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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S, PARTS I & II

Intermediary use only	[ ] Audited [ ] Desk Reviewed	Date Received: _____ Intermediary No. _____	[ ] Initial [ ] Reopening [ ] Final [ ] MCR Code	

PART I - CERTIFICATION

Check applicable box	[ ] Electronically filed cost report [ ] Manually submitted cost report	Date: _____	Time: _____

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 Names(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL					1
2	SUBPROVIDER					2
3	SWING BED - SNF					3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER (specify)					8
9	HEALTH CLINIC (specify)					9
100	TOTAL					100

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO	PERIOD: FROM_____ TO	WORKSHEET S-2 (CONT.)

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:		1
1.01	City: State:	Zip Code:	County:	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital								2
3	Subprovider								3
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7	Hospital-Based NF								7
8	Hospital-Based OLTC								8
9	Hospital-Based HHA								9
11	Separately Certified ASC								11
12	Hospital-Based Hospice								12
14	Hospital-Based Health Clinic (specify)								14
15	Outpatient Rehab. Clinic (specify)								15
16	Renal Dialysis								16

17	Cost Reporting Period (mm/dd/yyyy)	From:	To:		17
			1	2	
18	Type of Control (see instructions)				18
Type of hospital/subprovider (see instructions)					
19	Hospital				19
20	Subprovider				20

Other Information

21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.				21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106? Enter in column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.				21.01
21.02	Has your facility received a new geographic reclassification status change after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy) (See instructions)				21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural If you answered urban in column 1 indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy) (see instruction). Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA				21.03
21.04	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) urban and (2) rural.				21.04
21.05	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) urban and (2) rural.				21.05
21.06	Does this hospital qualifies for the three -year transition of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147? (See instructions). Enter "Y" for yes, and "N" for no.				21.06
21.07	Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA§147? Enter in column 1 "Y" for yes or "N" for no (see instructions) *Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Section 3121? Enter in colun 2 "Y" for yes or "N" for no.(See instructions)*				21.07
21.08	Which method is used to determine Medicaid days on S-3, Part I, col. 5 Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceeding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.				21.08
22	Are you classified as a referral center?				22

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PROVIDER NO	PERIOD: FROM TO	WORKSHEET S-2 (CONT.)

23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:					23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3					23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3					23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3.					23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3.					23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.					23.05
23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and term. in col. 3					23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.					23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in col.2 and termination date in col 3.					24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).					24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?					25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?					25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D, Parts III and IV and D-2, Part II if applicable.					25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians' services as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.					25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.					25.04
25.05	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns. (see instructions)					25.05
25.06	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR §413.79(c)(4)or 42 CFR §412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions).					25.06
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period. Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates.					26
26.01	Enter the applicable SCH dates: (see instructions) Beginning: Ending:					26.01
26.02	Enter the applicable SCH dates: (see instructions) Beginning: Ending:					26.02
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.					27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y" , if "N" complete lines 28.01 and 28.02.					28
28.01	If hospital based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instructions)					28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNP PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility					28.02
	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. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)					
28.03	Staffing					28.03
28.04	Recruitment					28.04
28.05	Retention of employees					28.05
28.06	Training					28.06
28.07	Other (Specify)					28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?					29

COMPLEX IDENTIFICATION DATA		FROM TO	(CONT.)	
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CFR 485.606ff)			30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.			30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services?(See instructions)			30.02
30.03	If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000).			30.03
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes, also complete Worksheet D-2, Part II, if applicable.			30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).			31

Miscellaneous Cost Reporting information					
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.				32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.				33
34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?				34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?				35

Prospective Payment System (PPS)-Capital		V	XVIII	XIX	
		1	2	3	
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)				36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320 ? (see instructions)				36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)				37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?				37.01

Title XIX inpatient services				
38	Do you have title XIX inpatient hospital services?			38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?			38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?			38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions)			38.03
38.04	Do you operate an ICF/MR facility for purposes of title XIX?			38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, *and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.)* If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.			40
40.01	Name: FI/Contractor's Name:	FI/Contractor's Number:		40.01
40.02	Street:	P. O. Box		40.02
40.03	City:	State:	Zip Code:	40.03
41	Are provider based physicians' costs included in Worksheet A?			41
42	Are physical therapy services provided by outside suppliers?			42
42.01	Are occupational therapy services provided by outside suppliers?			42.01
42.02	Are speech pathology services provided by outside suppliers?			42.02
43	Are respiratory therapy services provided by outside suppliers?			43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?			44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.			45
45.01	Was there a change in the statistical basis?			45.01
45.02	Was there a change in the order of allocation?			45.02
45.03	Was the change to the simplified cost finding method?			45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).			46

If this facility contains a 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. Enter "N" if not exempt. (See 42 CFR 413.13.)

		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital						47
48	Subprovider						48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers (specify)						51

			TO				
52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (see instructions)						52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV						52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.						53
53.01	MDH period beginning: ending:						53.01
54	List amounts of malpractice premiums and paid losses: Premiums: , Paid losses: , and/or Self insurance:						54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.						54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.						55
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.	Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	56
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
56.02							
57	Are you claiming nursing and allied health costs? (see instructions)						57
58	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.						58
58.01	If line 58 column 1 is Y, does this IRF have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with FR Vol. 70, No. 156 dated August 15, 2005 pg 47929? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)						58.01
59	Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. If yes have you made an election for100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (see instructions)						59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)						60
60.01	If line 60 column 1 is "Y", and the facility is an IPF subprovider, were residents training in this facility in its most recent cost reporting period filed before November 15, 2004? Enter "Y" for yes or "N" for no. Is this facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)(C)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instr.)						60.01
Multicampus							
61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.						61
	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County 1	State 2	Zip Code 3	CBSA 4	FTE/ Campus 5	
62	Name:						62
Settlement data							
63	Was the cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes and "N" for no in column 1. If column 1 is "Y", enter the "paid through" date of the PS&R in column 2 (mm/dd/yyyy)						63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
STATISTICAL DATA

PROVIDER NO.:

PERIOD
FROM _____
TO

WORKSHEET S-3,
PART I

	Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips: Title V	Title XVIII	Title XIX: Total Title XIX	Title XIX: Obs. Beds Admitted	Title XIX: Obs. Beds Not Adm	Total All Patients	Obs. Beds Admitted	Obs. Beds Not Adm	Interns & Residents FTEs: Total	Less I & R Replacing Non-Phys. Anesthetists	Net	Full Time Equivalent: Employees On Payroll	Nonpaid Workers	Discharges: Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	5.01	5.02	6	6.01	602	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 3, 4, 5 and 6, exclude Swing Bed, Observation Bed and Hospice days)																				1
2	HMO																				2
3	Hospital Adults & Peds. Swing Bed SNF																				3
4	Hospital Adults & Peds. Swing Bed NF																				4
5	Total Adults and Peds. (exclude observation beds) (see instructions)																				5
6	Intensive Care Unit																				6
7	Coronary Care Unit																				7
8	Burn Intensive Care Unit																				8
9	Surgical Intensive Care Unit																				9
10	Other Special Care																				10
11	Nursery																				11
12	Total (see instructions)																				12
13	RPCH\CAH visits																				13
14	Subprovider																				14
15	Skilled Nursing Facility																				15
16	Nursing Facility																				16
17	Other Long Term Care																				17
18	Home Health Agency																				18
20	ASC (Distinct Part)																				20
21	Hospice (Distinct Part)																				21
23	Outpatient Rehab. Provider (specify)																				23
24	RHC/FQHC (specify)																				24
25	Total (sum of lines 12-24)																				25
26	Observation Bed Days																				26
27	Ambulance Trips																				27
28	Employee discount days (see instru.)																				28
29	*Labor & delivery days (see instructions)*																				29

HOSPITAL WAGE INDEX INFORMATION	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART II

PART II - WAGE DATA

		Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)							1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A							4
4.01	Teaching physician salaries (see instructions)							4.01
5	Physician-Part B							5
5.01	Non-physician-Part B							5.01
6	Interns & residents (in an approved program)							6
6.01	Contract services, I&R (see instructions)							6.01
7	Home office personnel							7
8	SNF							8
8.01	Excluded area salaries (see instructions)							8.01
	OTHER WAGES & RELATED COSTS							
9	Contract labor (see instructions)							9
9.01	Pharmacy services under contract							9.01
9.02	Laboratory services under contract							9.02
9.03	Management and administrative services							9.03
10	Contract labor: physician-Part A							10
10.01	Teaching physician under contract (see instru.)							10.01
11	Home office salaries & wage-related costs							11
12	Home office: physician Part A							12
12.01	Teaching physician salaries (see instructions)							12.01
	WAGE-RELATED COSTS							
13	Wage-related costs (core)						CMS 339	13
14	Wage-related costs (other)						CMS 339	14
15	Excluded areas						CMS 339	15
16	Non-physician anesthetist Part A						CMS 339	16
17	Non-physician anesthetist Part B						CMS 339	17
18	Physician Part A						CMS 339	18
18.01	Part A teaching physicians (see instructions)						CMS 339	18.01
19	Physician Part B						CMS 339	19
19.01	Wage-related costs (RHC/FQHC)						CMS 339	19.01
20	Interns & residents (in an approved program)						CMS 339	20

HOSPITAL WAGE INDEX INFORMATION	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART III

PART II - WAGE DATA

		Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
		1	2	3	4	5	6	
	OVERHEAD COSTS - DIRECT SALARIES							
21	Employee Benefits							21
22	Administrative & General							22
22.01	Administrative & General under contract (see inst.)							22.01
23	Maintenance & Repairs							23
24	Operation of Plant							24
25	Laundry & Linen Service							25
26	Housekeeping							26
26.01	Housekeeping under contract (see instructions)							26.01
27	Dietary							27
27.01	Dietary under contract (see instructions)							27.01
28	Cafeteria							28
29	Maintenance of Personnel							29
30	Nursing Administration							30
31	Central Services and Supply							31
32	Pharmacy							32
33	Medical Records & Medical Records Library							33
34	Social Service							34
35	Other General Service							35

PART III - HOSPITAL WAGE INDEX SUMMARY

1	Net salaries (see instructions)							1
2	Excluded area salaries (see instructions)							2
3	Subtotal salaries (line 1 minus line 2)							3
4	Subtotal other wages & related costs (see inst.)							4
5	Subtotal wage-related costs (see inst.)							5
6	Total (sum of lines 3 thru 5)							6
7	Net salaries (see instructions)							7
8	Excluded area salaries							8
9	Subtotal salaries (line 7 minus line 8)							9
10	Subtotal other wages & related costs (see inst.)							10
11	Subtotal wage-related costs (see inst.)							11
12	Total (sum of lines 9 thru 11)							12
13	Total overhead costs (see inst.)							13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____ HHA NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County: _____

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Enter the number of hours in your normal work week _____

		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Directors and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service				6
7	Nursing Supervisor				7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY MSA CODES

		1	1.01	
19	How many MSAs in column 1 or CBSAs in column 1.01 did you provide services to during this cost reporting period.			19
20	List those MSA code(s) in column 1 and CBSA code(s) in column 1.01 serviced during this cost reporting period (line 20 contains the first code).			20

PPS ACTIVITY DATA - Applicable for Medicare Services Rendered on or after October 1, 2000

		Full Episodes							
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	SCIC within a PEP	SCIC only Episodes	Total (cols. 1-6)	
		1	2	3	4	5	6	7	
21	Skilled Nursing Visits								21
22	Skilled Nursing Visit Charges								22
23	Physical Therapy Visits								23
24	Physical Therapy Visit Charges								24
25	Occupational Therapy Visits								25
26	Occupational Therapy Visit Charges								26
27	Speech Pathology Visits								27
28	Speech Pathology Visit Charges								28
29	Medical Social Service Visits								29
30	Medical Social Service Visit Charges								30
31	Home Health Aide Visits								31
32	Home Health Aide Visit Charges								32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)								33
34	Other Charges								34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)								35
36	Total Number of Episodes (standard/non outlier)								36
37	Total Number of Outlier Episodes								37
38	Total Non-Routine Medical Supply Charges								38

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	PROVIDER NO.:	PERIOD: FROM TO	WORKSHEET S-5

RENAL DIALYSIS STATISTICS

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

TRANSPLANT INFORMATION

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

EPOIETIN

13	Net costs of Epoietin furnished to all maintenance dialysis patients by the provider.		13
13.01	Epoietin amount from Worksheet A for Home Dialysis program		13.01
14	Number of EPO units furnished relating to the renal dialysis department		14
14.01	Number of EPO units furnished relating to the home dialysis department		14.01

PHYSICIAN PAYMENT METHOD (enter "X" if method(s) is applicable)

15	MCP	INITIAL METHOD	15

ARANESP

16	Net costs of Aranesp furnished to all maintenance dialysis patients by the provider.		16
17	Aranesp amount from Worksheet A for Home Dialysis program		17
18	Number of Aransep units furnished relating to the renal dialysis department		18
19	Number of Aransep units furnished relating to the home dialysis department		19

HOSPITAL-BASED OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.	PERIOD: FROM_____ TO_____	WORKSHEET S-6

OUTPATIENT REHABILITATION PROVIDER - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Check Applicable Box	[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

Enter the number of hours in your normal workweek _____

		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	Is this component paid 100% under established fee schedules? If yes, enter "Y", if no, enter "N". If "Yes" you are not required to complete lines 1 through 18 above nor the related J series worksheets for cost reporting periods beginning on or after 4/1/2001.		19

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

PROVIDER NO.:

PERIOD:
FROM _____
TO

WORKSHEET S-7

	GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO October 1st		SERVICES ON OR AFTER October 1st		Services through (1) 4/1/2001 - 9/30/2001		High Cost (2) April 1, 2000	Swing Bed SNF	TOTAL (see instructions)	
			Rate	Days	Rate	Days	Rate	Days	Days	Days		
	1	2	3	3.01	4	4.01	4.02	4.03	4.05	4.06	5	
1	RUC											1
2	RUB											2
3	RUA											3
3.01	RUX											3.01
3.02	RUL											3.02
4	RVC											4
5	RVB											5
6	RVA											6
6.01	RVX											6.01
6.02	RVL											6.02
7	RHC											7
8	RHB											8
9	RHA											9
9.01	RHX											9.01
9.02	RHL											9.02
10	RMC											10
11	RMB											11
12	RMA											12
12.01	RMX											12
12.02	RML											12
13	RLB											13
14	RLA											14
14.01	RLX											14
15	SE3											15
16	SE2											16
17	SE1											17
18	SSC											18
19	SSB											19
20	SSA											20
21	CC2											21
22	CC1											22
23	CB2											23
24	CB1											24
25	CA2											25
26	CA1											26
27	IB2											27
28	IB1											28
29	IA2											29
30	IA1											30
31	BB2											31
32	BB1											32
33	BA2											33
34	BA1											34
35	PE2											35
36	PE1											36
37	PD2											37
38	PD1											38
39	PC2											39
40	PC1											40
41	PB2											41
42	PB1											42
43	PA2											43
44	PA1											44
45	AAA											45

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER NO.:	PERIOD: FROM _____ TO	WORKSHEET S-7 (CONT.)

	GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO October 1st		SERVICES ON OR AFTER October 1st		Services through (1) 4/1/2001 - 9/30/2001		High Cost (2) April 1, 2000	Swing Bed SNF	TOTAL (see instructions)	
			Rate	Days	Rate	Days	Rate	Days	Days	Days		
	1	2	3	3.01	4	4.01	4.02	4.03	4.05	4.06	5	
45.01	*ES3*											*45.01*
45.02	*ES2*											*45.02*
45.03	*ES1*											*45.03*
45.04	*HE2*											*45.04*
45.05	*HE1*											*45.05*
45.06	*HD2*											*45.06*
45.07	*HD1*											*45.07*
45.08	*HC2*											*45.08*
48.09	*HC1*											*48.09*
45.10	*HB2*											*45.10*
45.11	*HB1*											*45.11*
45.12	*LE2*											*45.12*
45.13	*LE1*											*45.13*
45.14	*LD2*											*45.14*
45.15	*LD1*											*45.15*
45.16	*LC2*											*45.16*
45.17	*LC1*											*45.17*
45.18	*LB2*											*45.18*
45.19	*LB1*											*45.19*
45.20	*CE2*											*45.20*
45.21	*CE1*											*45.21*
45.22	*CD2*											*45.22*
46	TOTAL											46

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additonal 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

(4) Additional Rugs were published in the "Federal Register", Vol. 74 No. 153 August 11, 2009, page 40288. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET S-8

Check Applicable Box:	[ ] RHC [ ] FQHC

Clinic Address and Identification:

1	Street:	1
1.01	City: State: Zip Code: County:	1.01
2	Designation (for FQHCs only) - Enter "R" for rural or "U" for urban	2

Source of Federal Funds:

		Grant Award	Date	
		1	2	
3	Community Health Center (Section 330(d), PHS Act)			3
4	Migrant Health Center (Section 329(d), PHS Act)			4
5	Health Services for the Homeless (Section 340(d), PHS Act)			5
6	Appalachian Regional Commission			6
7	Look-Alikes			7
8	Other (specify)			8

Physician Information:

		Physician name	Billing No.	
9	Physician(s) furnishing services at the clinic or under agreement (see instructions)			9

		Physician name	Hours	
10	Supervisory physician(s) and hours of supervision during period (see instructions)			10

11	Does this facility operate as other than an RHC or FQHC? If yes, indicate number of other operations in column 2. (Enter in subscripts of line 12 the type of other operation(s) and the operating hours.)			11

Facility hours of operations (1)

	Type 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	
12	Clinic															12

(1) Enter clinic hours of operation on line 12 and other type operations on subscripts of line 12 (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.

13	Have you received an approval for an exception to the productivity standard?			13
14	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			14
15	Provider name: _____ Provider number: _____			15

		V	XVIII	XIX	
16	Have you provided all or substantially all GME costs. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents. (See instructions)				16
17	Has the hospitals' bed size changed to less than 50 beds during the year for cost reporting periods overlapping 7/1/2001? Enter "Y" for yes and "N" for no. If yes. see instructions.				17

HOSPICE IDENTIFICATION DATA	PROVIDER NO.:_____ HOSPICE NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET S-9, PARTS I & II

PART I - ENROLLMENT DAYS

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

PART II - CENSUS DATA

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

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

HOSPITAL UNCOMPENSATED CARE DATA		PROVIDER NO.:	PERIOD: FROM_____ TO_____	WORKSHEET S-10	
Uncompensated Care Information					
1	Do you have a written charity care policy ?				1
2	Are patients write-offs identified as charity? If yes answer lines 2.01 thru 2.04				2
2.01	Is it at the time of admission?				2.01
2.02	Is it at the time of first billing?				2.02
2.03	Is it after some collection effort has been made?				2.03
2.04	Other methods of write-offs (specify)				2.04
3	Are charity write-offs made for partial bills?				3
4	Are charity determinations based upon administrative judgment without financial data?				4
5	Are charity determinations based upon income data only?				5
6	Are charity determinations based upon net worth (assets) data ?				6
7	Are charity determination based upon income and net worth data ?				7
8	Does your accounting system separately identify bad debt and charity care? If yes answer 8.01				8
8.01	Do you separately account for inpatient and outpatient services?				8.01
9	Is discerning charity from bad debt a high priority in your institution? If no answer 9.01 thru 9.04				9
9.01	Is it because there is not enough staff to determine eligibility?				9.01
9.02	Is it because there is no financial incentive to separate charity from bad debt?				9.02
9.03	Is it because there is no clear directive policy on charity determination?				9.03
9.04	Is it because your institution does not deem the distinction important?				9.04
10	If charity determinations are made based upon income data, what is the maximum income that can be earned by patients (single without dependent) and still determined to be a charity write off?				10
11	If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? If yes answer lines 11.01 thru 11.04				11
11.01	Is the percentage level used less than 100% of the Federal poverty level?				11.01
11.02	Is the percentage level used between 100% and 150% of the Federal poverty level?				11.02
11.03	Is the percentage level used between 150% and 200% of the Federal poverty level?				11.03
11.04	Is the percentage level used greater than or equal 200 % of the Federal poverty level?				11.04
12	Are partial write-offs given to higher income patients on a gradual scale?				12
13	Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses?				13
14	Is your hospital State or local government owned? If yes answer line 14.01 and 14.02				14
14.01	Do you receive direct financial support from that government entity for the purpose of providing uncompensated care?				14.01
14.02	What percentage of the amount on line 14.01 is from government funding?				14.02
15	Do you receive restricted grants for rendering care to charity patients?				15
16	Are other non-restricted grants used to subsidize charity care?				16
Uncompensated Care Revenues					
17	Revenues from uncompensated care				17
17.01	Gross Medicaid Revenues				17.01
18	Revenues from State and local indigent care programs				18
19	Revenues related to SCHIP (see instructions)				19
20	Restricted grants				20
21	Non-restricted grants				21
22	Total Gross Uncompensated Care Revenues				22
Uncompensated Care Costs					
23	Total charges for patients covered by State and local indigent care programs				23
24	Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)				24
25	Total State and local indigent care program cost (line 23 x line 24)				25
26	Total SCHIP charges from your records				26
27	Total SCHIP cost, (line 24 x line 26)				27
28	Total gross Medicaid charges from your records				28
29	Total gross Medicaid cost (line 24 x line 28)				29
30	Other uncompensated care charges from your records (see instructions)				30
31	Uncompensated care cost (line 24 x line 30)				31
32	Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)				32

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Old Capital Related Costs-Buildings and Fixtures								1
2	0200	Old Capital Related Costs-Movable Equipment								2
3	0300	New Capital Related Costs-Buildings and Fixtures								3
4	0400	New Capital Related Costs-Movable Equipment								4
5	0500	Employee Benefits								5
6	0600	Administrative and General								6
7	0700	Maintenance and Repairs								7
8	0800	Operation of Plant								8
9	0900	Laundry and Linen Service								9
10	1000	Housekeeping								10
11	1100	Dietary								11
12	1200	Cafeteria								12
13	1300	Maintenance of Personnel								13
14	1400	Nursing Administration								14
15	1500	Central Services and Supply								15
16	1600	Pharmacy								16
17	1700	Medical Records & Medical Records Library								17
18	1800	Social Service								18
19		Other General Service (specify)								19
20	2000	Nonphysician Anesthetists								20
21	2100	Nursing School								21
22	2200	Intern & Res. Service-Salary & Fringes (Approved)								22
23	2300	Intern & Res. Other Program Costs (Approved)								23
24	2400	Paramedical Ed. Program (specify)								24
		INPATIENT ROUTINE SERVICE COST CENTER								
25	2500	Adults and Pediatrics (General Routine Care)								25
26	2600	Intensive Care Unit								26
27	2700	Coronary Care Unit								27
28	2800	Burn Intensive Care Unit								28
29	2900	Surgical Intensive Care Unit								29
30		Other Special Care (specify)								30
31	3100	Subprovider (specify)								31
33	3300	Nursery								33
34	3400	Skilled Nursing Facility								34
35	3500	Nursing Facility								35
36	3600	Other Long Term Care								36

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3610)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO.:		PERIOD: FROM _____ TO _____			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		ANCILLARY SERVICE COST CENTERS								
37	3700	Operating Room								37
38	3800	Recovery Room								38
39	3900	Delivery Room and Labor Room								39
40	4000	Anesthesiology								40
41	4100	Radiology-Diagnostic								41
42	4200	Radiology-Therapeutic								42
43	4300	Radioisotope								43
44	4400	Laboratory								44
45	4500	PBP Clinical Laboratory Services-Program Only								45
46	4600	Whole Blood & Packed Red Blood Cells								46
47	4700	Blood Storing, Processing, & Trans.								47
48	4800	Intravenous Therapy								48
49	4900	Respiratory Therapy								49
50	5000	Physical Therapy								50
51	5100	Occupational Therapy								51
52	5200	Speech Pathology								52
53	5300	Electrocardiology								53
54	5400	Electroencephalography								54
55	5500	Medical Supplies Charged to Patients								55
55.30	*5530*	*Implantable Devices Charged to Patients*								*55.30*
56	5600	Drugs Charged to Patients								56
57	5700	Renal Dialysis								57
58	5800	ASC (Non-Distinct Part)								58
59		Other Ancillary (specify)								59
		OUTPATIENT SERVICE COST CENTERS								
60	6000	Clinic								60
61	6100	Emergency								61
62	6200	Observation Beds								62
63		Other Outpatient Service (specify)								63
		OTHER REIMBURSABLE COST CENTERS								
64	6400	Home Program Dialysis								64
65	6500	Ambulance Services								65
66	6600	Durable Medical Equipment-Rented								66
67	6700	Durable Medical Equipment-Sold								67
68		Other Reimbursable (specify)								68
69		Outpatient Rehabilitation Provider (specify)								69

FORM CMS-2552-96 (7/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3610)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO.: | PERIOD: | WORKSHEET A

							FROM _____ TO _____			
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
70	7000	Intern-Resident Service (not appvd. tchng. prgm.)								70
71	7100	Home Health Agency								71
		SPECIAL PURPOSE COST CENTERS								
82	8200	Lung Acquisition								82
83	8300	Kidney Acquisition								83
84	8400	Liver Acquisition								84
85	8500	Heart Acquisition								85
86		Other Organ Acquisition (specify)								86
88	8800	Interest Expense							- 0 -	88
89	8900	Utilization Review-SNF							- 0 -	89
90	9000	Other Capital-Related Costs (see instructions)							- 0 -	90
92	9200	Ambulatory Surgical Center (Distinct Part)								92
93	9300	Hospice								93
94		Other Special Purpose (specify)								94
95		SUBTOTALS (sum of lines 1-94)								95
		NONREIMBURSABLE COST CENTERS								
96	9600	Gift, Flower, Coffee Shop, & Canteen								96
97	9700	Research								97
98	9800	Physicians' Private Offices								98
99	9900	Nonpaid Workers								99
100		Other Nonreimbursable (specify)								100
101		TOTAL (sum of lines 95-100)				- 0 -				101

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3610)

RECLASSIFICATIONS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1												1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
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	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)											36

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

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS	PROVIDER NO:	PERIOD: FROM _____ TO	WORKSHEET A-7, PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

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

RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO.:	PERIOD: FROM _____ TO	WORKSHEET A-7, PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

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

*	Description	SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures								3
4	New Capital Related Costs-Movable Equipment								4
5	Total (sum of lines 1-4)								5

(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related Worksheet A-6 reclassificatons, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

*	Description	SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures								3
4	New Capital Related Costs-Movable Equipment								4
5	Total (sum of lines 1-4)								5

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 thru 4. Enter in each column the approporiate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 thru 4.

* All lines numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers.

