

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

FORM APPROVED
OMB NO. 0938-0463
Expires: 12/31/2021

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

Provider use only	1. <input type="checkbox"/> <i>Electronically prepared</i> cost report	Date: _____	Time: _____
	2. <input type="checkbox"/> Manually <i>prepared</i> cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report.		
	3.01. <input type="checkbox"/> No Medicare Utilization. Enter "Y" for yes or leave blank for no.		
Contractor use only:	4. <input type="checkbox"/> Cost Report Status [1] As Submitted: [2] Settled without audit [3] Settled with audit [4] Reopened [5] Amended	6. Contractor No. _____ 7. <input type="checkbox"/> First Cost Report for this Provider CCN 8. <input type="checkbox"/> Last Cost Report for this Provider CCN 9. NPR Date: _____ 10. If line 4, column 1 is "4": Enter number of times reopened _____ 11. Contractor Vendor Code _____ 12. Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization	
	5. Date Received _____		

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

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

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1	1	2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification to be the legally binding equivalent of my signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Signature date			4

PART III - SETTLEMENT SUMMARY

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

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

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART I
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Skilled Nursing Facility and Skilled Nursing Facility Complex Address:

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

SNF and SNF - Based Component Identification:

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

Type of Freestanding Skilled Nursing Facility

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

Miscellaneous Cost Reporting Information

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

Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on lines 20 - 22.

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

2020 FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER CCN:	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I
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If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.

		Part A	Part B	Other	
29	Skilled Nursing Facility				29
30	Nursing Facility				30
31	I C F/ID				31
32	SNF-Based HHA				32
33	SNF-Based RHC				33
34	SNF-Based FQHC				34
35	SNF-Based CMHC				35
36	SNF-Based OLTC				36

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

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

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

If this facility is part of a chain organization, enter the name and address of the home office on the lines below.					
45	Name:		Contractor Name:		45
46	Street:	P.O. Box:	46		
47	City	State	ZIP Code	47	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-2 PART II
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General Instruction: For all column 1 responses, enter in column 1, "Y" for Yes or "N" for No
For all dates responses, use the format mm/dd/yyyy.

Completed by All Skilled Nursing Facilities

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

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

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

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

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

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

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

Cost Report Preparer Contact Information

19	First Name:	Last Name:	Title:	19
20	Employer:			20
21	Phone Number:	Email Address:		21

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-3 PART I
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Component	Number of Beds	Bed Days Available	Inpatient Days / Visits					Discharges					
			Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Facility													1
2 Nursing Facility													2
3 ICF / IID													3
4 Home Health Agency													4
5 Other Long Term Care													5
6 SNF-Based CMHC													6
7 Hospice													7
8 Total (sum of lines 1-7)													8

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

SNF WAGE INDEX INFORMATION

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET S-3
PARTS II & III

PART II - DIRECT SALARIES

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

PART III - OVERHEAD COST - DIRECT SALARIES

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

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

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

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

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

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

HOME HEALTH AGENCY CBSA CODES

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

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

SNF-BASED RHC/FQHC STATISTICAL DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-5
	RHC/FQHC CCN:		

Check applicable box: <input type="checkbox"/> RHC <input type="checkbox"/> FQHC
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Clinic Address and Identification:			
1	Street:	County:	1
2	City:	State:	2
3	Designation (for FQHC's only) - "U" for urban or "R" for rural		3

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

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

Facility hours of operations (1)

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

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

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

SNF-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION FACILITIES STATISTICAL DATA	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-6
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Check applicable box: <input type="checkbox"/> CMHC <input type="checkbox"/> CORF <input type="checkbox"/> OPT <input type="checkbox"/> OOT <input type="checkbox"/> OSP
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Enter the number of hours in your normal workweek _____

NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

		Staff	Contract	Total (col. 1 + col. 2)	
		1	2	3	
1	Administrator and Assistant Administrator(s)				1
2	Director(s) and Assistant Director(s)				2
3	Other Administrative Personnel				3
4	Direct Nursing Service				4
5	Nursing Supervisor				5
6	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
16	Psychiatric/Psychological Service				16
17	Psychiatric/Psychological Service Supervisor				17
18	Other (specify)				18
19	Other (specify)				19

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S-7
	RUG GROUPS (Through September 30, 2019)			
	1		Days 2	
1	RUX			1
2	RUL			2
3	RVX			3
4	RVL			4
5	RHX			5
6	RHL			6
7	RMX			7
8	RML			8
9	RLX			9
10	RUC			10
11	RUB			11
12	RUA			12
13	RVC			13
14	RVB			14
15	RVA			15
16	RHC			16
17	RHB			17
18	RHA			18
19	RMC			19
20	RMB			20
21	RMA			21
22	RLB			22
23	RLA			23
24	ES3			24
25	ES2			25
26	ES1			26
27	HE2			27
28	HE1			28
29	HD2			29
30	HD1			30
31	HC2			31
32	HC1			32
33	HB2			33
34	HB1			34
35	LE2			35
36	LE1			36
37	LD2			37
38	LD1			38
39	LC2			39
40	LC1			40
41	LB2			41
42	LB1			42
43	CE2			43
44	CE1			44
45	CD2			45
46	CD1			46
47	CC2			47
48	CC1			48
49	CB2			49
50	CB1			50
51	CA2			51
52	CA1			52
53	SE3			53
54	SE2			54
55	SE1			55
56	SSC			56
57	SSB			57
58	SSA			58
59	IB2			59
60	IB1			60
61	IA2			61
62	IA1			62
63	BB2			63
64	BB1			64
65	BA2			65
66	BA1			66

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-7
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	RUG GROUPs (Through September 30, 2019)	Days	
	1	2	
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PA1		76
99	AAA		99
100	Total (Sum of column 2, lines 1 through 99)		100

A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I line 1 column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (see instructions)

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

SNF-BASED HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET S - 8
	HOSPICE CCN:		PARTS I, II, III & IV

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

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

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

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

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

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

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

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

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

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	I N C R E A S E				D E C R E A S E				
		COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
100	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9 (2))									100

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

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

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-7
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		Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
Description		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 7 minus line 8)								9

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

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

(2) Basis for adjustment (see instructions)

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-8-1
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PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

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

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

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

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

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

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator or key person of provider or organization.

