injections administered				13		
	to Medicare beneficiaries						
14	Cost of pneumococcal and influenza vaccines and their				14		
	administration costs furnished to Medicare beneficiaries (line 12 x line 13)						
15	Total cost of pneumococcal and influenza vaccines and their administration costs.				15		
	(sum of columns 1 and 2, line 10)				$\perp$		
16	Total Medicare cost of pneumococcal and influenza vaccines and their administration cost	ts (sum			16		
	of columns 1 and 2, line 14) (transfer this amount to Worksheet N-4, line 2)						

4090 (Cont.)	FORM CM	IS-2552-10			11-16
CALCULATION OF HOSPITAL-BASED FQHC RE	IMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET N-4	

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

11-16	FORM CMS-2552-1	0		4090 (Cont.)			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERV	ICES RENDERED	PROVIDER CCN: 	F	PERIOD: FROM: FO:	WORKSHEET N-5		
Description					Part B		
				mm/dd/yyyy	Amount 2		
1 Total interim payments paid to hospital-based FQHC				1	2	1	
2 Interim payments payable on individual bills, either submitted						2	
for services rendered in the cost reporting period. If none, wri 3 List separately each retroactive	e NONE or emer a zero		.01			3.01	
lump sum adjustment amount based			.02			3.02	
on subsequent revision of the		Program to	.03			3.03	
interim rate for the cost reporting period.		Provider	.04			3.04	
Also show date 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 .54			3.53 3.54	
Subtotal (sum of lines 3.01 through 3.49 minus sum of lines 3.5	() through 3 (18)		.99			3.99	
4 Total interim payments (sum of lines 1, 2, and 3.99)	0 (mrough 5.90)		.99			3.99	
(transfer to Wkst. N-4, line 17)							
TO BE COMPLETED BY CONTRACTOR							
5 List separately each tentative settlement		Program to	.01			5.01	
payment after desk review. Also show		Provider	.02			5.02	
date of each payment.			.03			5.03	
If none, write "NONE" or enter a zero. (1)			.50			5.50	
		Provider to	.51			5.51	
	50.4 J 5.00)	Program	.52			5.52	
Subtotal (sum of lines 5.01 through 5.49 minus sum of lines 5.5	U through 5.98)	December 11	.99			5.99	
6 Determine net settlement amount (balance		Program to provider Provider to program	.01 .02			6.01 6.02	
due) based on the cost report <sup>(1)</sup> 7 Total Medicare program liability (see instructions)		r roviaer io program	.02			0.02	
7 Total meancare program additity (see instructions)							

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

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

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

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEE	T ARE PUBLISHED IN CMS PUB	15-2, SECTION 4072)
10		

Rev. 10

11-16		FC	ORM CMS-2552-1	0			4090 ( <b>C</b>	Cont.)
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS	TOTAL ( col. 5 ± col. 6 ) 7	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)	1		5		5	0	,	<u> </u>
40 Imaging Services**								40
41 Labs and Diagnostics**								41
42 Medical Supplies-Non-routine**								42
43 Outpatient Services**								43
44 Palliative Radiation Therapy**								44
45 Palliative Chemotherapy**								45
46 Other Patient Care Services**								46
NONREIMBURSABLE COST CENTERS								
60 Bereavement Program *								60
61 Volunteer Program *								61
62 Fundraising*								62
63 Hospice/Palliative Medicine Fellows*								63
64 Palliative Care Program*								64
65 Other Physician Services*								65
66 Residential Care *								66
67 Advertising*								67
68 Telehealth/Telemonitoring*								68
69 Thrift Store*								69
70 Nursing Facility Room & Board*								70
71 Other Nonreimbursable*								71
100 Total								100

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

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072)

409	0 (Cont.)		FORM	CMS-2552-10					11-16
ANA	LYSIS OF HOSPITAL-BASED HOSPICE COSTS PICE CONTINUOUS HOME CARE					PERIOD: FROM TO	WORKSHEET O-1		
		SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS 4	SUBTOTAL	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 ) 7	
DIRF	CCT PATIENT CARE SERVICE COST CENTERS	1	2	5		5	0	,	<u> </u>
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

11-16	-16 FORM CMS-2552-10								
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE ROUTINE HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	4090 (( <i>WORKSHEET 0-2</i>		
	SALARIES	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 )	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 ) 7		
DIRECT PATIENT CARE SERVICE COST CENTERS	1	4	<u>y</u>	7		V	,	<u> </u>	
25 Inpatient Care - Contracted								25	
26 Physician Services								26	
27 Nurse Practitioner								27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								31	
32 Speech/Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								35	
36 Counseling - Other								36	
37 Hospice Aide and Homemaker Services								37	
38 Durable Medical Equipment/Oxygen								38	
39 Patient Transportation								39	
40 Imaging Services								40	
41 Labs and Diagnostics								41	
42 Medical Supplies-Non-routine								42	
43 Outpatient Services								43	
44 Palliative Radiation Therapy								44	
45 Palliative Chemotherapy								45	
46 Other Patient Care Svc								46	
100 Total *								100	