ADJUSTMENTS TO EXPENSES | PROVIDER NO. | PERIOD: FROM _____ TO | WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER 3	LINE # 4	Wkst. A-7 Ref. 5	
1	Investment income - old buildings and fixtures (chapter 2)			Old Buildings and Fixtures	1		1
2	Investment income - old movable equipment (chapter 2)			Old Movable Equipment	2		2
3	Investment income - new buildings and fixtures (chapter 2)			New Buildings and Fixtures	3		3
4	Investment income - new movable equipment (chapter 2)			New Movable Equipment	4		4
5	Investment income - other (chapter 2)						5
6	Trade, quantity, and time discounts (chapter 8)						6
7	Refunds and rebates of expenses (chapter 8)						7
8	Rental of provider space by suppliers (chapter 8)						8
9	Telephone services (pay stations excluded) (chapter 21)						9
10	Television and radio service (chapter 21)						10
11	Parking lot (chapter 21)						11
12	Provider-based physician adjustment	Wkst. A-7					12
13	Sale of scrap, waste, etc. (chapter 23)						13
14	Related organization transactions (chapter 10)	Wkst. A-7					14
15	Laundry and linen service						15
16	Cafeteria-employees and guests						16
17	Rental of quarters to employee and others						17
18	Sale of medical and surgical supplies to other than patients						18
19	Sale of drugs to other than patients						19
20	Sale of medical records and abstracts						20
21	Nursing school (tuition, fees, books, etc.)						21
22	Vending machines						22
23	Income from imposition of interest, finance or penalty charges (chapter 21)						23
24	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						24
25	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst. A-7 Wkst. A-8		Respiratory Therapy	25		25
26	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst. A-7 Wkst. A-8		Physical Therapy	26		26
27	Adjustment for HHA physical therapy costs in excess of limitation	Wkst. A-7		HHA	27		27
28	Utilization review - physicians' compensation (chapter 21)			Utilization Review (UR)	28		28
29	Depreciation - old buildings and fixtures			Old Buildings and Fixtures	1		29
30	Depreciation - old movable equipment			Old Movable Equipment	2		30
31	Depreciation - new buildings and fixtures			New Buildings and Fixtures	3		31
32	Depreciation - new movable equipment			New Movable Equipment	4		32
33	Non-physician Anesthetist			Non-physician Anesthesia	29		33
34	Physicians' assistant						34
35	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst. A-8		Occupational Therapy	31		35
36	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst. A-8		Speech Pathology	32		36
37	Other adjustments (specify) (3)						37
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)						50

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER NO:	PERIOD: FROM_____ TO	WORKSHEET A-8-1

A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 14.							5

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

B. Interrelationship to related organization(s) and/or home office:

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5

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

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

PROVIDER-BASED PHYSICIANS ADJUSTMENTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-2

	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
101	TOTAL									101

	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
101	TOTAL									101

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3615)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS I & II

Check applicable box: ( ) Physical Therapy ( ) Respiratory Therapy

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instuctions).		1
2	Line 1 multiplied by 15 hours per week		2
	Number of unduplicated days in which the following categories, as appropriate, are on the provider's site and have the highest AHSEA, where applicable.		
3	Supervisors or therapists		3
4	Therapy assistants and no supervisors or therapists.		4
5	Registered Therapists		5
6	Certified Therapists		6
7	Non-registered, non-certified therapists		7
8	Number of unduplicated HHA visits - supervisors or therapists (see instructions)		8
9	Number of unduplicated HHA visits - therapy assistants (include only visits made by therapy assistant and in which supervisor and/or therapist was not present during the visit(s)) (see instructions)		9
10	Standard travel expense rate		10
11	Optional travel expense rate per mile		11

		Supervisors				Therapists							
		Reg.	Cert.	Non-Reg. Non-Cert.	Total	Reg.	Cert.	Non-Reg. Non-Cert.	Total	Assistants	Aides	Trainees	
		1	2	3	4	5	6	7	8	9	10	11	
12	Total hours worked												12
13	AHSEA (see instructions)												13
14	Standard travel allowance (enter ½ of the amounts from cols. 5-8, line 13, in cols. 1-4 and 5-8 and enter ½ the amount from col. 9, line 13 in col. 9)												14
15	Number of travel hours (HHA only)												15
16	Number of miles driven (HHA only)												16

PART II - SALARY EQUIVALENCY COMPUTATION

17	Supervisors total (column 4, line 12 times column 4, line 13)		17
18	Supervisory Registered Therapist (column 1, line 12 times column 1, line 13)		18
19	Supervisory Certified Therapists (column 2, line 12 times column 2, line 13)		19
20	Supervisory non-registered, non-certified therapists (column 3, line 12 times column 3, line 13)		20
21	Therapists total (column 8, line 12 times column 8, line 13)		21
22	Registered Therapists (column 5, line 12 tines column 5, line 13)		22

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.1-3616.2)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.	PERIOD FROM: TO:	WORKSHEET A-8-3, PARTS II, III, & IV

Check applicable box: ( ) Physical Therapy ( ) Respiratory Therapy

PART II (Continued) - SALARY EQUIVALENCY COMPUTATION

23	Certified Therapists (column 6, line 12 time column 6, line 13)		23
24	Non-registered, non-certified therapists (column 7, line 12 times column 7, line 13)		24
25	Assistants (column 9, line 12 times column 9, line 13)		25
26	Subtotal allowance amount (see instructions)		26
27	Aides (column 10, line 12 times column 10, line 13)		27
28	Trainees (column 11, line 12 times column 11, line 13)		28
29	Total allowance amount (see instructions)		29
	If the sum of columns 1-3 and 5-7 for respiratory therapy or columns 4, 8, and 9 for physical therapy is greater than line 2, make no entries on lines 30 and 31 and enter on line 32 the amount from line 29. Otherwise complete lines 30-32.		
30	Weighted average rate excluding aides and trainees		30
31	Weighted allowance excluding aides and trainees		31
32	Total salary equivalency (see instructions)		32

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

	Standard Travel Allowance		
33	Therapists total (line 3 times column 4, line 14)		33
34	Registered Therapists (line 5 times column 1, line 14)		34
35	Certified Therapists (line 6 times column 2, line 14)		35
36	Non-registered, non-certified therapists (line 7 times column 3, line 14)		36
37	Assistants (line 4 times column 9, line 14)		37
38	Subtotal (see instructions)		38
39	Standard travel expense (see instructions)		39
40	Total standard travel allowance and travel expense (sum of lines 38 and 39)		40

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

	Standard Travel Expense		
41	Therapists (line 8 times column 8, line 14)		41
42	Assistants (line 9 times column 9, line 14)		42
43	Subtotal (sum of lines 41 and 42)		43
44	Standard Travel Expense (line 10 times the sum of lines 8 and 9)		44
	Optional Travel Allowance and Optional Travel Expense		
45	Therapists (sum of columns 4 and 8, line 15 times column 8, line 13)		45
46	Assistants (column 9, line 15 times column 9, line 13)		46
47	Subtotal (sum of lines 45 and 46)		47
48	Optional Travel Expense (line 11 times the sum of columns 4, 8, and 9, line 16)		48
	Total Travel Allowance and Travel Expense - HHA Services. Complete one of the following three lines (49, 50, or 51, as appropriate).		
49	Standard Travel Allowance and Standard Travel Expense (sum of lines 43 and 44) (see instructions)		49
50	Optional Travel Allowance and Standard Travel Expense (sum of lines 47 and 44) (see instructions)		50
51	Optional Travel Allowance and Optional Travel Expense (sum of lines 47 and 48) (see instructions)		51

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS V, VI, & VII

Check applicable box: ( ) Physical Therapy ( ) Respiratory Therapy

		Therapists								
		Registered	Certified	Non-registered Non-certified	Total	Assistants	Aides	Trainees	Total	
	PART V - OVERTIME COMPUTATION	1	2	3	4	5	6	7	8	
52	Overtime hours worked during cost reporting period (if column 8, line 52, is zero or equal to or greater than 2,080, do not complete lines 53 through 60 and enter zero in each column on line 61)									52
53	Overtime rate (see instructions)									53
54	Total overtime (including base and overtime allowance) (line 52 times line 53)									54
	Calculation of Limitation									
55	Percentage of overtime hours by category (divide the hours in each column on line 52 by the total overtime worked - column 8, line 52)									55
56	Allocation of provider's standard workyear for one full-time employee times the percentages on line 55 (see instructions)									56
	Determination of Overtime Allowance									
57	Adjusted hourly salary equivalency amount (AHSEA) (see instructions)									57
58	Overtime cost limitation (line 56 times line 57)									58
59	Maximum overtime cost (enter the lesser of lines 54 or 58)									59
60	Portion of overtime already included in hourly computation at the AHSEA (multiply line 52 times line 57)									60
61	Overtime allowance (line 59 minus line 60. If negative, enter zero.) (column 8, see instructions)									61

	PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
62	Salary equilavency amount (from Part II, line 32)		62
63	Travel allowance and expense - provider site (from Part III, line 40)		63
64	Travel allowance and expense - HHA services (from Part IV, lines 49, 50, or 51)		64
65	Overtime allowance (from Part V, column 8, line 61)		65
66	Equipment cost (see instructions)		66
67	Supplies (see instructions)		67
68	Total allowance (sum of lines 62-67)		68
69	Total cost of outside supplier services (from your records)		69
70	Excess over limitation (line 69 minus line 68. If negative, enter zero. See instructions.)		70

	PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
71	Cost of outside supplier services - hospital (from your records)		71
72	Cost of outside supplier services - HHA (from your records)		72
73	Total cost (sum of lines 71 and 72. This amount must agree with the amount on line 69.)		73
74	Ratio of hospital cost of outside supplier services to total cost (line 71 divided by line 73)		74
75	Ratio of HHA cost of outside supplier services to total cost (line 72 divided by line 73)		75
76	Hospital excess of cost over limitation (line 70 times line 74) (transfer to Worksheet A-8, lines 25 or 26, as applicable)		76
77	HHA excess of cost over limitation (line 70 times line 75) (transfer to Worksheet A-8, line 27)		77

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.5-3616.7)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS I & II

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

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.

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

FORM CMS-2552-96 (5/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8-3616.10)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS III & IV

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

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

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

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

	Standard Travel Expense		
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
	Optional Travel Allowance and Optional Travel Expense		
40	Therapists (sum of columns 1 and 2, line 12 .01 times column 2, line 10)		40
41	Assistants (column 3, line 12.01 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		43
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		46

FORM CMS-2552-96 (12/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8, 3616.11-3616.12)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS V-VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	Cost of outside supplier services - (see instructions) (from your records)		66
67	Total cost (sum of line 66 and subscripts) (this line must agree with line 64)		67
68	Ratio of cost of outside supplier services to total cost (line 66 and subscripts divided by line 67)		68
69	Excess of cost over limitation (see instructions) (transfer to Wkst. A-8, lines as indicated in instructions)		69
70	Total excess of cost over limitation (sum of line 69 and subscripts of line 69) (this line must agree with line 65)		70

FORM CMS-2552-96 (5/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8 and 3616.13-3616.15)

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART I | COST

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
		0	BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2	BLDGS. & FIXTURES 3	MOVABLE EQUIPMENT 4	5	5A	6	7	8		
	GENERAL SERVICE COST CENTERS												
1	Old Capital Related Costs-Buildings and Fixtures											1	1
2	Old Capital Related Costs-Movable Equipment											2	2
3	New Capital Related Costs-Buildings and Fixtures											3	3
4	New Capital Related Costs-Movable Equipment											4	4
5	Employee Benefits											5	5
6	Administrative and General											6	6
7	Maintenance and Repairs											7	7
8	Operation of Plant											8	8
9	Laundry and Linen Service											9	9
10	Housekeeping											10	10
11	Dietary											11	11
12	Cafeteria											12	12
13	Maintenance of Personnel											13	13
14	Nursing Administration											14	14
15	Central Services and Supply											15	15
16	Pharmacy											16	16
17	Medical Records & Medical Records Library											17	17
18	Social Service											18	18
19	Other General Service (specify)											19	19
20	Nonphysician Anesthetists											20	20
21	Nursing School											21	21
22	Intern & Res. Service-Salary & Fringes (Approved)											22	22
23	Intern & Res. Other Program Costs (Approved)											23	23
24	Paramedical Ed. Program (specify)											24	24
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)											25	25
26	Intensive Care Unit											26	26
27	Coronary Care Unit											27	27
28	Burn Intensive Care Unit											28	28
29	Surgical Intensive Care Unit											29	29
30	Other Special Care Unit (specify)											30	30
31	Subprovider (specify)											31	31
33	Nursery											33	33
34	Skilled Nursing Facility											34	34
35	Nursing Facility											35	35
36	Other Long Term Care											36	36

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) FORM

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART I | COST

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	5	5A	6	7	8		
	ANCILLARY SERVICE COST CENTERS												
37	Operating Room											37	37
38	Recovery Room											38	38
39	Delivery Room and Labor Room											39	39
40	Anesthesiology											40	40
41	Radiology-Diagnostic											41	41
42	Radiology-Therapeutic											42	42
43	Radioisotope											43	43
44	Laboratory											44	44
45	PBP Clinical Laboratory Services-Program Only											45	45
46	Whole Blood & Packed Red Blood Cells											46	46
47	Blood Storing, Processing, & Trans.											47	47
48	Intravenous Therapy											48	48
49	Respiratory Therapy											49	49
50	Physical Therapy											50	50
51	Occupational Therapy											51	51
52	Speech Pathology											52	52
53	Electrocardiology											53	53
54	Electroencephalography											54	54
55	Medical Supplies Charged to Patients											55	55
55.30	*Implantable Devices Charged to Patients*											*55.30*	*55.30*
56	Drugs Charged to Patients											56	56
57	Renal Dialysis											57	57
58	ASC (Non-Distinct Part)											58	58
59	Other Ancillary (specify)											59	59
	OUTPATIENT SERVICE COST CENTERS												
60	Clinic											60	60
61	Emergency											61	61
62	Observation Beds											62	62
63	Other Outpatient Service (specify)											63	63
	OTHER REIMBURSABLE COST CENTERS												
64	Home Program Dialysis											64	64
65	Ambulance Services											65	65
66	Durable Medical Equipment-Rented											66	66
67	Durable Medical Equipment-Sold											67	67
68	Other Reimbursable (specify)											68	68
69	Outpatient Rehabilitation Provider (specify)											69	69
70	Intern-Resident Service (not appvd. tchng. prgm.)											70	70

FORM CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) FORM

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART I | COST

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	5	5A	6	7	8		
71	Home Health Agency											71	71
	SPECIAL PURPOSE COST CENTERS												
82	Lung Acquisition											82	82
83	Kidney Acquisition											83	83
84	Liver Acquisition											84	84
85	Heart Acquisition											85	85
86	Other Organ Acquisition (specify)											86	86
92	Ambulatory Surgical Center (Distinct Part)											92	92
93	Hospice											93	93
94	Other Special Purpose (specify)											94	94
95	SUBTOTALS (sum of lines 1-94)											95	95
	NONREIMBURSABLE COST CENTERS												
96	Gift, Flower, Coffee Shop, & Canteen											96	96
97	Research											97	97
98	Physicians' Private Offices											98	98
99	Nonpaid Workers											99	99
100	Other Nonreimbursable (specify)											100	100
101	Cross Foot Adjustments											101	101
102	Negative Cost Centers											102	102
103	TOTAL (sum of lines 95-102)											103	103

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617)

FORM

: ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART I | COST

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
GENERAL SERVICE COST CENTERS												
Old Capital Related Costs-Buildings and Fixtures											1	1
Old Capital Related Costs-Movable Equipment											2	2
New Capital Related Costs-Buildings and Fixtures											3	3
New Capital Related Costs-Movable Equipment											4	4
Employee Benefits											5	5
Administrative and General											6	6
Maintenance and Repairs											7	7
Operation of Plant											8	8
Laundry and Linen Service											9	9
Housekeeping											10	10
Dietary											11	11
Cafeteria											12	12
Maintenance of Personnel											13	13
Nursing Administration											14	14
Central Services and Supply											15	15
Pharmacy											16	16
Medical Records & Medical Records Library											17	17
Social Service											18	18
Other General Service (specify)											19	19
Nonphysician Anesthetists											20	20
Nursing School											21	21
Intern & Res. Service-Salary & Fringes (Approved)											22	22
Intern & Res. Other Program Costs (Approved)											23	23
Paramedical Ed. Program (specify)											24	24
INPATIENT ROUTINE SERVICE COST CENTERS												
Adults and Pediatrics (General Routine Care)											25	25
Intensive Care Unit											26	26
Coronary Care Unit											27	27
Burn Intensive Care Unit											28	28
Surgical Intensive Care Unit											29	29
Other Special Care Unit (specify)											30	30
Subprovider (specify)											31	31
Nursery											33	33
Skilled Nursing Facility											34	34
Nursing Facility											35	35
Other Long Term Care											36	36

M CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) FORM

: ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART I | COST

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
ANCILLARY SERVICE COST CENTERS												
Operating Room											37	37
Recovery Room											38	38
Delivery Room and Labor Room											39	39
Anesthesiology											40	40
Radiology-Diagnostic											41	41
Radiology-Therapeutic											42	42
Radioisotope											43	43
Laboratory											44	44
PBP Clinical Laboratory Services-Program Only											45	45
Whole Blood & Packed Red Blood Cells											46	46
Blood Storing, Processing, & Trans.											47	47
Intravenous Therapy											48	48
Respiratory Therapy											49	49
Physical Therapy											50	50
Occupational Therapy											51	51
Speech Pathology											52	52
Electrocardiology											53	53
Electroencephalography											54	54
Medical Supplies Charged to Patients											55	55
Implantable Devices Charged to Patents											*55.30*	*55.30*
Drugs Charged to Patients											56	56
Renal Dialysis											57	57
ASC (Non-Distinct Part)											58	58
Other Ancillary (specify)											59	59
OUTPATIENT SERVICE COST CENTERS												
Clinic											60	60
Emergency											61	61
Observation Beds											62	62
Other Outpatient Service (specify)											63	63
OTHER REIMBURSABLE COST CENTERS												
Home Program Dialysis											64	64
Ambulance Services											65	65
Durable Medical Equipment-Rented											66	66
Durable Medical Equipment-Sold											67	67
Other Reimbursable (specify)											68	68
Outpatient Rehabilitation Provider (specify)											69	69
Intern-Resident Service (not appvd. tchng. prgm.)											70	70

: ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART I | COST

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
Home Health Agency											71	71
SPECIAL PURPOSE COST CENTERS												
Lung Acquisition											82	82
Kidney Acquisition											83	83
Liver Acquisition											84	84
Heart Acquisition											85	85
Other Organ Acquisition (specify)											86	86
Ambulatory Surgical Center (Distinct Part)											92	92
Hospice											93	93
Other Special Purpose (specify)											94	94
SUBTOTALS (sum of lines 1-94)											95	95
NONREIMBURSABLE COST CENTERS												
Gift, Flower, Coffee Shop, & Canteen											96	96
Research											97	97
Physicians' Private Offices											98	98
Nonpaid Workers											99	99
Other Nonreimbursable (specify)											100	100
Cross Foot Adjustments											101	101
Negative Cost Centers											102	102
TOTAL (sum of lines 95-102)											103	103

' ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO:		PERIOD: FROM _____ TO _____		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
GENERAL SERVICE COST CENTERS										
Old Capital Related Costs-Buildings and Fixtures										1
Old Capital Related Costs-Movable Equipment										2
New Capital Related Costs-Buildings and Fixtures										3
New Capital Related Costs-Movable Equipment										4
Employee Benefits										5
Administrative and General										6
Maintenance and Repairs										7
Operation of Plant										8
Laundry and Linen Service										9
Housekeeping										10
Dietary										11
Cafeteria										12
Maintenance of Personnel										13
Nursing Administration										14
Central Services and Supply										15
Pharmacy										16
Medical Records & Medical Records Library										17
Social Service										18
Other General Service (specify)										19
Nonphysician Anesthetists										20
Nursing School										21
Intern & Res. Service-Salary & Fringes (Approved)										22
Intern & Res. Other Program Costs (Approved)										23
Paramedical Ed. Program (specify)										24
INPATIENT ROUTINE SERVICE COST CENTERS										
Adults and Pediatrics (General Routine Care)										25
Intensive Care Unit										26
Coronary Care Unit										27
Burn Intensive Care Unit										28
Surgical Intensive Care Unit										29
Other Special Care Unit (specify)										30
Subprovider (specify)										31
Nursery										33
Skilled Nursing Facility										34
Nursing Facility										35
Other Long Term Care										36

ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.:		PERIOD: FROM _____ TO		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (specify)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
ANCILLARY SERVICE COST CENTERS										
Operating Room										37
Recovery Room										38
Delivery Room and Labor Room										39
Anesthesiology										40
Radiology-Diagnostic										41
Radiology-Therapeutic										42
Radioisotope										43
Laboratory										44
PBP Clinical Laboratory Services-Program Only										45
Whole Blood & Packed Red Blood Cells										46
Blood Storing, Processing, & Trans.										47
Intravenous Therapy										48
Respiratory Therapy										49
Physical Therapy										50
Occupational Therapy										51
Speech Pathology										52
Electrocardiology										53
Electroencephalography										54
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										*55.30*
Drugs Charged to Patients										56
Renal Dialysis										57
ASC (Non-Distinct Part)										58
Other Ancillary (specify)										59
OUTPATIENT SERVICE COST CENTERS										
Clinic										60
Emergency										61
Observation Beds										62
Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										
Home Program Dialysis										64
Ambulance Services										65
Durable Medical Equipment-Rented										66
Durable Medical Equipment-Sold										67
Other Reimbursable (specify)										68
Outpatient Rehabilitation Provider (specify)										69
Intern-Resident Service (not appvd. tchng. prgm.)										70

: ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART I

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (specify)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
Home Health Agency										71
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition										84
Heart Acquisition										85
Other Organ Acquisition (specify)										86
Ambulatory Surgical Center (Distinct Part)										92
Hospice										93
Other Special Purpose (specify)										94
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Gift, Flower, Coffee Shop, & Canteen										96
Research										97
Physicians' Private Offices										98
Nonpaid Workers										99
Other Nonreimbursable (specify)										100
Cross Foot Adjustments										101
Negative Cost Centers										102
TOTAL (sum of lines 95-102)										103

ALLOCATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II | ALLOC

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED OLD CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
	GENERAL SERVICE COST CENTERS												
1	Old Capital Related Costs-Buildings and Fixtures											1	1
2	Old Capital Related Costs-Movable Equipment											2	2
3	New Capital Related Costs-Buildings and Fixtures											3	3
4	New Capital Related Costs-Movable Equipment											4	4
5	Employee Benefits											5	5
6	Administrative and General											6	6
7	Maintenance and Repairs											7	7
8	Operation of Plant											8	8
9	Laundry and Linen Service											9	9
10	Housekeeping											10	10
11	Dietary											11	11
12	Cafeteria											12	12
13	Maintenance of Personnel											13	13
14	Nursing Administration											14	14
15	Central Services and Supply											15	15
16	Pharmacy											16	16
17	Medical Records & Medical Records Library											17	17
18	Social Service											18	18
19	Other General Service (specify)											19	19
20	Nonphysician Anesthetists											20	20
21	Nursing School											21	21
22	Intern & Res. Service-Salary & Fringes (Approved)											22	22
23	Intern & Res. Other Program Costs (Approved)											23	23
24	Paramedical Education Program (specify)											24	24
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)											25	25
26	Intensive Care Unit											26	26
27	Coronary Care Unit											27	27
28	Burn Intensive Care Unit											28	28
29	Surgical Intensive Care Unit											29	29
30	Other Special Care Unit (specify)											30	30
31	Subprovider (specify)											31	31
33	Nursery											33	33
34	Skilled Nursing Facility											34	34
35	Nursing Facility											35	35
36	Other Long Term Care											36	36

ALLOCATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART II | ALLOC

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED OLD CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
	ANCILLARY SERVICE COST CENTERS												
37	Operating Room											37	37
38	Recovery Room											38	38
39	Delivery Room and Labor Room											39	39
40	Anesthesiology											40	40
41	Radiology-Diagnostic											41	41
42	Radiology-Therapeutic											42	42
43	Radioisotope											43	43
44	Laboratory											44	44
45	PBP Clinical Laboratory Services-Program Only											45	45
46	Whole Blood & Packed Red Blood Cells											46	46
47	Blood Storing, Processing, & Trans.											47	47
48	Intravenous Therapy											48	48
49	Respiratory Therapy											49	49
50	Physical Therapy											50	50
51	Occupational Therapy											51	51
52	Speech Pathology											52	52
53	Electrocardiology											53	53
54	Electroencephalography											54	54
55	Medical Supplies Charged to Patients											55	55
55.30	*Implantable Devices Charged to Patients*											*55.30*	*55.30*
56	Drugs Charged to Patients											56	56
57	Renal Dialysis											57	57
58	ASC (Non-Distinct Part)											58	58
59	Other Ancillary (specify)											59	59
	OUTPATIENT SERVICE COST CENTERS												
60	Clinic											60	60
61	Emergency											61	61
62	Observation Beds											62	62
63	Other Outpatient Service (specify)											63	63
	OTHER REIMBURSABLE COST CENTERS												
64	Home Program Dialysis											64	64
65	Ambulance Services											65	65
66	Durable Medical Equipment-Rented											66	66
67	Durable Medical Equipment-Sold											67	67
68	Other Reimbursable (specify)											68	68
69	Outpatient Rehabilitation Provider (specify)											69	69
70	Intern-Resident Service (not appvd. tchng. prgm.)											70	70

ALLOCATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART II | ALLOC

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED OLD CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
71	Home Health Agency											71	71
	SPECIAL PURPOSE COST CENTERS												
82	Lung Acquisition											82	82
83	Kidney Acquisition											83	83
84	Liver Acquisition											84	84
85	Heart Acquisition											85	85
86	Other Organ Acquisition (specify)											86	86
92	Ambulatory Surgical Center (Distinct Part)											92	92
93	Hospice											93	93
94	Other Special Purpose (specify)											94	94
95	SUBTOTALS (sum of lines 1-94)											95	95
	NONREIMBURSABLE COST CENTERS												
96	Gift, Flower, Coffee Shop, & Canteen											96	96
97	Research											97	97
98	Physicians' Private Offices											98	98
99	Nonpaid Workers											99	99
100	Other Nonreimbursable (specify)											100	100
101	Cross Foot Adjustments											101	101
102	Negative Cost Centers											102	102
103	TOTAL (sum lines 95-102)											103	103

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618) FORM

CATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
GENERAL SERVICE COST CENTERS												
Old Capital Related Costs-Buildings and Fixtures											1	1
Old Capital Related Costs-Movable Equipment											2	2
New Capital Related Costs-Buildings and Fixtures											3	3
New Capital Related Costs-Movable Equipment											4	4
Employee Benefits											5	5
Administrative and General											6	6
Maintenance and Repairs											7	7
Operation of Plant											8	8
Laundry and Linen Service											9	9
Housekeeping											10	10
Dietary											11	11
Cafeteria											12	12
Maintenance of Personnel											13	13
Nursing Administration											14	14
Central Services and Supply											15	15
Pharmacy											16	16
Medical Records & Medical Records Library											17	17
Social Service											18	18
Other General Service (specify)											19	19
Nonphysician Anesthetists											20	20
Nursing School											21	21
Intern & Res. Service-Salary & Fringes (Approved)											22	22
Intern & Res. Other Program Costs (Approved)											23	23
Paramedical Education Program (specify)											24	24
INPATIENT ROUTINE SERVICE COST CENTERS												
Adults and Pediatrics (General Routine Care)											25	25
Intensive Care Unit											26	26
Coronary Care Unit											27	27
Burn Intensive Care Unit											28	28
Surgical Intensive Care Unit											29	29
Other Special Care Unit (specify)											30	30
Subprovider (specify)											31	31
Nursery											33	33
Skilled Nursing Facility											34	34
Nursing Facility											35	35
Other Long Term Care											36	36

ATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
ANCILLARY SERVICE COST CENTERS												
Operating Room											37	37
Recovery Room											38	38
Delivery Room and Labor Room											39	39
Anesthesiology											40	40
Radiology-Diagnostic											41	41
Radiology-Therapeutic											42	42
Radioisotope											43	43
Laboratory											44	44
PBP Clinical Laboratory Services-Program Only											45	45
Whole Blood & Packed Red Blood Cells											46	46
Blood Storing, Processing, & Trans.											47	47
Intravenous Therapy											48	48
Respiratory Therapy											49	49
Physical Therapy											50	50
Occupational Therapy											51	51
Speech Pathology											52	52
Electrocardiology											53	53
Electroencephalography											54	54
Medical Supplies Charged to Patients											55	55
Implantable Devices Charged to Patients											*55.30*	*55.30*
Drugs Charged to Patients											56	56
Renal Dialysis											57	57
ASC (Non-Distinct Part)											58	58
Other Ancillary (specify)											59	59
OUTPATIENT SERVICE COST CENTERS												
Clinic											60	60
Emergency											61	61
Observation Beds											62	62
Other Outpatient Service (specify)											63	63
OTHER REIMBURSABLE COST CENTERS												
Home Program Dialysis											64	64
Ambulance Services											65	65
Durable Medical Equipment-Rented											66	66
Durable Medical Equipment-Sold											67	67
Other Reimbursable (specify)											68	68
Outpatient Rehabilitation Provider (specify)											69	69
Intern-Resident Service (not appvd. tchng. prgm.)											70	70

CATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
Home Health Agency											71	71
SPECIAL PURPOSE COST CENTERS												
Lung Acquisition											82	82
Kidney Acquisition											83	83
Liver Acquisition											84	84
Heart Acquisition											85	85
Other Organ Acquisition (specify)											86	86
Ambulatory Surgical Center (Distinct Part)											92	92
Hospice											93	93
Other Special Purpose (specify)											94	94
SUBTOTALS (sum of lines 1-94)											95	95
NONREIMBURSABLE COST CENTERS												
Gift, Flower, Coffee Shop, & Canteen											96	96
Research											97	97
Physicians' Private Offices											98	98
Nonpaid Workers											99	99
Other Nonreimbursable (specify)											100	100
Cross Foot Adjustments											101	101
Negative Cost Centers											102	102
TOTAL (sum lines 95-102)											103	103