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

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

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

PROVIDER - BASED PHYSICIAN ADJUSTMENTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET A-8-2
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	Wkst. A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider Component Hours	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN:

PERIOD:
FROM _____
TO _____WORKSHEET B
PART I

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET B
PART I

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

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

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

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

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

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

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

COST ALLOCATION - STATISTICAL BASIS					PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B - 1	
Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDU EDUCATION (Assigned Time)	GENERAL SERVICE COST COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL			
	12	13	14	15	16	17	18			
OUTPATIENT SERVICE COST CENTERS										
60 Clinic								60		
61 Rural Health Clinic (RHC)								61		
62 FQHC								62		
63 Other Outpatient Service Cost								63		
OTHER REIMBURSABLE COST CENTERS										
70 Home Health Agency Cost								70		
71 Ambulance								71		
72 Outpatient Rehabilitation (specify)								72		
73 CMHC								73		
74 Other Reimbursable Cost								74		
SPECIAL PURPOSE COST CENTERS										
83 Hospice								83		
84 Other Special Purpose Cost								84		
89 Subtotals								89		
NON REIMBURSABLE COST CENTERS										
90 Gift, Flower, Coffee Shops and Canteen								90		
91 Barber and Beauty Shop								91		
92 Physicians' Private Offices								92		
93 Nonpaid Workers								93		
94 Patients' Laundry								94		
95 Other Nonreimbursable Cost								95		
98 Cross Foot Adjustments								98		
99 Negative Cost Center								99		
102 Cost to be allocated (Per Wkst. B, Pt. I.)								102		
103 Unit Cost Multiplier (Wkst. B, Pt. I.)								103		
104 Cost to be allocated (Per Wkst. B, Pt. II)								104		
105 Unit Cost Multiplier (Wkst B, Pt. II)								105		

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

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

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

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

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

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

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

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

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D PART I
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Check applicable box:	<input type="checkbox"/> Title V (1)	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX (1)	
Check applicable box:	<input type="checkbox"/> SNF	<input type="checkbox"/> NF	<input type="checkbox"/> ICF / IID	<input type="checkbox"/> Other _____ <input type="checkbox"/> PPS - Must also complete Part II

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

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

(1) For titles V and XIX use columns 1, 2 and 4 only.

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

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

PART II - APPORTIONMENT OF VACCINE COST

1	Drugs charged to patients - ratio of cost to charges (from Wkst. C, col. 3, line 49)		1
2	Program vaccine charges (From your records or the PS&R report)		2
3	Program costs (line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst. E, Pt. I, line 18)		3

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

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

COMPUTATION OF INPATIENT ROUTINE COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET D-1 PARTS I & II
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Check applicable box:	<input type="checkbox"/> Title V	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check applicable box:	<input type="checkbox"/> SNF	<input type="checkbox"/> NF	<input type="checkbox"/> ICF / IID

PART I - CALCULATION OF INPATIENT ROUTINE COSTS

INPATIENT DAYS

1	Inpatient days including private room days		1
2	Private room days		2
3	Inpatient days including private room days applicable to the Program		3
4	Medically necessary private room days applicable to the Program		4
5	Total general inpatient routine service cost		5

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

6	General inpatient routine service charges		6
7	General inpatient routine service cost/charge ratio (line 5 divided by line 6)		7
8	Enter private room charges from your records		8
9	Average private room per diem charge (private room charges on line 8 divided by private room days on line 2)		9
10	Enter semi-private room charges from your records		10
11	Average semi-private room per diem charge (semi-private room charges on line 10 divided by semi-private room days)		11
12	Average per diem private room charge differential (line 9 minus line 11)		12
13	Average per diem private room cost differential (line 7 times line 12)		13
14	Private room cost differential adjustment (line 2 times line 13)		14
15	General inpatient routine service cost net of private room cost differential (line 5 minus line 14)		15

PROGRAM INPATIENT ROUTINE SERVICE COSTS

16	Adjusted general inpatient service cost per diem (line 15 divided by line 11)		16
17	Program routine service cost (line 3 times line 16)		17
18	Medically necessary private room cost applicable to program (line 4 times line 13)		18
19	Total program general inpatient routine service cost (line 17 plus line 18)		19
20	Capital related cost allocated to inpatient routine service costs (from Wkst. B, Pt. II, col. 18, line 30 for SNF; line 31 for NF; or line 32 for ICF/IID)		20
21	Per diem capital related costs (line 20 divided by line 1)		21
22	Program capital related cost (line 3 times line 21)		22
23	Inpatient routine service cost (line 19 minus line 22)		23
24	Aggregate charges to beneficiaries for excess costs (from provider records)		24
25	Total program routine service costs for comparison to the cost limitation (line 23 minus line 24)		25
26	Enter the per diem limitation (1)		26
27	Inpatient routine service cost limitation (line 3 times the per diem limitation line 26) (1)		27
28	Reimbursable inpatient routine service costs (line 22 plus the lesser of line 25 or line 27) (Transfer to Wkst. E, Pt. II, line 4) (see instructions)		28

PART II - CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH

1	Total inpatient days		1
2	Program inpatient days (see instructions)		2
3	Total nursing & allied health costs (see instructions)		3
4	Nursing & allied health ratio (line 2 divided by line 1)		4
5	Program nursing & allied health costs for pass-through (line 3 times line 4)		5

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART I
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PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT

1	Inpatient PPS amount (see instructions)		1
2	Nursing and Allied Health Education Activities (pass through payments)		2
3	Subtotal (sum of lines 1 and 2)		3
4	Primary payer amounts		4
5	Coinsurance		5
6	Allowable bad debts (from your records)		6
7	Allowable bad debts for dual eligible beneficiaries (see instructions)		7
8	Reimbursable bad debts (see instructions)		8
9	Recovery of bad debts - for statistical records only		9
10	Utilization review		10
11	Subtotal (see instructions)		11
12	Interim payments (see instructions)		12
13	Tentative adjustment		13
14	Other adjustment (see instructions)		14
14.50	Demonstration payment adjustment amount before sequestration		14.50
14.55	Demonstration payment adjustment amount after sequestration		14.55
14.75	Sequestration for non-claims based amounts (see instructions)		14.75
14.99	Sequestration amount (see instructions)		14.99
15	Balance due provider/program (see instructions) (Indicate overpayment in parentheses)		15
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		16

PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY

17	Ancillary services Part B		17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)		18
19	Total reasonable costs (sum of lines 17 and 18)		19
20	Medicare Part B ancillary charges (see instructions)		20
21	Cost of covered services (lesser of line 19 or line 20)		21
22	Primary payer amounts		22
23	Coinsurance and deductibles		23
24	Allowable bad debts (from your records)		24
24.01	Allowable bad debts for dual eligible beneficiaries (see instructions)		24.01
24.02	Reimbursable bad debts (see instructions)		24.02
25	Subtotal (sum of lines 21 and 24.02, minus lines 22 and 23)		25
26	Interim payments (see instructions)		26
27	Tentative adjustment		27
28	Other Adjustments (Specify _____) (see instructions)		28
28.50	Demonstration payment adjustment amounts before sequestration		28.50
28.55	Demonstration payment adjustment amount after sequestration		28.55
28.99	Sequestration amount (see instructions)		28.99
29	Balance due provider/program (see instructions) (indicate overpayments in parentheses)		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		30

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE V and TITLE XIX ONLY	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E PART II
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Check applicable box: <input type="checkbox"/> Title V <input type="checkbox"/> Title XIX
Check applicable box: <input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> ICF / IID

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED					PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET E-1	
Description					Inpatient Part A		Part B	
					mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
					1	2	3	4
1	Total interim payments paid to provider							1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01				3.01	
			.02				3.02	
			.03				3.03	
			.04				3.04	
			.05				3.05	
		Provider to Program	.50				3.50	
			.51				3.51	
			.52				3.52	
			.53				3.53	
			.54				3.54	
		SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)				.99		
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99) (Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)							4
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01				5.01	
			.02				5.02	
			.03				5.03	
		Provider to Program	.50				5.50	
			.51				5.51	
			.52				5.52	
		SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)				.99		
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01			6.01		
		Provider to Program	.02			6.02		
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor				Contractor Number			8

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G
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		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Less: allowances for uncollectible notes and accounts receivable	()	()	()	()	6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (sum of lines 1 - 10)					11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Less: Accumulated depreciation	()	()	()	()	14
15	Buildings					15
16	Less: Accumulated depreciation	()	()	()	()	16
17	Leasehold improvements					17
18	Less: Accumulated Amortization	()	()	()	()	18
19	Fixed equipment					19
20	Less: Accumulated depreciation	()	()	()	()	20
21	Automobiles and trucks					21
22	Less: Accumulated depreciation	()	()	()	()	22
23	Major movable equipment					23
24	Less: Accumulated depreciation	()	()	()	()	24
25	Minor equipment - Depreciable					25
26	Minor equipment nondepreciable					26
27	Other fixed assets					27
28	TOTAL FIXED ASSETS (sum of lines 12 - 27)					28
OTHER ASSETS						
29	Investments					29
30	Deposits on leases					30
31	Due from owners/officers					31
32	Other assets					32
33	TOTAL OTHER ASSETS (sum of lines 29 - 32)					33
34	TOTAL ASSETS (sum of lines 11, 28 and 33)					34

() = contra amount

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only.)	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G
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	Liabilities and Fund Balances	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
	CURRENT LIABILITIES					
35	Accounts payable					35
36	Salaries, wages & fees payable					36
37	Payroll taxes payable					37
38	Notes & loans payable (short term)					38
39	Deferred income					39
40	Accelerated payments					40
41	Due to other funds					41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES (sum of lines 35 - 42)					43
	LONG TERM LIABILITIES					
44	Mortgage payable					44
45	Notes payable					45
46	Unsecured loans					46
47	Loans from owners:					47
48	Other long term liabilities					48
49	Other (specify)					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 44 - 49)					50
51	TOTAL LIABILITIES (sum of lines 43 and 50)					51
	CAPITAL ACCOUNTS					
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement and expansion					58
59	TOTAL FUND BALANCES (sum of lines 52 thru 58)					59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)					60

() = contra amount

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER CCN:

PERIOD :

FROM _____

TO _____

WORKSHEET G - 1

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

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

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

PART II - OPERATING EXPENSES

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

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET G-3
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1	Total patient revenues (from Wkst. G-2, Pt. I, col. 3, line 14)		1
2	Less: contractual allowances and discounts on patients accounts		2
3	Net patient revenues (line 1 minus line 2)		3
4	Less: total operating expenses (form Wkst. G-2, Pt. II, line 15)		4
5	Net income from service to patients (line 3 minus 4)		5
	Other income:		
6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from communications (telephone and internet service)		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flower, coffee shops, canteen		20
21	Rental of vending machines		21
22	Rental of skilled nursing space		22
23	Governmental appropriations		23
24	Other miscellaneous revenue (specify _____)		24
24.50	COVID-19 PHE Funding		24.50
25	Total other income (sum of lines 6 - 24)		25
26	Total (line 5 plus line 25)		26
27	Other expenses (specify _____)		27
28			28
29			29
30	Total other expenses (sum of lines 27 - 29)		30
31	Net income (or loss) for the period (line 26 minus line 30)		31