4090 (Cont.)		FORM	CMS-2552-10					11-16
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE INPATIENT RESPITE CARE				PERIOD: FROM TO	WORKSHEET O-3			
	SALARIES I	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	<i>TOTAL</i> ( <i>col.</i> 5 ± <i>col.</i> 6 ) 7	Γ
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy								45
46 Other Patient Care Svc								46
100 Total *								100

11-16	-16 FORM CMS-2552-10								
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS HOSPICE GENERAL INPATIENT CARE					PERIOD: FROM TO	4090 (0 WORKSHEET 0-4			
	SALARIES 1	OTHER 2	SUBTOTAL ( col. 1 plus col. 2 ) 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL ( col. 5 ± col. 6 ) 7	$\Box$	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25 Inpatient Care - Contracted								25	
26 Physician Services								26	
27 Nurse Practitioner								27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								31	
32 Speech/Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								35	
36 Counseling - Other								36	
37 Hospice Aide and Homemaker Services								37	
38 Durable Medical Equipment/Oxygen								38	
39 Patient Transportation								39	
40 Imaging Services								40	
41 Labs and Diagnostics								41	
42 Medical Supplies-Non-routine								42	
43 Outpatient Services								43	
44 Palliative Radiation Therapy								44	
45 Palliative Chemotherapy								45	
46 Other Patient Care Svc								46	
100 Total *								100	

4090	(Cont.) FORM	FORM CMS-2552-10								
	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE XPENSES FOR ALLOCATION	PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-5						
		HOSPICE CCN:	то							
		HOSPICE DIRECT EXPENSES ( see instructions )	GENERAL SERVICE EXPENSES FROM WKST B PART I ( see instructions )	TOTAL EXPENSES (sum of cols. 1 + 2)						
	Descriptions	1	2	3	_					
	RAL SERVICE COST CENTERS									
	Cap Rel Costs-Bldg & Fixt				1					
	Cap Rel Costs-Mvble Equip				2					
3 1	Employee Benefits				3					
4 /	Administrative & General				4					
5 1	Plant Operation and Maintenance				5					
6 1	Laundry & Linen Service				6					
7 1	Housekeeping				7					
8 1	Dietary				8					
9 1	Nursing Administration				9					
10 1	Routine Medical Supplies				10					
11 1	Medical Records				- 11					
12 \$	Staff Transportation				12					
13 \	Volunteer Service Coordination				13					
14 1	Pharmacy				14					
15 1	Physician Administrative Services				15					
16 0	Other General Service				16					
17 1	Patient/Residential Care Services				17					
LEVEL	OF CARE									
50 1	Hospice Continuous Home Care				50					
	Hospice Routine Home Care				51					
	Hospice Inpatient Respite Care				52					
	Hospice General Inpatient Care				53					
_	EIMBURSABLE COST CENTERS									
	Bereavement Program				60					
_	Volunteer Program				61					
	Fundraising				62					
	Hospice/Palliative Medicine Fellows	1			63					
64 1	Palliative Care Program				64					
	Other Physician Services				65					
	Residential Care				66					
	Advertising				67					
68 1	Telehealth/Telemonitoring				68					
	Thrift Store				69					
_	Nursing Facility Room & Board				70					
	Other Nonreimbursable				71					
	Negative Cost Center				99					
	Total				100					

11-1	6			FC	ORM CMS-255	2-10					4090 (0	Cont.)
COST	ALLOCATION - HOSPITAL-BASED HOSPICE GE	ENERAL SERVICE COST					PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET O PART I	
		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	
	Descriptions	0	1	2	3	3A	4	5	6	7	8	
GEN	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance									_		5
6	Laundry & Linen Service										_	6
	Housekeeping											7
8	Dietary											8
9	Nursing Administration											
10	Routine Medical Supplies Medical Records											10
11												11 12
<u>12</u> 13	Staff Transportation Volunteer Service Coordination					-					-	12
13	Pharmacy					-					-	13
14	Physician Administrative Services					-					-	14
15	Other General Service					-					-	15
17	Patient/Residential Care Services											10
	L OF CARE											17
50	Hospice Continuous Home Care											50
51	Hospice Commons Home Care											50
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
	REIMBURSABLE COST CENTERS											55
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care			<u> </u>		<u> </u>						66
67												67
68	Advertising Telehealth/Telemonitoring				-							68
_	~											
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
100	Total											100