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618) FORM

CATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART II

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
GENERAL SERVICE COST CENTERS										
Old Capital Related Costs-Buildings and Fixtures										1
Old Capital Related Costs-Movable Equipment										2
New Capital Related Costs-Buildings and Fixtures										3
New Capital Related Costs-Movable Equipment										4
Employee Benefits										5
Administrative and General										6
Maintenance and Repairs										7
Operation of Plant										8
Laundry and Linen Service										9
Housekeeping										10
Dietary										11
Cafeteria										12
Maintenance of Personnel										13
Nursing Administration										14
Central Services and Supply										15
Pharmacy										16
Medical Records & Medical Records Library										17
Social Service										18
Other General Service (specify)										19
Nonphysician Anesthetists										20
Nursing School										21
Intern & Res. Service-Salary & Fringes (Approved)										22
Intern & Res. Other Program Costs (Approved)										23
Paramedical Education Program (specify)										24
INPATIENT ROUTINE SERVICE COST CENTERS										
Adults and Pediatrics (General Routine Care)										25
Intensive Care Unit										26
Coronary Care Unit										27
Burn Intensive Care Unit										28
Surgical Intensive Care Unit										29
Other Special Care Unit (specify)										30
Subprovider (specify)										31
Nursery										33
Skilled Nursing Facility										34
Nursing Facility										35
Other Long Term Care										36

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618)

CATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART II

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
ANCILLARY SERVICE COST CENTERS										
Operating Room										37
Recovery Room										38
Delivery Room and Labor Room										39
Anesthesiology										40
Radiology-Diagnostic										41
Radiology-Therapeutic										42
Radioisotope										43
Laboratory										44
PBP Clinical Laboratory Services-Program Only										45
Whole Blood & Packed Red Blood Cells										46
Blood Storing, Processing, & Trans.										47
Intravenous Therapy										48
Respiratory Therapy										49
Physical Therapy										50
Occupational Therapy										51
Speech Pathology										52
Electrocardiology										53
Electroencephalography										54
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										*55.30*
Drugs Charged to Patients										56
Renal Dialysis										57
ASC (Non-Distinct Part)										58
Other Ancillary (specify)										59
OUTPATIENT SERVICE COST CENTERS										
Clinic										60
Emergency										61
Observation Beds										62
Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										
Home Program Dialysis										64
Ambulance Services										65
Durable Medical Equipment-Rented										66
Durable Medical Equipment-Sold										67
Other Reimbursable (specify)										68
Outpatient Rehabilitation Provider (specify)										69
Intern-Resident Service (not appvd. tchng. prgm.)										70

CMS-2552-96 (01/2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618)

CATION OF OLD CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART II

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
Home Health Agency										71
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition										84
Heart Acquisition										85
Other Organ Acquisition (specify)										86
Ambulatory Surgical Center (Distinct Part)										92
Hospice										93
Other Special Purpose (specify)										94
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Gift, Flower, Coffee Shop, & Canteen										96
Research										97
Physicians' Private Offices										98
Nonpaid Workers										99
Other Nonreimbursable (specify)										100
Cross Foot Adjustments										101
Negative Cost Centers										102
TOTAL (sum lines 95-102)										103

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618)

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART III | ALLOC

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
	GENERAL SERVICE COST CENTERS												
1	Old Capital Related Costs-Buildings and Fixtures											1	1
2	Old Capital Related Costs-Movable Equipment											2	2
3	New Capital Related Costs-Buildings and Fixtures											3	3
4	New Capital Related Costs-Movable Equipment											4	4
5	Employee Benefits											5	5
6	Administrative and General											6	6
7	Maintenance and Repairs											7	7
8	Operation of Plant											8	8
9	Laundry and Linen Service											9	9
10	Housekeeping											10	10
11	Dietary											11	11
12	Cafeteria											12	12
13	Maintenance of Personnel											13	13
14	Nursing Administration											14	14
15	Central Services and Supply											15	15
16	Pharmacy											16	16
17	Medical Records & Medical Records Library											17	17
18	Social Service											18	18
19	Other General Service (specify)											19	19
20	Nonphysician Anesthetists											20	20
21	Nursing School											21	21
22	Intern & Res. Service-Salary & Fringes (Approved)											22	22
23	Intern & Res. Other Program Costs (Approved)											23	23
24	Paramedical Education Program (specify)											24	24
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)											25	25
26	Intensive Care Unit											26	26
27	Coronary Care Unit											27	27
28	Burn Intensive Care Unit											28	28
29	Surgical Intensive Care Unit											29	29
30	Other Special Care Unit (specify)											30	30
31	Subprovider (specify)											31	31
33	Nursery											33	33
34	Skilled Nursing Facility											34	34
35	Nursing Facility											35	35
36	Other Long Term Care											36	36

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III | ALLOC

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
	ANCILLARY SERVICE COST CENTERS												
37	Operating Room											37	37
38	Recovery Room											38	38
39	Delivery Room and Labor Room											39	39
40	Anesthesiology											40	40
41	Radiology-Diagnostic											41	41
42	Radiology-Therapeutic											42	42
43	Radioisotope											43	43
44	Laboratory											44	44
45	PBP Clinical Laboratory Services-Program Only											45	45
46	Whole Blood & Packed Red Blood Cells											46	46
47	Blood Storing, Processing, & Trans.											47	47
48	Intravenous Therapy											48	48
49	Respiratory Therapy											49	49
50	Physical Therapy											50	50
51	Occupational Therapy											51	51
52	Speech Pathology											52	52
53	Electrocardiology											53	53
54	Electroencephalography											54	54
55	Medical Supplies Charged to Patients											55	55
55.30	*Implantable Devices Charged to Patients*											*55.30*	*55.30*
56	Drugs Charged to Patients											56	56
57	Renal Dialysis											57	57
58	ASC (Non-Distinct Part)											58	58
59	Other Ancillary (specify)											59	59
	OUTPATIENT SERVICE COST CENTERS												
60	Clinic											60	60
61	Emergency											61	61
62	Observation Beds											62	62
63	Other Outpatient Service (specify)											63	63
	OTHER REIMBURSABLE COST CENTERS												
64	Home Program Dialysis											64	64
65	Ambulance Services											65	65
66	Durable Medical Equipment-Rented											66	66
67	Durable Medical Equipment-Sold											67	67
68	Other Reimbursable (specify)											68	68
69	Outpatient Rehabilitation Provider (specify)											69	69
70	Intern-Resident Service (not appvd. tchng. prgm.)											70	70

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III | ALLOC.

	COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT		
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	4A	5	6	7	8		
71	Home Health Agency											71	71
	SPECIAL PURPOSE COST CENTERS												
82	Lung Acquisition											82	82
83	Kidney Acquisition											83	83
84	Liver Acquisition											84	84
85	Heart Acquisition											85	85
86	Other Organ Acquisition (specify)											86	86
92	Ambulatory Surgical Center (Distinct Part)											92	92
93	Hospice											93	93
94	Other Special Purpose (specify)											94	94
95	SUBTOTALS (sum of lines 1-94)											95	95
	NONREIMBURSABLE COST CENTERS												
96	Gift, Flower, Coffee Shop, & Canteen											96	96
97	Research											97	97
98	Physicians' Private Offices											98	98
99	Nonpaid Workers											99	99
100	Other Nonreimbursable (specify)											100	100
101	Cross Foot Adjustments											101	101
102	Negative Cost Centers											102	102
103	TOTAL (sum lines 95-102)											103	103

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618) FORM C

ATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART III | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
GENERAL SERVICE COST CENTERS												
Old Capital Related Costs-Buildings and Fixtures											1	1
Old Capital Related Costs-Movable Equipment											2	2
New Capital Related Costs-Buildings and Fixtures											3	3
New Capital Related Costs-Movable Equipment											4	4
Employee Benefits											5	5
Administrative and General											6	6
Maintenance and Repairs											7	7
Operation of Plant											8	8
Laundry and Linen Service											9	9
Housekeeping											10	10
Dietary											11	11
Cafeteria											12	12
Maintenance of Personnel											13	13
Nursing Administration											14	14
Central Services and Supply											15	15
Pharmacy											16	16
Medical Records & Medical Records Library											17	17
Social Service											18	18
Other General Service (specify)											19	19
Nonphysician Anesthetists											20	20
Nursing School											21	21
Intern & Res. Service-Salary & Fringes (Approved)											22	22
Intern & Res. Other Program Costs (Approved)											23	23
Paramedical Education Program (specify)											24	24
INPATIENT ROUTINE SERVICE COST CENTERS												
Adults and Pediatrics (General Routine Care)											25	25
Intensive Care Unit											26	26
Coronary Care Unit											27	27
Burn Intensive Care Unit											28	28
Surgical Intensive Care Unit											29	29
Other Special Care Unit (specify)											30	30
Subprovider (specify)											31	31
Nursery											33	33
Skilled Nursing Facility											34	34
Nursing Facility											35	35
Other Long Term Care											36	36

ATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
ANCILLARY SERVICE COST CENTERS												
Operating Room											37	37
Recovery Room											38	38
Delivery Room and Labor Room											39	39
Anesthesiology											40	40
Radiology-Diagnostic											41	41
Radiology-Therapeutic											42	42
Radioisotope											43	43
Laboratory											44	44
PBP Clinical Laboratory Services-Program Only											45	45
Whole Blood & Packed Red Blood Cells											46	46
Blood Storing, Processing, & Trans.											47	47
Intravenous Therapy											48	48
Respiratory Therapy											49	49
Physical Therapy											50	50
Occupational Therapy											51	51
Speech Pathology											52	52
Electrocardiology											53	53
Electroencephalography											54	54
Medical Supplies Charged to Patients											55	55
Implantable Devices Charged to Patients											*55.30*	*55.30*
Drugs Charged to Patients											56	56
Renal Dialysis											57	57
ASC (Non-Distinct Part)											58	58
Other Ancillary (specify)											59	59
OUTPATIENT SERVICE COST CENTERS												
Clinic											60	60
Emergency											61	61
Observation Beds											62	62
Other Outpatient Service (specify)											63	63
OTHER REIMBURSABLE COST CENTERS												
Home Program Dialysis											64	64
Ambulance Services											65	65
Durable Medical Equipment-Rented											66	66
Durable Medical Equipment-Sold											67	67
Other Reimbursable (specify)											68	68
Outpatient Rehabilitation Provider (specify)											69	69
Intern-Resident Service (not appvd. tchng. prgm.)											70	70

ATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III | ALLO

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	9	10	11	12	13	14	15	16	17	18		
Home Health Agency											71	71
SPECIAL PURPOSE COST CENTERS												
Lung Acquisition											82	82
Kidney Acquisition											83	83
Liver Acquisition											84	84
Heart Acquisition											85	85
Other Organ Acquisition (specify)											86	86
Ambulatory Surgical Center (Distinct Part)											92	92
Hospice											93	93
Other Special Purpose (specify)											94	94
SUBTOTALS (sum of lines 1-94)											95	95
NONREIMBURSABLE COST CENTERS												
Gift, Flower, Coffee Shop, & Canteen											96	96
Research											97	97
Physicians' Private Offices											98	98
Nonpaid Workers											99	99
Other Nonreimbursable (specify)											100	100
Cross Foot Adjustments											101	101
Negative Cost Centers											102	102
TOTAL (sum lines 95-102)											103	103

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618) FORM

CATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET B, PART III

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
GENERAL SERVICE COST CENTERS										
Old Capital Related Costs-Buildings and Fixtures										1
Old Capital Related Costs-Movable Equipment										2
New Capital Related Costs-Buildings and Fixtures										3
New Capital Related Costs-Movable Equipment										4
Employee Benefits										5
Administrative and General										6
Maintenance and Repairs										7
Operation of Plant										8
Laundry and Linen Service										9
Housekeeping										10
Dietary										11
Cafeteria										12
Maintenance of Personnel										13
Nursing Administration										14
Central Services and Supply										15
Pharmacy										16
Medical Records & Medical Records Library										17
Social Service										18
Other General Service (specify)										19
Nonphysician Anesthetists										20
Nursing School										21
Intern & Res. Service-Salary & Fringes (Approved)										22
Intern & Res. Other Program Costs (Approved)										23
Paramedical Education Program (specify)										24
INPATIENT ROUTINE SERVICE COST CENTERS										
Adults and Pediatrics (General Routine Care)										25
Intensive Care Unit										26
Coronary Care Unit										27
Burn Intensive Care Unit										28
Surgical Intensive Care Unit										29
Other Special Care Unit (specify)										30
Subprovider (specify)										31
Nursery										33
Skilled Nursing Facility										34
Nursing Facility										35
Other Long Term Care										36

CATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
ANCILLARY SERVICE COST CENTERS										
Operating Room										37
Recovery Room										38
Delivery Room and Labor Room										39
Anesthesiology										40
Radiology-Diagnostic										41
Radiology-Therapeutic										42
Radioisotope										43
Laboratory										44
PBP Clinical Laboratory Services-Program Only										45
Whole Blood & Packed Red Blood Cells										46
Blood Storing, Processing, & Trans.										47
Intravenous Therapy										48
Respiratory Therapy										49
Physical Therapy										50
Occupational Therapy										51
Speech Pathology										52
Electrocardiology										53
Electroencephalography										54
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										*55.30*
Drugs Charged to Patients										56
Renal Dialysis										57
ASC (Non-Distinct Part)										58
Other Ancillary (specify)										59
OUTPATIENT SERVICE COST CENTERS										
Clinic										60
Emergency										61
Observation Beds										62
Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										
Home Program Dialysis										64
Ambulance Services										65
Durable Medical Equipment-Rented										66
Durable Medical Equipment-Sold										67
Other Reimbursable (specify)										68
Outpatient Rehabilitation Provider (specify)										69
Intern-Resident Service (not appvd. tchng. prgm.)										70

CATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET B, PART III

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
Home Health Agency										71
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition										84
Heart Acquisition										85
Other Organ Acquisition (specify)										86
Ambulatory Surgical Center (Distinct Part)										92
Hospice										93
Other Special Purpose (specify)										94
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Gift, Flower, Coffee Shop, & Canteen										96
Research										97
Physicians' Private Offices										98
Nonpaid Workers										99
Other Nonreimbursable (specify)										100
Cross Foot Adjustments										101
Negative Cost Centers										102
TOTAL (sum lines 95-102)										103

[CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618)