ANALYSIS OF SNF-BASED HOME HEALTH AGENCY COSTS						PROVIDER CCN: HHA CCN:		PERIOD : FROM _____ TO _____		WORKSHEET H	
COST CENTER DESCRIPTIONS	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
	1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS											
1 Capital Related - Bldgs. and Fixtures											1
2 Capital Related - Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General											5
HHA REIMBURSABLE SERVICES											
6 Skilled Nursing Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech Pathology											9
10 Medical Social Services											10
11 Home Health Aide											11
12 Supplies (see instructions)											12
13 Drugs											13
14 DME											14
15 Telemedicine											15
HHA NONREIMBURSABLE SERVICES											
16 Home Dialysis Aide Services											16
17 Respiratory Therapy											17
18 Private Duty Nursing											18
19 Clinic											19
20 Health Promotion Activities											20
21 Day Care Program											21
22 Home Delivered Meals Program											22
23 Homemaker Service											23
24 All Others											24
25 Total (sum of lines 1-24)											25

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

COST ALLOCATION - HHA GENERAL SERVICE COST

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTAL (cols. 0 through 4)	ADMINIS- TRATIVE & GENERAL	TOTAL (cols. 4A + 5)	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTERS										
1	Capital Related - Bldgs. and Fixtures									1
2	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25

COST ALLOCATION - HHA STATISTICAL BASIS

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET H-1,
PART II

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE (Square Feet)	TRANS- PORTATION (Mileage)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
			BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						
GENERAL SERVICE COST CENTERS										
1	Capital Related - Bldgs. and Fixtures									1
2	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
14	DME									14
15	Telemedicine									15
HHA NONREIMBURSABLE SERVICES										
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25
26	Cost to be allocated									26
27	Unit Cost Multiplier									27

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET H-2,
PART I

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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS					PROVIDER CCN:	PERIOD: FROM _____ TO _____		WORKSHEET H-2, PART I				
HHA COST CENTER					HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
					7	8	9	10	11	12	13	
1	Administrative and General											1
2	Skilled Nursing Care											2
3	Physical Therapy											3
4	Occupational Therapy											4
5	Speech Pathology											5
6	Medical Social Services											6
7	Home Health Aide											7
8	Supplies											8
9	Drugs											9
10	DME											10
11	Telemedicine											11
12	Home Dialysis Aide Services											12
13	Respiratory Therapy											13
14	Private Duty Nursing											14
15	Clinic											15
16	Health Promotion Activities											16
17	Day Care Program											17
18	Home Delivered Meals Program											18
19	Homemaker Service											19
20	All Others											20
21	Totals (sum of lines 1-20) (2)											21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.											22

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

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS

PROVIDER CCN:

HHA CCN:

PERIOD :

FROM _____

TO _____

WORKSHEET H-2,
PART I

HHA COST CENTER		NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

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

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS
STATISTICAL BASIS

PROVIDER CCN:

HHA CCN:

PERIOD :

FROM _____
TO _____

WORKSHEET H-2,
PART II

HHA COST CENTER		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	OPERATION OF PLANT (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						
		1	2	3	4A	4	5	6	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS
STATISTICAL BASIS

PROVIDER CCN:

HHA CCN:

PERIOD :

FROM _____

TO _____

WORKSHEET H-2,
PART II

HHA COST CENTER		HOUSE-KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nursing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	
		7	8	9	10	11	12	13	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS
STATISTICAL BASIS

PROVIDER CCN:

HHA CCN:

PERIOD :

FROM _____

TO _____

WORKSHEET H-2,
PART II

HHA COST CENTER		NURSING AND ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (SPECIFY)	SUBTOTAL (sum of cols. 3A through 15)	POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 16 ± 17)	ALLOCATED HHA A&G (see Pt. II)	TOTAL HHA COSTS	
		14	15	16	17	18	19	20	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

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

Check applicable box:		<input type="checkbox"/> Title V												<input type="checkbox"/> Title XVIII												<input type="checkbox"/> Title XIX											
PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST																																					
Cost Per Visit Computation		From, Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Costs (col. 1 + col. 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits				Cost of Services				Total Program Cost (sum of cols. 9-10)																					
								Part A	Part B		Part A	Part B																									
									Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance																								
Patient Services		1	2	3	4	5	6	7	8	9	10	11	12																								
1	Skilled Nursing Care	2													1																						
2	Physical Therapy	3													2																						
3	Occupational Therapy	4													3																						
4	Speech Pathology	5													4																						
5	Medical Social Services	6													5																						
6	Home Health Aide	7													6																						
7	Total (sum of lines 1-6)														7																						

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

Supplies and Drugs Cost Computations	From Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Cost (cols. 1 + 2)	Total Charges (from HHA records)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services		
							Part A	Part B		Part A	Part B	
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
Other Patient Services		1	2	3	4	5	6	7	8	9	10	11
15 Cost of Medical Supplies	8											15
16 Cost of Drugs	9											16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED SKILLED NURSING FACILITY DEPARTMENTS													
						From Wkst. C, col. 3, line -	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Pt. 1 -			
							1	2	3	4			
1 Physical Therapy						44				col. 2, line 2			1
2 Occupational Therapy						45				col. 2, line 3			2
3 Speech Pathology						46				col. 2, line 4			3
4 Cost of Medical Supplies						48				col. 2, line 15			4
5 Cost of Drugs						49				col. 2, line 16			5

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

CALCULATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-4, Parts I & II
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Check applicable box: ☐ Title V ☐ Title XVIII ☐ Title XIX