FORM CMS-2552-10 (11-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4072.3)

Rev. 10

4090	) (Cont.)			FO	RM CMS-255	2-10						11-16
COST	ALLOCATION - HOSPITAL-BASED HOSPICE GEN	IERAL SERVICE COS	TS				PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET C PART I	D-6
		NURSING ADMINIS- TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS- PORTATION	VOLUNTEER SVC COOR- DINATION	PHARMACY	PHYSICIAN ADMIN SERVICES	OTHER GENERAL SERVICE	PATIENT / RESIDENT CARE SVCS	TOTAL	
	Descriptions	9	10	11	12	13	14	15	16	17	18	
GENI	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service (specify)											16
17	Patient/Residential Care Services											17
LEVE	L OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
	REIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable (specify)											71
99	Negative Cost Center											99
100	Total											100

11-1	6		FC	ORM CMS-2552	2-10					4090 (	Cont.)
COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SER	RVICE COSTS STATISTICAL BA	SIS			PROVIDER CCN:		PERIOD: FROM TO	FROM PART II		-6
		CAP REL BLDG & FIX ( Square Feet )	CAP REL MVBLE EQUIP ( Dollar Value )	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT ( Square Feet )	LAUNDRY & LINEN ( In-Facil- ity Days )	HOUSE- KEEPING ( Square Feet )	DIETARY ( In-Facil- ity Days )	
	Cost Center Descriptions	1	2	3	4A	4	5	6	7	8	
GENI	ERAL SERVICE COST CENTERS										
1	Cap Rel Costs-Bldg & Fixt										1
2	Cap Rel Costs-Myble Equip										2
3	Employee Benefits										3
4	Administrative & General										4
5	Plant Operation and Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping										7
8	Dietary										8
9	Nursing Administration							_			9
	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation Volunteer Service Coordination							_			12 13
14	Pharmacy							-			13
15	Physician Administrative Services										14
16	Other General Service										16
17	Patient/Residential Care Services										10
LEVE	L OF CARE										
50	Hospice Continuous Home Care										50
51	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
53	Hospice General Inpatient Care										53
NON	REIMBURSABLE COST CENTERS										
60	Bereavement Program										60
61	Volunteer Program										61
62	Fundraising										62
63	Hospice/Palliative Medicine Fellows										63
64	Palliative Care Program										64
65	Other Physician Services										65
66	Residential Care										66
67	Advertising										67
68	Telehealth/Telemonitoring										68
69	Thrift Store		1								69
70	Nursing Facility Room & Board										70
71	Other Nonreimbursable										71
99	Negative Cost Center										99
100	Cost to be allocated (per Wkst. O-6, Part I)										100
101	Unit cost multiplier										101

409	0 (Cont.)			FC	ORM CMS-2552	2-10						11-16
COS	T ALLOCATION - HOSPITAL-BASED HOSPICE GEN	ENERAL SERVICE COSTS STATISTICAL BASIS					PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET O PART II	0-6
		NURSING ADMINIS- TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS- PORTATION ( Mileage )	VOLUNTEER SVC COOR- DINATION ( Hours of Service )	PHARMACY ( Charges )	PHYSICIAN ADMIN SERVICES (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENT CARE SVCS (In-Facil- ity Days)	TOTAL	
	Cost Center Descriptions	9	10	11	12	13	14	15	16	17	18	
GEN.	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
- 11	Medical Records											- 11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services									ļ		15
- 16	Other General Service											16
17	Patient/Residential Care Services											17
LEVE	EL OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
	REIMBURSABLE COST CENTERS											_
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
100	Cost to be allocated (per Wkst. O-6, Part I)											100
101	Unit cost multiplier											101

11-16				FORM CMS-	2552-10					4090 (C	lont.)
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SH	ARED SERVICE COSTS	BY LEVEL OF O	CARE			PROVIDER CCN: HOSPICE CCN: _		PERIOD: FROM TO		WORKSHEET O-7	
	Wkst. C,	Cost to		Charges by LOC (fr	om Provider Records	5)		Shared Service	e Costs by LOC		<u> </u>
	Pt. I, col. 9, line	Charge Ratio	НСНС	HRHC	HIRC	HGIP	HCHC ( $col. 1 x col. 2$ )	HRHC ( col. 1 x col. 3 )	HIRC $(col. 1 x col. 4)$	HGIP (col. 1 x col. 5)	]
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	1
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	66										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				Î						8

55 76

-11

Totals (sum of lines 1 through 10)

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