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1 | COST A

	COST CENTER DESCRIPTIONS	OLD CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	OLD CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	NEW CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	NEW CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)		
		1	2	3	4	5	6A	6	7	8		
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures										1	1
2	Old Capital Related Costs-Movable Equipment										2	2
3	New Capital Related Costs-Buildings and Fixtures										3	3
4	New Capital Related Costs-Movable Equipment										4	4
5	Employee Benefits										5	5
6	Administrative and General										6	6
7	Maintenance and Repairs										7	7
8	Operation of Plant										8	8
9	Laundry and Linen Service										9	9
10	Housekeeping										10	10
11	Dietary										11	11
12	Cafeteria										12	12
13	Maintenance of Personnel										13	13
14	Nursing Administration										14	14
15	Central Services and Supply										15	15
16	Pharmacy										16	16
17	Medical Records & Medical Records Library										17	17
18	Social Service										18	18
19	Other General Service (specify)										19	19
20	Nonphysician Anesthetists										20	20
21	Nursing School										21	21
22	Intern & Res. Service-Salary & Fringes (Approved)										22	22
23	Intern & Res. Other Program Costs (Approved)										23	23
24	Paramedical Education Program (specify)										24	24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)										25	25
26	Intensive Care Unit										26	26
27	Coronary Care Unit										27	27
28	Burn Intensive Care Unit										28	28
29	Surgical Intensive Care Unit										29	29
30	Other Special Care Unit (specify)										30	30
31	Subprovider (specify)										31	31
33	Nursery										33	33
34	Skilled Nursing Facility										34	34
35	Nursing Facility										35	35
36	Other Long Term Care										36	36

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1 COST A

	COST CENTER DESCRIPTIONS	OLD CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	OLD CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	NEW CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	NEW CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)		
		1	2	3	4	5	6A	6	7	8		
	ANCILLARY SERVICE COST CENTERS											
37	Operating Room										37	37
38	Recovery Room										38	38
39	Delivery Room and Labor Room										39	39
40	Anesthesiology										40	40
41	Radiology-Diagnostic										41	41
42	Radiology-Therapeutic										42	42
43	Radioisotope										43	43
44	Laboratory										44	44
45	PBP Clinical Laboratory Services-Program Only										45	45
46	Whole Blood & Packed Red Blood Cells										46	46
47	Blood Storing, Processing, & Trans.										47	47
48	Intravenous Therapy										48	48
49	Respiratory Therapy										49	49
50	Physical Therapy										50	50
51	Occupational Therapy										51	51
52	Speech Pathology										52	52
53	Electrocardiology										53	53
54	Electroencephalography										54	54
55	Medical Supplies Charged to Patients										55	55
55.30	*Implantable Devices Charged to Patients*										*55.30*	*55.30*
56	Drugs Charged to Patients										56	56
57	Renal Dialysis										57	57
58	ASC (Non-Distinct Part)										58	58
59	Other Ancillary (specify)										59	59
	OUTPATIENT SERVICE COST CENTERS											
60	Clinic										60	60
61	Emergency										61	61
62	Observation Beds										62	62
63	Other Outpatient Service (specify)										63	63
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis										64	64
65	Ambulance Services										65	65
66	Durable Medical Equipment-Rented										66	66
67	Durable Medical Equipment-Sold										67	67
68	Other Reimbursable (specify)										68	68
69	Outpatient Rehabilitation Provider (specify)										69	69
70	Intern-Resident Service (not appvd. tchng. prgm.)										70	70

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1 | COST A

	COST CENTER DESCRIPTIONS	OLD CAPITAL RELATED COST		NEW CAPITAL RELATED COST		EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)		
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)							
		1	2	3	4	5	6A	6	7	8		
71	Home Health Agency										71	71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition										82	82
83	Kidney Acquisition										83	83
84	Liver Acquisition										84	84
85	Heart Acquisition										85	85
86	Other Organ Acquisition (specify)										86	86
92	Ambulatory Surgical Center (Distinct Part)										92	92
93	Hospice										93	93
94	Other Special Purpose (specify)										94	94
95	SUBTOTALS (sum of lines 1-94)										95	95
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, & Canteen										96	96
97	Research										97	97
98	Physicians' Private Offices										98	98
99	Nonpaid Workers										99	99
100	Other Nonreimbursable (specify)										100	100
101	Cross foot adjustments										101	101
102	Negative cost centers										102	102
103	Cost to be allocated (per Wkst. B, Part I)										103	103
104	Unit cost multiplier (Wkst. B, Part I)										104	104
105	Cost to be allocated (per Wkst. B, Part II)										105	105
106	Unit cost multiplier (Wkst. B, Part II)										106	106
107	Cost to be allocated (per Wkst. B, Part III)										107	107
108	Unit cost multiplier (Wkst. B, Part III)										108	108

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1 | COST A

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	9	10	11	12	13	14	15	16	17	18		
GENERAL SERVICE COST CENTERS												
Old Capital Related Costs-Buildings and Fixtures											1	1
Old Capital Related Costs-Movable Equipment											2	2
New Capital Related Costs-Buildings and Fixtures											3	3
New Capital Related Costs-Movable Equipment											4	4
Employee Benefits											5	5
Administrative and General											6	6
Maintenance and Repairs											7	7
Operation of Plant											8	8
Laundry and Linen Service											9	9
Housekeeping											10	10
Dietary											11	11
Cafeteria											12	12
Maintenance of Personnel											13	13
Nursing Administration											14	14
Central Services and Supply											15	15
Pharmacy											16	16
Medical Records & Medical Records Library											17	17
Social Service											18	18
Other General Service (specify)											19	19
Nonphysician Anesthetists											20	20
Nursing School											21	21
Intern & Res. Service-Salary & Fringes (Approved)											22	22
Intern & Res. Other Program Costs (Approved)											23	23
Paramedical Education Program (specify)											24	24
INPATIENT ROUTINE SERVICE COST CENTERS												
Adults and Pediatrics (General Routine Care)											25	25
Intensive Care Unit											26	26
Coronary Care Unit											27	27
Burn Intensive Care Unit											28	28
Surgical Intensive Care Unit											29	29
Other Special Care Unit (specify)											30	30
Subprovider (specify)											31	31
Nursery											33	33
Skilled Nursing Facility											34	34
Nursing Facility											35	35
Other Long Term Care											36	36

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO _____ | WORKSHEET B-1 | COST A

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	9	10	11	12	13	14	15	16	17	18		
ANCILLARY SERVICE COST CENTERS												
Operating Room											37	37
Recovery Room											38	38
Delivery Room and Labor Room											39	39
Anesthesiology											40	40
Radiology-Diagnostic											41	41
Radiology-Therapeutic											42	42
Radioisotope											43	43
Laboratory											44	44
PBP Clinical Laboratory Services-Program Only											45	45
Whole Blood & Packed Red Blood Cells											46	46
Blood Storing, Processing, & Trans.											47	47
Intravenous Therapy											48	48
Respiratory Therapy											49	49
Physical Therapy											50	50
Occupational Therapy											51	51
Speech Pathology											52	52
Electrocardiology											53	53
Electroencephalography											54	54
Medical Supplies Charged to Patients											55	55
Implantable Devices Charged to Patients											*55.30*	*55.30*
Drugs Charged to Patients											56	56
Renal Dialysis											57	57
ASC (Non-Distinct Part)											58	58
Other Ancillary (specify)											59	59
OUTPATIENT SERVICE COST CENTERS												
Clinic											60	60
Emergency											61	61
Observation Beds											62	62
Other Outpatient Service (specify)											63	63
OTHER REIMBURSABLE COST CENTERS												
Home Program Dialysis											64	64
Ambulance Services											65	65
Durable Medical Equipment-Rented											66	66
Durable Medical Equipment-Sold											67	67
Other Reimbursable (specify)											68	68
Outpatient Rehabilitation Provider (specify)											69	69
Intern-Resident Service (not appvd. tchng. prgm.)											70	70

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1 | COST A

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	9	10	11	12	13	14	15	16	17	18		
Home Health Agency											71	71
SPECIAL PURPOSE COST CENTERS												
Lung Acquisition											82	82
Kidney Acquisition											83	83
Liver Acquisition											84	84
Heart Acquisition											85	85
Other Organ Acquisition (specify)											86	86
Ambulatory Surgical Center (Distinct Part)											92	92
Hospice											93	93
Other Special Purpose (specify)											94	94
SUBTOTALS (sum of lines 1-94)											95	95
NONREIMBURSABLE COST CENTERS												
Gift, Flower, Coffee Shop, & Canteen											96	96
Research											97	97
Physicians' Private Offices											98	98
Nonpaid Workers											99	99
Other Nonreimbursable (specify)											100	100
Cross foot adjustments											101	101
Negative cost centers											102	102
Cost to be allocated (per Wkst. B, Part I)											103	103
Unit cost multiplier (Wkst. B, Part I)											104	104
Cost to be allocated (per Wkst. B, Part II)											105	105
Unit cost multiplier (Wkst. B, Part II)											106	106
Cost to be allocated (per Wkst. B, Part III)											107	107
Unit cost multiplier (Wkst. B, Part III)											108	108

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) FORM

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY AND FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
GENERAL SERVICE COST CENTERS										
Old Capital Related Costs-Buildings and Fixtures										1
Old Capital Related Costs-Movable Equipment										2
New Capital Related Costs-Buildings and Fixtures										3
New Capital Related Costs-Movable Equipment										4
Employee Benefits										5
Administrative and General										6
Maintenance and Repairs										7
Operation of Plant										8
Laundry and Linen Service										9
Housekeeping										10
Dietary										11
Cafeteria										12
Maintenance of Personnel										13
Nursing Administration										14
Central Services and Supply										15
Pharmacy										16
Medical Records & Medical Records Library										17
Social Service										18
Other General Service (specify)										19
Nonphysician Anesthetists										20
Nursing School										21
Intern & Res. Service-Salary & Fringes (Approved)										22
Intern & Res. Other Program Costs (Approved)										23
Paramedical Education Program (specify)										24
INPATIENT ROUTINE SERVICE COST CENTER										
Adults and Pediatrics (General Routine Care)										25
Intensive Care Unit										26
Coronary Care Unit										27
Burn Intensive Care Unit										28
Surgical Intensive Care Unit										29
Other Special Care Unit (specify)										30
Subprovider (specify)										31
Nursery										33
Skilled Nursing Facility										34
Nursing Facility										35
Other Long Term Care										36

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617)

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY AND FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
ANCILLARY SERVICE COST CENTERS										
Operating Room										37
Recovery Room										38
Delivery Room and Labor Room										39
Anesthesiology										40
Radiology-Diagnostic										41
Radiology-Therapeutic										42
Radioisotope										43
Laboratory										44
PBP Clinical Laboratory Services-Program Only										45
Whole Blood & Packed Red Blood Cells										46
Blood Storing, Processing, & Trans.										47
Intravenous Therapy										48
Respiratory Therapy										49
Physical Therapy										50
Occupational Therapy										51
Speech Pathology										52
Electrocardiology										53
Electroencephalography										54
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										*55.30*
Drugs Charged to Patients										56
Renal Dialysis										57
ASC (Non-Distinct Part)										58
Other Ancillary (specify)										59
OUTPATIENT SERVICE COST CENTERS										
Clinic										60
Emergency										61
Observation Beds										62
Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										
Home Program Dialysis										64
Ambulance Services										65
Durable Medical Equipment-Rented										66
Durable Medical Equipment-Sold										67
Other Reimbursable (specify)										68
Outpatient Rehabilitation Provider (specify)										69
Intern-Resident Service (not appvd. tchng. prgm.)										70

ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM _____ TO | WORKSHEET B-1

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY AND FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
Home Health Agency										71
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition										84
Heart Acquisition										85
Other Organ Acquisition (specify)										86
Ambulatory Surgical Center (Distinct Part)										92
Hospice										93
Other Special Purpose (specify)										94
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Gift, Flower, Coffee Shop, & Canteen										96
Research										97
Physicians' Private Offices										98
Nonpaid Workers										99
Other Nonreimbursable (specify)										100
Cross foot adjustments										101
Negative cost centers										102
Cost to be allocated (per Wkst. B, Part I)										103
Unit cost multiplier (Wkst. B, Part I)										104
Cost to be allocated (per Wkst. B, Part II)										105
Unit cost multiplier (Wkst. B, Part II)										106
Cost to be allocated (per Wkst. B, Part III)										107
Unit cost multiplier (Wkst. B, Part III)										108

CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617)

COMPUTATION OF RATIO OF COSTS TO CHARGES	PROVIDER NO.:		PERIOD: FROM _____ TO		WORKSHEET C, PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 27)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS					
25	Adults and Pediatrics (General Routine Care)					25
26	Intensive Care Unit					26
27	Coronary Care Unit					27
28	Burn Intensive Care Unit					28
29	Surgical Intensive Care Unit					29
30	Other Special Care (specify)					30
31	Subprovider					31
33	Nursery					33
34	Skilled Nursing Facility					34
35	Other Nursing Facility					35
36	Other Long Term Care					36
	ANCILLARY SERVICE COST CENTERS					
37	Operating Room					37
38	Recovery Room					38
39	Delivery Room and Labor Room					39
40	Anesthesiology					40
41	Radiology-Diagnostic					41
42	Radiology-Therapeutic					42
43	Radioisotope					43
44	Laboratory					44
45	PBP Clinical Laboratory Services-Prgm. Only					45
46	Whole Blood & Packed Red Blood Cells					46
47	Blood Storing, Processing, & Trans.					47
48	Intravenous Therapy					48
49	Respiratory Therapy					49
50	Physical Therapy					50
51	Occupational Therapy					51
52	Speech Pathology					52
53	Electrocardiology					53
54	Electroencephalography					54
55	Medical Supplies Charged to Patients					55
55.30	*Implantable Devices Charged to Patients*					*55.30*
56	Drugs Charged to Patients					56
57	Renal Dialysis					57
58	ASC (Non-Distinct Part)					58
59	Other Ancillary (specify)					59
	OUTPATIENT SERVICE COST CENTERS					
60	Clinic					60
61	Emergency					61
62	Observation Beds (see instructions)					62
63	Other Outpatient Service (specify)					63
	OTHER REIMBURSABLE COST CENTERS					
64	Home Program Dialysis					64
65	Ambulance Services					65
66	Durable Medical Equipment-Rented					66
67	Durable Medical Equipment-Sold					67
68	Other Reimbursable (specify)					68
101	Subtotal (sum of lines 25 thru 68)					101
102	Less Observation Beds					102
103	Total (line 101 minus line 102)					103