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

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

PART II - COMPUTATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT

Description	Part A Services 1	Part B Services 2	
10 Total reasonable cost (see instructions)			10
11 Total PPS Reimbursement - Full Episodes without Outliers			11
12 Total PPS Reimbursement - Full Episodes with Outliers			12
13 Total PPS Reimbursement - LUPA Episodes			13
14 Total PPS Reimbursement - PEP Episodes			14
15 Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16 Total PPS Outlier Reimbursement - PEP Episodes			16
17 Total Other Payments			17
18 DME Payments			18
19 Oxygen Payments			19
20 Prosthetic and Orthotic Payments			20
21 Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22 Subtotal (sum of lines 10 through 20 minus line 21)			22
23 Excess reasonable cost (from line 8)			23
24 Subtotal (line 22 minus line 23)			24
25 Coinsurance billed to program patients (from your records)			25
26 Net cost (line 24 minus line 25)			26
27 Allowable bad debts (from your records)			27
28 Allowable bad debts for dual eligible beneficiaries (see instructions)			28
29 Total costs - current cost reporting period (line 26 plus line 27)			29
30 Other adjustments (see instructions) (specify)			30
30.50 Demonstration payment adjustment amount before sequestration			30.50
30.55 Demonstration payment adjustment amount after sequestration			30.55
30.99 Sequestration amount (see instructions)			30.99
31 Subtotal (see instructions)			31
32 Interim payments (see instructions)			32
33 Tentative settlement (for contractor use only)			33
34 Balance due provider/program (see instructions)			34
35 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			35

ANALYSIS OF PAYMENTS TO SNF-BASED HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES				PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-5		
Description				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider						1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero.						2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider					3.01	
.02						3.02		
.03						3.03		
.04						3.04		
.05						3.05		
		Provider to Program	.50				3.50	
			.51				3.51	
			.52				3.52	
			.53				3.53	
			.54				3.54	
	SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			.99			3.99	
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)						4	
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero. (1)	Program to Provider	.01				5.01	
.02						5.02		
.03						5.03		
		Provider to Program	.50				5.50	
			.51				5.51	
			.52				5.52	
		SUBTOTAL (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			.99			5.99
6		Determine net settlement amount (balance due) based on the cost report (1)	Program to Provider	.01				6.01
	Provider to Program		.02				6.02	
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						7	
8	Name of Contractor		Contractor Number				8	

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

ANALYSIS OF SNF-BASED RHC/FQHC COSTS	PROVIDER CCN:	PERIOD :	WORKSHEET I-1
	RHC/FQHC CCN:	FROM _____ TO _____	

Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC
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	COMPEN- SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 +/- col.6)	
	1	2	3	4	5	6	7	
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 health care staff costs								9
10 Subtotal (sum of lines 1 - 9)								10
COSTS UNDER AGREEMENT								
11 Physician Services Under Agreement								11
12 Physician Supervision Under Agreement								12
13 Other costs under agreement								13
14 Subtotal (sum of lines 11 - 13)								14
OTHER HEALTH CARE COSTS								
15 Medical Supplies								15
16 Transportation (Health Care Staff)								16
17 Depreciation - Medical Equipment								17
18 Professional Liability Insurance								18
19 Other health care costs								19
21 Subtotal (sum of lines 15 - 19)								21
22 Total cost of health care services (sum of lines 10, 14, and 21)								22
COSTS OTHER THAN RHC / FQHC SERVICES								
23 Pharmacy								23
24 Dental								24
25 Optometry								25
26 All other non reimbursable costs								26
28 Total nonreimbursable costs (sum of lines 23 - 26)								28
RHC/FQHC OVERHEAD								
29 RHC/FQHC costs								29
30 Administrative costs								30
31 Total RHC/FQHC overhead (sum of lines 29-30)								31
32 Total RHC/FQHC costs (sum of lines 22, 28 and 31)								32

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

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

Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC
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PART I - VISITS AND PRODUCTIVITY

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

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

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

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

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

Check applicable box:	<input type="checkbox"/> Title V	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC	

PART I - DETERMINATION OF RATE FOR SNF-BASED RHC/FQHC SERVICES

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

CALCULATION OF LIMIT

Lines 8 through 14: Fiscal year RHC/FQHC use columns 1 and 2.
Lines 8 through 14: Calendar year RHC/FQHC use column 2 only.

	Prior to January 1	On or after January 1	
8	1	2	8
9			9

PART II - CALCULATION OF SETTLEMENT FOR SNF-BASED RHC/FQHC SERVICES

10	Program covered visits excluding mental health services (from contractor records)		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		11
12	Program covered visits for mental health services (from contractor records)		12
13	Program covered cost for mental health services (line 9 x line 12)		13
14	Limit adjustment for mental health services (see instructions)		14
15	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 and 2)		15
15.01	Total Program charges (see instructions) (from contractor records)		15.01
15.02	Total Program preventive charges (see instructions) (from provider records)		15.02
15.03	Total Program preventive costs ((line 15.02/line 15.01) times line 15)		15.03
15.04	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17) times .80)		15.04
15.05	Total Program cost (see instructions)		15.05
16	Primary payer amounts		16
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17
18	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18
19	Net Program cost excluding vaccines (see instructions)		19
20	Program cost of vaccines and their administration (from Wkst. I-4, line 16)		20
21	Total reimbursable Program cost (line 19 plus 20)		21
22	Allowable bad debts		22
22.01	Reimbursable bad debts (see instructions)		22.01
23	Allowable bad debts for dual eligible beneficiaries (see instructions)		23
24	Other adjustments		24
24.50	Demonstration payment adjustment amount before sequestration		24.50
24.55	Demonstration payment adjustment amount after sequestration		24.55
25	Net reimbursable amount (see instructions)		25
25.01	Sequestration amount (see instructions)		25.01
26	Interim payments (from Wkst. I-5, line 4)		26
27	Tentative settlement (for contractor use only)		27
28	Balance due RHC/FQHC/Program (see instructions)		28
29	Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2		29

COMPUTATION OF SNF-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN: RHC/FQHC CCN:	PERIOD : FROM _____ TO _____	WORKSHEET I-4
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Check applicable box:	<input type="checkbox"/> Title V	<input type="checkbox"/> Title XVIII	<input type="checkbox"/> Title XIX
Check applicable box:	<input type="checkbox"/> RHC	<input type="checkbox"/> FQHC	