FORM CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3620 & 3620.1)

COMPUTATION OF RATIO OF COSTS TO CHARGES		PROVIDER NO.:			PERIOD: FROM _____ TO _____		WORKSHEET C, PART I (CONT.)	
		Charges						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
25	Adults and Pediatrics (General Routine Care)							25
26	Intensive Care Unit							26
27	Coronary Care Unit							27
28	Burn Intensive Care Unit							28
29	Surgical Intensive Care Unit							29
30	Other Special Care (specify)							30
31	Subprovider							31
33	Nursery							33
34	Skilled Nursing Facility							34
35	Other Nursing Facility							35
36	Other Long Term Care							36
	ANCILLARY SERVICE COST CENTERS							
37	Operating Room							37
38	Recovery Room							38
39	Delivery Room and Labor Room							39
40	Anesthesiology							40
41	Radiology-Diagnostic							41
42	Radiology-Therapeutic							42
43	Radioisotope							43
44	Laboratory							44
45	PBP Clinical Laboratory Services-Prgm. Only							45
46	Whole Blood & Packed Red Blood Cells							46
47	Blood Storing, Processing, & Trans.							47
48	Intravenous Therapy							48
49	Respiratory Therapy							49
50	Physical Therapy							50
51	Occupational Therapy							51
52	Speech Pathology							52
53	Electrocardiology							53
54	Electroencephalography							54
55	Medical Supplies Charged to Patients							55
55.30	*Implantable Devices Charged to Patients*							*55.30*
56	Drugs Charged to Patients							56
57	Renal Dialysis							57
58	ASC (Non-Distinct Part)							58
59	Other Ancillary (specify)							59
	OUTPATIENT SERVICE COST CENTERS							
60	Clinic							60
61	Emergency							61
62	Observation Beds (see instructions)							62
63	Other Outpatient Service (specify)							63
	OTHER REIMBURSABLE COST CENTERS							
64	Home Program Dialysis							64
65	Ambulance Services							65
66	Durable Medical Equipment-Rented							66
67	Durable Medical Equipment-Sold							67
68	Other Reimbursable (specify)							68
101	Subtotal (sum of lines 25 thru 68)							101
102	Less Observation Beds							102
103	Total (line 101 minus line 102)							103

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET C, PART II

	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS										
37	Operating Room										37
38	Recovery Room										38
39	Delivery Room and Labor Room										39
40	Anesthesiology										40
41	Radiology-Diagnostic										41
42	Radiology-Therapeutic										42
43	Radioisotope										43
44	Laboratory										44
45	PBP Clinical Laboratory Services-Prgm. Only										45
46	Whole Blood & Packed Red Blood Cells										46
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy										48
49	Respiratory Therapy										49
50	Physical Therapy										50
51	Occupational Therapy										51
52	Speech Pathology										52
53	Electrocardiology										53
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
56	Drugs Charged to Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59	Other Ancillary (specify)										59

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

PROVIDER NO.:

PERIOD
FROM: _____
TO:

WORKSHEET C, PART II (CONT.)

	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	OUTPATIENT SERVICE COST CENTERS										
60	Clinic										60
61	Emergency										61
62	Observation Beds (see instructions)										62
63	Other Outpatient Service (specify)										63
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66	Durable Medical Equipment - Rented										66
67	Durable Medical Equipment - Sold										67
68	Other Reimbursable (specify)										68
101	Subtotal (sum of lines 37-68)										101
102	Less Observation Beds										102
103	Total (sum of line 101 minus line 102)										103

FORM CMS-2552-96 (9/2000) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3620 & 3620.2)

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COST AND INPATIENT RPCH OPERATING COST	PROVIDER NO.:	PERIOD: FROM_____ TO	WORKSHEET C, PARTS III & IV

PART III - COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 27)	Total Ancillary Charges	Total Inpatient Ancillary Charges	Charge to Charge Ratio (col. 3 ÷ col. 2)	Total Inpatient Cost (col. 1 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
37	Operating Room						37
38	Recovery Room						38
39	Delivery Room and Labor Room						39
40	Anesthesiology						40
41	Radiology-Diagnostic						41
42	Radiology-Therapeutic						42
43	Radioisotope						43
44	Laboratory						44
45	PBP Clinical Laboratory Services-Prgm. Only						45
46	Whole Blood & Packed Red Blood Cells						46
47	Blood Storing, Processing, & Transfusion						47
48	Intravenous Therapy						48
49	Respiratory Therapy						49
50	Physical Therapy						50
51	Occupational Therapy						51
52	Speech Pathology						52
53	Electrocardiology						53
54	Electroencephalography						54
55	Medical Supplies Charged to Patients						55
56	Drugs Charged to Patients						56
57	Renal Dialysis						57
58	ASC (Non-Distinct Part)						58
59	Other Ancillary (specify)						59
	OUTPATIENT SERVICE COST CENTERS						
60	Clinic						60
61	Emergency						61
62	Observation Beds (see instructions)						62
63	Other Outpatient Services (specify)						63
	OTHER REIMBURSABLE COST CENTERS						
64	Home Program Dialysis						64
65	Ambulance Services						65
66	Durable Medical Equipment-Rented						66
67	Durable Medical Equipment-Sold						67
68	Other Reimbursable (specify)						68
101	Subtotal (sum of lines 37-68)						101

PART IV - COMPUTATION OF INPATIENT RPCH OPERATING COST

1	General inpatient routine services cost (see instructions)		1
2	Total inpatient ancillary service cost (Worksheet C, Part III, column 5, line 101)		2
3	Total inpatient service cost (sum of lines 1 and 2)		3
4	Total inpatient days (Worksheet S-3, Part I, column 6, line 1)		4
5	Inpatient service cost per diem (see instructions)		5

		Title V	Title XVIII	Title XIX	
		1	2	3	
6	Program inpatient service cost (line 5 times Wkst. D-1, line 9)				6
	PROGRAM INPATIENT ROUTINE SWING BED COST				
7	Program swing-bed (SNF/NF) inpatient routine cost through December 31 of the cost reporting period (Wkst. D-1, Part I, line 10 times line 17 for title XVIII and line 12 times line 19 for titles V and XIX)				7
8	Program swing-bed (SNF/NF) inpatient routine costs after December 31 of the cost reporting period (Wkst. D-1, Part I, line 11 times line 18 for title XVIII and line 13 times line 20 for titles V and XIX)				8
9	Total program swing-bed inpatient routine costs (line 7 plus line 8)				9

FROM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3620.3-3620.4)

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL	PROVIDER NO.:	PERIOD: FROM_____ TO	WORKSHEET C, PART V

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 27)	Provider-based Physician Adjustment (see instructions)	Total Costs (col. 1 + col. 2)	Total Ancillary Charges (from Wkst. C, Part III, col. 2)	Total Outpatient Charges (see instructions)	Ratio of Outpatient Charges to Total Charges (col. 5 ÷ col. 4)	Total Outpatient Costs (col. 3 x col. 6)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
37	Operating Room								37
38	Recovery Room								38
39	Delivery Room and Labor Room								39
40	Anesthesiology								40
41	Radiology-Diagnostic								41
42	Radiology-Therapeutic								42
43	Radioisotope								43
44	Laboratory								44
45	PBP Clinical Laboratory Services-Prgm. Only								45
46	Whole Blood & Packed Red Blood Cells								46
47	Blood Storing, Processing, & Transfusion								47
48	Intravenous Therapy								48
49	Respiratory Therapy								49
50	Physical Therapy								50
51	Occupational Therapy								51
52	Speech Pathology								52
53	Electrocardiology								53
54	Electroencephalography								54
55	Medical Supplies Charged to Patients								55
56	Drugs Charged to Patients								56
57	Renal Dialysis								57
58	ASC (Non-Distinct Part)								58
59	Other Ancillary (specify)								59

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL		PROVIDER NO.:		PERIOD: FROM_____ TO		WORKSHEET C, PART V (CONT.)	
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 27)	Provider-based Physician Adjustment (see instructions)	Total Costs (col. 1 + col. 2)	Total Ancillary Charges (from Wkst. C, Part III, col. 2)	Total Outpatient Charges (see instructions)	Ratio of Outpatient Charges to Total Charges (col. 5 ÷ col. 4)	Total Outpatient Costs (col. 3 x col. 6)	
		1	2	3	4	5	6	7	
	OUTPATIENT SERVICE COST CENTERS								
60	Clinic								60
61	Emergency								61
62	Observation Beds (see instructions)								62
63	Other Outpatient Services (specify)								63
	OTHER REIMBURSABLE COST CENTERS								
64	Home Program Dialysis								64
65	Ambulance Services								65
66	Durable Medical Equipment-Rented								66
67	Durable Medical Equipment-Sold								67
68	Other Reimbursable (specify)								68
101	Total (sum of lines 37-68)								101
102	Total outpatient visits								102
103	Aggregate cost per visit (line 101 ' line 102)								103
104	Title V outpatient visits								104
105	Title XVIII outpatient visits								105
106	Title XIX outpatient visits								106
107	Title V outpatient costs (line 103 x line 104)								107
108	Title XVIII outpatient costs (line 103 x line 105)								108
109	Title XIX outpatient costs (line 103 x line 106)								109

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3620.5)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER NO.:	PERIOD: FROM: _____ TO: _____	WORKSHEET D, PART I

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

	Cost Center Description	Old Capital: Capital Related Cost (from Wkst. B, Part II, col. 27)	Old Capital: Swing Bed Adj.	Old Capital: Reduced Capital Related Cost (col. 1 - col. 2)	New Capital: Capital Related Cost (from Wkst. B, Part III, col. 27)	New Capital: Swing Bed Adjustment	New Capital: Reduced Capital Related Cost (col. 4 - col. 5)	Total Patient Days	Inpatient Program Days	Old Capital: Per Diem (col. 3 ÷ col. 7)	Old Capital: Inpatient Program Capital Cost (col. 9 x col. 8)	New Capital: Per Diem (col. 6 ÷ col. 7)	New Capital: Inpatient Program Capital Cost (col. 11 x col. 8)	
		1	2	3	4	5	6	7	8	9	10	11	12	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS													
25	Adults & Pediatrics (General Routine Care)													25
26	Intensive Care Unit													26
27	Coronary Care Unit													27
28	Burn Intensive Care Unit													28
29	Surgical Intensive Care Unit													29
30	Other Special Care Unit (specify)													30
31	Subprovider													31
33	Nursery													33
101	Total (lines 25-33)													101

(A) Worksheet A line numbers

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3621.1)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET D, PART II

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

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital Capital Costs (col. 4 x col. 5)	New Capital Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37	Operating Room									37
38	Recovery Room									38
39	Delivery Room and Labor Room									39
40	Anesthesiology									40
41	Radiology-Diagnostic									41
42	Radiology-Therapeutic									42
43	Radioisotope									43
44	Laboratory									44
45	PBP Clinical Laboratory Services-Prgm. Only									45
46	Whole Blood & Packed Red Blood Cells									46
47	Blood Storing, Processing, & Transfusing									47
48	Intravenous Therapy									48
49	Respiratory Therapy									49
50	Physical Therapy									50
51	Occupational Therapy									51
52	Speech Pathology									52
53	Electrocardiology									53
54	Electroencephalography									54
55	Medical Supplies Charged to Patients									55
55.30	*Implantable Devices Charged to Patients*									*55.30*
56	Drugs Charged to Patients									56
57	Renal Dialysis									57
58	ASC (Non-Distinct Part)									58
59	Other Ancillary (specify)									59

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO.:_____ COMPONENT NO.:	PERIOD: FROM_____ TO	WORKSHEET D, PART II (CONT.)

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

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
60	Clinic									60
61	Emergency									61
62	Observation Beds									62
63	Other Outpatient Service (specify)									63
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66	Durable Medical Equipment-Rented									66
67	Durable Medical Equipment-Sold									67
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)									101

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO.:	PERIOD: FROM _____ TO	WORKSHEET D, PART III

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

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1+2, minus col. 3)	Total Patient Days	Per Diem (col. 4 ÷ col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col. 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)									25
26	Intensive Care Unit									26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30	Other Special Care Unit (specify)									30
31	Subprovider									31
33	Nursery									33
34	Skilled Nursing Facility									34
35	Nursing Facility									35
101	Total (sum of lines 25-35)									101

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO.:_____ COMPONENT NO.:	PERIOD: FROM_____ TO	WORKSHEET D, PART IV

Check applicable boxes	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/MR	[ ] PPS [ ] TEFRA

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 x col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 x col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37	Operating Room										37
38	Recovery Room										38
39	Delivery Room and Labor Room										39
40	Anesthesiology										40
41	Radiology-Diagnostic										41
42	Radiology-Therapeutic										42
43	Radioisotope										43
44	Laboratory										44
45	PBP Clinical Laboratory Services-Prgm. Only										45
46	Whole Blood & Packed Red Blood Cells										46
47	Blood Storing, Processing, & Tranfusing										47
48	Intravenous Therapy										48
49	Respiratory Therapy										49
50	Physical Therapy										50
51	Occupational Therapy										51
52	Speech Pathology										52
53	Electrocardiology										53
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
55.30	*Implantable Devices Charged to Patients*										*55.30*
56	Drugs Charged to Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59	Other Ancillary (specify)										59

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO.:_____ COMPONENT NO.:	PERIOD: FROM_____ TO	WORKSHEET D, PART IV (CONT.)