CALCULATION OF COST		PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22)			6
7	Total overhead (from Wkst. I-2, line 19)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and their administration (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			15
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			16

ANALYSIS OF PAYMENTS TO SNF-BASED RHC/FQHC FOR SERVICES RENDERED	PROVIDER CCN: RHC/FQHC CCN:	PERIOD : FROM _____ TO _____	WORKSHEET 1-5
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Check applicable box: ☐ RHC ☐ FQHC

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

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

ALLOCATION OF GENERAL SERVICE COSTS
TO COST CENTERS FOR CMHC

PROVIDER CCN:

PERIOD :
FROM _____
TO _____WORKSHEET J-1
PART I

COMPONENT CCN:

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

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

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

COMPONENT COST CENTER		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS- TRATION	
		5	6	7	8	9	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	Appr. Patient Training & Education						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21	All Other						21
22	Totals (sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

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

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC	PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-1 PART I
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COMPONENT COST CENTER		CENTRAL SERVICES & SUPPLY 10	PHARMACY 11	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICES 13	NURSING & ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE 15	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	Appr. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	All Other							21
22	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

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

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

COMPONENT COST CENTER		SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	SUBTOTAL	ALLOCATED A & G (see Pt. II)	TOTAL (sum of cols. 18 and 19 ()	
		16	17	18	19	20	
1	Administrative and General						1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Respiratory Therapy						7
8	Psychiatric/Psychological Services						8
9	Individual Therapy						9
10	Group Therapy						10
11	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
14	Appr. Patient Training & Education						14
15	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
21	All Other						21
22	Totals (Sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

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

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

COMPONENT COST CENTER	CAPITAL RELATED		EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION 4A	ADMINIS- TRATIVE & GENERAL (Accumulated Cost) 4	
	BUILDS. & FIXTURES (Square Feet) 1	MOVABLE EQUIPMENT (Dollar Value or Square Feet) 2				
1 Administrative and General						1
2 Skilled Nursing Care						2
3 Physical Therapy						3
4 Occupational Therapy						4
5 Speech Pathology						5
6 Medical Social Services						6
7 Respiratory Therapy						7
8 Psychiatric/Psychological Services						8
9 Individual Therapy						9
10 Group Therapy						10
11 Individualized Activity Therapy						11
12 Family Counseling						12
13 Diagnostic Services						13
14 App. Patient Training & Education						14
15 Prosthetic and Orthotic Devices						15
16 Drugs and Biologicals						16
17 Medical Supplies						17
18 Medical Appliances						18
19 Durable Medical Equipment - Rented						19
20 Durable Medical Equipment - Sold						20
21 All Other						21
22 Totals (sum of lines 1-21)						22
23 Total cost to be allocated						23
24 Unit Cost Multiplier						24

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

COMPONENT COST CENTER	PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE - KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nursing Hours of Service)	
	5	6	7	8	9	
1 Administrative and General						1
2 Skilled Nursing Care						2
3 Physical Therapy						3
4 Occupational Therapy						4
5 Speech Pathology						5
6 Medical Social Services						6
7 Respiratory Therapy						7
8 Psychiatric/Psychological Services						8
9 Individual Therapy						9
10 Group Therapy						10
11 Individualized Activity Therapy						11
12 Family Counseling						12
13 Diagnostic Services						13
14 App. Patient Training & Education						14
15 Prosthetic and Orthotic Devices						15
16 Drugs and Biologicals						16
17 Medical Supplies						17
18 Medical Appliances						18
19 Durable Medical Equipment - Rented						19
20 Durable Medical Equipment - Sold						20
21 All Other						21
22 Totals (sum of lines 1-21)						22
23 Total cost to be allocated						23
24 Unit Cost Multiplier						24

ALLOCATION OF GENERAL SERVICE COSTS
TO COST CENTERS FOR CMHC

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET J-1
PART II

COMPONENT CCN:

		CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE ()	
COMPONENT COST CENTER		10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Respiratory Therapy							7
8	Psychiatric/Psychological Services							8
9	Individual Therapy							9
10	Group Therapy							10
11	Individualized Activity Therapy							11
12	Family Counseling							12
13	Diagnostic Services							13
14	App. Patient Training & Education							14
15	Prosthetic and Orthotic Devices							15
16	Drugs and Biologicals							16
17	Medical Supplies							17
18	Medical Appliances							18
19	Durable Medical Equipment - Rented							19
20	Durable Medical Equipment - Sold							20
21	All Other							21
22	Totals (sum of lines 1-21)							22
23	Total cost to be allocated							23
24	Unit Cost Multiplier							24

COMPUTATION OF CMHC REHABILITATION COSTS	PROVIDER CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J - 2 PART 1
	COMPONENT CCN:		

PART I - APPORTIONMENT OF CMHC COST CENTERS

		Total Costs (from Wkst. J-1, Pt. I, col. 20)	Total Charges	Ratio of Costs to Charges	Title V		Title XVIII		Title XIX		
					Charges	Costs (col. 3 x col. 4)	Charges	Costs (col. 3 x col. 6)	Charges	Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	App. Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment - Rented										19
20	Durable Medical Equipment - Sold										20
21	All Other										21
22	Totals (sum of lines 2-21)										22

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

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR SNF-BASED COMMUNITY MENTAL HEALTH CENTER SERVICES		PROVIDER CCN: COMPONENT CCN:	PERIOD : FROM _____ TO _____	WORKSHEET J-3
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Check applicable box: <input type="checkbox"/> Title V <input type="checkbox"/> Title XVIII <input type="checkbox"/> Title XIX				
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	PROGRAM COST	
1 Cost of component services (from Wkst. J-2, Pt. II, line 31)		1
2 PPS payments received excluding outliers		2
3 Outlier payments		3
4 Primary payer payments		4
5 Total reasonable cost (see instructions)		5
CUSTOMARY CHARGES		
6 Total charges for program services		6
7 Excess of customary charges over reasonable cost (see instructions)		7
8 Excess of reasonable cost over customary charges (see instructions)		8
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
9 Total reasonable cost (see instructions)		9
10 Part B deductible billed to program patients		10
11 Part B coinsurance billed to program patients (from provider records)		11
12 Net cost (line 9 minus lines 10 and 11)		12
13 Allowable bad debts (from provider records) (see instructions)		13
13.01 Reimbursable bad debts (see instructions)		13.01
14 Allowable bad debts for dual eligible beneficiaries (see instructions)		14
15 Net reimbursable amount (see instructions)		15
16 Other adjustments (see instructions) (specify)		16
16.50 Demonstration payment adjustment amount before sequestration		16.50
16.55 Demonstration payment adjustment amount after sequestration		16.55
17 Total cost (see instructions)		17
17.01 Sequestration amount (see instructions)		17.01
18 Interim payments (see instructions)		18
19 Tentative settlement (for contractor use only)		19
20 Balance due component/program (see instructions)		20
21 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		21

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

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

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

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER CCN:

PERIOD :

FROM _____
TO _____

WORKSHEET K-1

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

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

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

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

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

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

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

COST ALLOCATION - HOSPICE
STATISTICAL BASIS

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET K-4
PART II

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		PLANT OPERATION & MAINT. (Square Feet)	TRANS- PORTATION (Mileage)	VOLUNTEER SERVICE COORDINATOR (Hours)	RECONCI- LIATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
	BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)							
	1	2	3	4	5	6A	6	7	
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Bldg. and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker-Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Cost to be allocated (per Wkst. K-4, Pt. I)									39
40 Unit Cost Multiplier									40

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

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

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

ALLOCATION OF GENERAL SERVICE
COSTS TO HOSPICE COST CENTERS

PROVIDER CCN:

PERIOD :

FROM _____
TO _____WORKSHEET K-5
Part I

HOSPICE COST CENTER (1)		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS				PROVIDER CCN: HOSPICE CCN:		PERIOD : FROM _____ TO _____		WORKSHEET K-5 Part I	
HOSPICE COST CENTER (1)		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE	SUBTOTAL (sum of cols. 3A through 15)	ALLOCATED HOSPICE A & G (see Pt. II)	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: HOSPICE CCN:		PERIOD : FROM _____ TO _____		WORKSHEET K-5, PART II	
HOSPICE COST CENTER (1)		CAPITAL RELATED BLDGS. & FIXTURES (Square Feet)	CAPITAL RELATED MOVABLE EQUIPMENT (Dollar Value)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	
		1	2	3	4a	4	
1	Administrative and General						1
2	Inpatient - General Care						2
3	Inpatient - Respite Care						3
4	Physician Services						4
5	Nursing Care						5
6	Nursing Care- Continuous Home Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech/ Language Pathology						9
10	Medical Social Services - Direct						10
11	Spiritual Counseling						11
12	Dietary Counseling						12
13	Counseling - Other						13
14	Home Health Aide and Homemakers						14
15	HH Aide & Homemaker - Cont. Home Care						15
16	Other						16
17	Drugs, Biologicals and Infusion						17
18	Analgesics						18
19	Sedative/Hypnotics						19
20	Other - Specify						20
21	Durable Medical Equipment/Oxygen						21
22	Patient Transportation						22
23	Imaging Services						23
24	Labs and Diagnostics						24
25	Medical Supplies						25
26	Outpatient Services (incl. E/R Dept.)						26
27	Radiation Therapy						27
28	Chemotherapy						28
29	Other						29
30	Bereavement Program Costs						30
31	Volunteer Program Costs						31
32	Fundraising						32
33	Other Program Costs						33
34	Totals (sum of lines 1 through 33)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier						36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: HOSPICE CCN:		PERIOD : FROM _____ TO _____		WORKSHEET K-5 PART II			
HOSPICE COST CENTER (1)		PLANT OPERATION MAINTENANCE & REPAIRS (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	HOUSE KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nursing Hours)	CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	
		5	6	7	8	9	10	11	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

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

PROVIDER CCN:

HOSPICE CCN:

PERIOD :

FROM _____
TO _____WORKSHEET K-5
PART II

HOSPICE COST CENTER (1)		MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE (Specify)	SUBTOTAL	ALLOCATED HOSPICE A&G	TOTAL HOSPICE COSTS	
		12	13	14	15	16	17	18	
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Total cost to be allocated								35
36	Unit Cost Multiplier								36

APPORTIONMENT OF HOSPICE SHARED SERVICES	PROVIDER CCN: HOSPICE CCN:	PERIOD : FROM _____ TO _____	WORKSHEET K-5 Part III
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PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

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

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

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

ANALYSIS OF SNF-BASED HOSPICE COSTS

					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM _____ TO _____	WORKSHEET O	
			SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
			1	2	3	4	5	6
GENERAL SERVICE COST CENTERS								
1	0100	Cap Rel Costs-Bldg & Fixt*						1
2	0200	Cap Rel Costs-Mvble Equip*						2
3	0300	Employee Benefits Department*						3
4	0400	Administrative & General *						4
5	0500	Plant Operation & Maintenance*						5
6	0600	Laundry & Linen Service*						6
7	0700	Housekeeping*						7
8	0800	Dietary*						8
9	0900	Nursing Administration*						9
10	1000	Routine Medical Supplies*						10
11	1100	Medical Records*						11
12	1200	Staff Transportation*						12
13	1300	Volunteer Service Coordination*						13
14	1400	Pharmacy*						14
15	1500	Physician Administrative Services*						15
16	1600	Other General Service*						16
17	1700	Patient/Residential Care Services						17
DIRECT PATIENT CARE SERVICE COST CENTERS								
25	2500	Inpatient Care-Contracted**						25
26	2600	Physician Services**						26
27	2700	Nurse Practitioner**						27
28	2800	Registered Nurse**						28
29	2900	LPN/LVN**						29
30	3000	Physical Therapy**						30
31	3100	Occupational Therapy**						31
32	3200	Speech/ Language Pathology**						32
33	3300	Medical Social Services**						33
34	3400	Spiritual Counseling**						34
35	3500	Dietary Counseling**						35
36	3600	Counseling - Other**						36
37	3700	Hospice Aide and Homemaker Services**						37
38	3800	Durable Medical Equipment/Oxygen**						38
39	3900	Patient Transportation**						39

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

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

ANALYSIS OF SNF-BASED HOSPICE COSTS

ANALYSIS OF SNF-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM _____ TO _____	WORKSHEET 0		
			SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)		
			1	2	3	4	5	6	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)									
40	4000	Imaging Services**							40
41	4100	Labs and Diagnostics**							41
42	4200	Medical Supplies-Non-routine**							42
43	4300	Outpatient Services**							43
44	4400	Palliative Radiation Therapy**							44
45	4500	Palliative Chemotherapy**							45
46		Other Patient Care Services **							46
NONREIMBURSABLE COST CENTERS									
60	6000	Bereavement Program *							60
61	6100	Volunteer Program *							61
62	6200	Fundraising*							62
63	6300	Hospice/Palliative Medicine Fellows*							63
64	6400	Palliative Care Program*							64
65	6500	Other Physician Services*							65
66	6600	Residential Care *							66
67	6700	Advertising*							67
68	6800	Telehealth/Telemonitoring*							68
69	6900	Thrift Store*							69
70	7000	Nursing Facility Room & Board*							70
71	7100	Other Nonreimbursable*							71
100		Total							100

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

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

ANALYSIS OF SNF-BASED HOSPICE COSTS
HOSPICE CONTINUOUS HOME CAREPROVIDER CCN: _____
HOSPICE CCN: _____PERIOD:
FROM _____
TO _____

WORKSHEET O-1

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

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

ANALYSIS OF SNF-BASED HOSPICE COSTS
HOSPICE ROUTINE HOME CAREPROVIDER CCN: _____
HOSPICE CCN: _____PERIOD:
FROM _____
TO _____

WORKSHEET O-2

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

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

ANALYSIS OF SNF-BASED HOSPICE COSTS
HOSPICE INPATIENT RESPITE CARE

					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM _____ TO _____	WORKSHEET O-3	
	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	
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 Services								46
100 Total *								100

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

ANALYSIS OF SNF-BASED HOSPICE COSTS
HOSPICE GENERAL INPATIENT CARE

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

HOSPICE CCN: _____

WORKSHEET O-4

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

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

COST ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE
NET EXPENSES FOR ALLOCATION

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

WORKSHEET O-5

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

COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS

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

COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____PERIOD:
FROM _____
TO _____WORKSHEET O-6
Part I

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

COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COST STATISTICAL BASIS

PROVIDER CCN: _____
HOSPICE CCN: _____PERIOD: _____
FROM _____
TO _____WORKSHEET O-6
PART II

Cost Center Descriptions	CAP REL BLDG & FIX (Square Feet)	CAP REL MVBLE EQUIP (Dollar Value)	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT (Square Feet)	LAUNDRY & LINEN (In-Facility Days)	HOUSE- KEEPING (Square Feet)	DIETARY (In-Facility Days)	
	1	2	3	4A	4	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Cap Rel Costs-Bldg & Fixt										1
2 Cap Rel Costs-Mvble Equip										2
3 Employee Benefits										3
4 Administrative & General										4
5 Plant Operation and Maintenance										5
6 Laundry & Linen Service										6
7 Housekeeping										7
8 Dietary										8
9 Nursing Administration										9
10 Routine Medical Supplies										10
11 Medical Records										11
12 Staff Transportation										12
13 Volunteer Service Coordination										13
14 Pharmacy										14
15 Physician Administrative Services										15
16 Other General Service										16
17 Patient/Residential Care Services										17
LEVEL OF CARE										
50 Hospice Continuous Home Care										50
51 Hospice Routine Home Care										51
52 Hospice Inpatient Respite Care										52
53 Hospice General Inpatient Care										53
NONREIMBURSABLE COST CENTERS										
60 Bereavement Program										60
61 Volunteer Program										61
62 Fundraising										62
63 Hospice/Palliative Medicine Fellows										63
64 Palliative Care Program										64
65 Other Physician Services										65
66 Residential Care										66
67 Advertising										67
68 Telehealth/Telemonitoring										68
69 Thrift Store										69
70 Nursing Facility Room & Board										70
71 Other Nonreimbursable										71
99 Negative Cost Center										99
101 Cost to be allocated (per Wkst. O-6, Part I)										101
102 Unit cost multiplier										102

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COST STATISTICAL BASIS

PROVIDER CCN: _____

HOSPICE CCN: _____

PERIOD:

FROM _____

TO _____

WORKSHEET O-6

Part II

		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 ADMINISTRA- TIVE SVCS (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENTIAL CARE SVCS (In-Facility Days)	TOTAL	
Cost Center Descriptions		9	10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS												
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
LEVEL OF CARE												
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
NONREIMBURSABLE COST CENTERS												
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
101	Cost to be allocated (per Wkst. O-6, Part I)											101
102	Unit cost multiplier											102

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

Cost Center Descriptions	Wkst. C, col. 3, line	Cost to Charge Ratio	Charges by LOC (from Provider Records)				Shared Service Costs by LOC				
			HCHC	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)	
	0	1	2	3	4	5	6	7	8	9	
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	44										1
2 Occupational Therapy	45										2
3 Speech/ Language Pathology	46										3
4 Drugs, Biological and Infusion Therapy	49										4
5 Durable Medical Equipment/Oxygen	51										5
6 Labs and Diagnostics	41										6
7 Medical Supplies	48										7
8 Outpatient Services (including E/R Dept.)	63										8
9 Radiation Therapy	40										9
10 Other	52										10
11 Totals (sum of lines 1 through 10)											11

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