Check applicable boxes	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/MR	[ ] PPS [ ] TEFRA

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 x col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 x col. 8)	
		1	2	3	4	5	6	7	8	9	
	OUTPATIENT SERVICE COST CENTERS										
60	Clinic										60
61	Emergency										61
62	Observation Beds										62
63	Other Outpatient Service (specify)										63
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66	Durable Medical Equipment-Rented										66
67	Durable Medical Equipment-Sold										67
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)										101

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D, PARTS V & VI

Check Applicable Boxes	[ ] Title V - O/P	[ ] Hospital	[ ] NF	[ ] ICF/MR
	[ ] Title XVIII, Part B	[ ] Subprovider	[ ] Swing Bed SNF	
	[ ] Title XIX - O/P	[ ] SNF	[ ] Swing Bed NF	

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part II, col. 8	Part I, col. 9	Part II, col. 9	PROGRAM CHARGES Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	
(A)	ANCILLARY SERVICE COST CENTERS										
37	Operating Room										37
38	Recovery Room										38
39	Delivery & Labor Room										39
40	Anesthesiology										40
41	Radiology-Diagnostic										41
42	Radiology-Therapeutic										42
43	Radioisotope										43
44	Laboratory										44
45	PBP Clinic Laboratory Services-Prgm. Only										45
46	Whole Blood & Packed Red Blood Cells										46
47	Blood Storing, Processing, & Transfusing										47
48	Intravenous Therapy										48
49	Respiratory Therapy										49
50	Physical Therapy										50
51	Occupational Therapy										51
52	Speech Pathology										52
53	Electrocardiology										53
54	Electroencephalography										54
55	Medical Supplies Charged To Patients										55
55.30	*Implantable Devices Charged to Patients*										*55.30*
56	Drugs Charged To Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59	Other Ancillary (specify)										59

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D, PARTS V (Cont.) & VI

Check Applicable Boxes	[ ] Title V - O/P	[ ] Hospital	[ ] NF	[ ] ICF/MR
	[ ] Title XVIII, Part B	[ ] Subprovider	[ ] Swing Bed SNF	
	[ ] Title XIX - O/P	[ ] SNF	[ ] Swing Bed NF	

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part II, col. 8	Part I, col. 9	Part II, col. 9	PROGRAM CHARGES Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	
	OUTPATIENT SERVICE COST CENTERS										
60	Clinic										60
61	Emergency										61
62	Observation Bed										62
63	Other Outpatient Service (specify)										63
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance										65
66	Durable Medical Equipment-Rented										66
67	Durable Medical Equipment-Sold										67
68	Other Reimbursable Cost Center										68
101	Subtotal (see instructions)										101
102	CRNA Charges (see instructions)										102
103	Less PBP Clinic Lab. Services-Program Only Charges										103
104	Net Charges (line 101 ± lines 102 and 103)										104

(A) Worksheet A line numbers

(1) Report non hospital and non subprovider components cost for the period here (see instructions)

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 x line 2) (see instructions for transfer)		3

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D, PART V (Cont.)

Check Applicable Boxes	[ ] Title V - O/P	[ ] Hospital	[ ] NF	[ ] ICF/MR
	[ ] Title XVIII, Part B	[ ] Subprovider	[ ] Swing Bed SNF	
	[ ] Title XIX - O/P	[ ] SNF	[ ] Swing Bed NF	

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		PROGRAM COSTS								
		Outpatient Ambulatory Surgical Center (cols. 1 x 2)	Outpatient Radiology (cols. 1 x 3)	Other Outpatient Diagnostic (cols. 1 x 4)	All Other (cols. 1 x 5)	PPS services (columns 1.01 x 5.01)	All Other (columns 1.01 x 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P Part B Cost (columns 1.02 x 10)	
		6	7	8	9	9.01	9.02	10	11	
(A)	ANCILLARY SERVICE COST CENTERS									
37	Operating Room									37
38	Recovery Room									38
39	Delivery & Labor Room									39
40	Anesthesiology									40
41	Radiology-Diagnostic									41
42	Radiology-Therapeutic									42
43	Radioisotope									43
44	Laboratory									44
45	PBP Clinic Laboratory Services-Prgm. Only									45
46	Whole Blood & Packed Red Blood Cells									46
47	Blood Storing, Processing, & Transfusing									47
48	Intravenous Therapy									48
49	Respiratory Therapy									49
50	Physical Therapy									50
51	Occupational Therapy									51
52	Speech Pathology									52
53	Electrocardiology									53
54	Electroencephalography									54
55	Medical Supplies Charged To Patients									55
55.30	*Implantable Devices Charged to Patients*									*55.30*
56	Drugs Charged To Patients									56
57	Renal Dialysis									57
58	ASC (Non-Distinct Part)									58
59	Other Ancillary (specify)									59

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D, PART V (Cont.)

Check Applicable Boxes	[ ] Title V - O/P	[ ] Hospital	[ ] NF	[ ] ICF/MR
	[ ] Title XVIII, Part B	[ ] Subprovider	[ ] Swing Bed SNF	
	[ ] Title XIX - O/P	[ ] SNF	[ ] Swing Bed NF	

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		PROGRAM COSTS								
		Outpatient Ambulatory Surgical Center (cols. 1 x 2)	Outpatient Radiology (cols. 1 x 3)	Other Outpatient Diagnostic (cols. 1 x 4)	All Other (cols. 1 x 5)	PPS services (columns 1.01 x 5.01)	All Other (columns 1.01 x 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P Part B Cost (columns 1.02 x 10)	
		6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS									
60	Clinic									60
61	Emergency									61
62	Observation Bed									62
63	Other Outpatient Service (specify)									63
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance									65
66	Durable Medical Equipment-Rented									66
67	Durable Medical Equipment-Sold									67
68	Other Reimbursable Cost Center									68
101	Subtotal (see instructions)									101
102	CRNA Charges (see instructions)									102
103	Less PBP Clinic Lab. Services-Program Only Charges									103
104	Net Charges (line 101 ± lines 102 and 103)									104

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO.:	COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PART I

Check applicable boxes				
	[ ] Title V - I/P	[ ] Hospital	[ ] NF	[ ] PPS
	[ ] Title XVIII, Part A	[ ] Subprovider	[ ] ICF/MR	[ ] TEFRA
	[ ] Title XIX - I/P	[ ] SNF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)		1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		2
3	Private room days (excluding swing-bed private room days)		3
4	Semi-private room days (excluding swing-bed private room days)		4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days		9
10	Swing-bed SNF type inpatient days applicable to title XVIII (including private room days) through December 31 of the cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX (including private room days) through December 31 of the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO.:	COMPONENT NO.:	PERIOD: FROM _____ TO	WORKSHEET D-1, PART II

Check applicable boxes			
	[ ] Title V - I/P	[ ] Hospital	[ ] PPS
	[ ] Title XVIII, Part A	[ ] Subprovider	[ ] TEFRA
	[ ] Title XIX - I/P		[ ] Other

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)		38
39	Program general inpatient routine service cost (line 9 x line 38)		39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)		41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)		48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)		49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket.		58.02
58.03	If line 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 58.02), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
59.01	Allowable inpatient cost per discharge (line 59 divided by line 54) (LTCH only)		59.01
59.02	Program discharges prior to July 1		59.02
59.03	Program discharges after July 1		59.03
59.04	Program discharges (see instructions)		59.04
59.05	Reduced inpatient cost per discharge for discharges prior to July 1 (see instructions) (LTCH only)		59.05
59.06	Reduced inpatient cost per discharge for discharges after July 1 (see instructions) (LTCH only)		59.06
59.07	Reduced inpatient cost per discharge (see instructions) (LTCH only)		59.07
59.08	Reduced inpatient cost plus incentive payment (see instructions)		59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine costs (line 60 plus line 61) (title XVIII only). For CAH (see instructions)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		63
64	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO.:	COMPONENT NO.:	PERIOD: FROM _____ TO	WORKSHEET D-1, PARTS III & IV

Check applicable boxes	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P	[ ] Hospital [ ] NF [ ] Subprovider [ ] ICF/MR [ ] SNF	[ ] PPS [ ] TEFRA [ ] Other

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 x line 67)		68
69	Medically necessary private room cost applicable to Program (line 14 x line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 x line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine service costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 x line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

83	Total observation bed days (see instructions)		83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		84
85	Observation bed cost (line 83 x line 84) (see instructions)		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost						86
87	New capital-related cost						87
88	Non Physician Anesthetist						88
89	Medical Education						89

FORM CMS-2552-96 (11/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3622.3-3622.4)

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET D-2, PARTS I-III

PART I - NOT IN APPROVED TEACHING PROGRAM

	Cost Centers	Percent of Assigned Time	Expense Allocation	Total Inpatient Days - All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			1
	Hospital Inpatient Routine Services:				
2	Adults & pediatrics (general routine care)				2
3	Intensive care unit				3
4	Coronary care unit				4
5	Burn Intensive Care Unit				5
6	Surgical Intensive Care Unit				6
7	Other Special Care (specify)				7
8	Nursery				8
9	Subtotal (sum of lines 2 through 8)				9
10	Subprovider - Inpatient routine service				10
12	Skilled Nursing Facility				12
13	Nursing Facility				13
14	Other Long Term Care				14
15	Home Health Agency				15
16	Outpatient Rehabilitation Providers				16
17	Ambulatory Surgical Center				17
18	Hospice				18
19	Subtotal (sum of lines 9 through 18)				19
	Hospital Outpatient Services:			Total Charges (from Wkst. C. Part I, col. 8, lns 60 thru 63)	
20	Clinic				20
21	Emergency				21
22	Observation beds				22
23	Other Outpatient Service (specify)				23
24	Subtotal (sum of lines 20 through 23)				24
25	Total (sum of lines 19 and 24)	100.00			25

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

		Expenses allocated To cost centers on Wkst. B, Part I cols. 22 & 23	Swing bed Amount	Net cost (col. 1 plus col. 2)	
	Hospital Inpatient Routine Services:	1	2	3	
26	Adults & Pediatrics (general routine care)				26
27	Swing Bed - SNF				27
28	Swing Bed - NF				28
29	Intensive care unit				29
30	Coronary care unit				30
31	Burn Intensive Care Unit				31
32	Surgical Intensive Care Unit				32
33	Other Special Care (specify)				33
34	Subtotal (sum of lines 26, and 29 through 33)				34
35	Subprovider - Inpatient routine service				35
37	Skilled Nursing Facility				37
38	Total (sum of lines 34 through 37)				38

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

		Not In Approved Teaching Program (from Part I:)	Amount	
	Hospital	1	2	
39	Inpatient	col. 9, line 9		39
40	Outpatient	col. 9, line 24		40
41	Total Hospital (sum of lines 39 and 40)			41
42	Subprovider	col. 9, line 10		42
44	Skilled Nursing Facility	col. 9, line 12		44

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET D-2, PARTS I-III (Cont.)

PART I - NOT IN APPROVED TEACHING PROGRAM

		Health Care Program Inpatient Days						
	Average Cost Per Day	Title V	Title XVIII Part B	Title XIX	Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	4	5	6	7	8	9	10	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
12								11
13								12
14								14
15								15
16								16
17								17
18								18
19								19

	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges			Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title V	Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX	
20								20
21								21
22								22
23								23
24								24
25								25

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

	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)				
	4	5	6	7				
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
37								37
38								38

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

	In Approved Teaching Program		Total Title XVIII Costs					
	(from Part II, col. 7, -	Amount	to Wkst. E, Part B -	(col. 2 + col. 4)				
	3	4	5	6				
39	line 34							39
40								40
41			line 2					41
42	line 35		line 2					42
44	line 37		line 2					44

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D-4

Check Applicable Boxes					
	[ ] Title V	[ ] Hospital	[ ] NF	[ ] ICF/MR	[ ] PPS
	[ ] Title XVIII, Part A	[ ] Subprovider	[ ] Swing-Bed SNF		[ ] TEFRA
	[ ] Title XIX	[ ] SNF	[ ] Swing-Bed NF		[ ] Other

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)				25
26	Intensive Care Unit				26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30	Other Special Care Unit (specify)				30
31	Subprovider				31
	ANCILLARY SERVICE COST CENTERS				
37	Operating Room				37
38	Recovery Room				38
39	Delivery Room and Labor Room				39
40	Anesthesiology				40
41	Radiology-Diagnostic				41
42	Radiology-Therapeutic				42
43	Radioisotope				43
44	Laboratory				44
45	PBP Clinic Laboratory Services-Program Only				45
46	Whole Blood and Packed Red Blood Cells				46
47	Blood Storing, Processing, & Transfusing				47
48	Intravenous Therapy				48
49	Respiratory Therapy				49
50	Physical Therapy				50
51	Occupational Therapy				51
52	Speech Pathology				52
53	Electrocardiology				53
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	*Implantable Devices Charged to Patients*				*55.30*
56	Drugs Charged to Patients				56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59	Other Ancillary (specify)				59
	OUTPATIENT SERVICE COST CENTERS				
60	Clinic				60
61	Emergency				61
62	Observation Beds				62
63	Other Outpatient Service (specify)				63
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66	DME-Rented				66
67	DME-Sold				67
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)				101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)				103

(A) Worksheet A line numbers

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES	PROVIDER NO.: _____ OPO NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-6, PART I

Check Applicable Box	[ ] HEART	[ ] LIVER	[ ] PANCREAS	[ ] ISLET
	[ ] KIDNEY	[ ] LUNG	[ ] INTESTINE	[ ] OTHER (specify)

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

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

	Computation of Ancillary Service Cost Applicable to Organ Acquisition	Ratio of Cost/ Charges (from Wkst. C, Part I)		Organ Acquisition Ancillary Charges	Organ Acquisition Ancillary Costs	
		C	1	2	3	
8	Operating Room	37				8
9	Recovery Room	38				9
10	Delivery Room & Labor Room	39				10
11	Anesthesiology	40				11
12	Radiology-Diagnostic	41				12
13	Radiology-Theraputic	42				13
14	Radioisotope	43				14
15	Laboratory	44				15
16	PBP Clinical Laboratory Services-Program Only	45				16
17	Whole Blood & Packed Red Blood Cells	46				17
18	Blood Storage, Processing, & Transfusing	47				18
19	IV Therapy	48				19
20	Respiratory Therapy	49				20
21	Physical Therapy	50				21
22	Occupational Therapy	51				22
23	Speech Pathology	52				23
24	Electrocardiology	53				24
25	Electroencephalography	54				25
26	Medical Supplies Charged to Patients	55				26
26.30	*Implantable Devices Charged to Patients*	55.30				*26.30*
27	Drugs Charged to Patients	56				27
28	Renal Dialysis	57				28
29	ASC (non-distinct part)	58				29
30	Other Ancillary (specify)	59				30
31	Clinic	60				31
32	Emergency Room	61				32
33	Observation Beds	62				33
34	Other Outpatient Service (specify)	63				34
35	TOTAL (sum of lines 8-34)					35

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES	PROVIDER NO.: _____ OPO NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-6, PART II

Check Applicable Box				
	[ ] HEART	[ ] LIVER	[ ] PANCREAS	[ ] ISLET
	[ ] KIDNEY	[ ] LUNG	[ ] INTESTINE	[ ] OTHER (specify)

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

	Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program	Average Cost Per Day (from Wkst. D-2, Part I, col. 4) D	1	Organ Acquisition Days 2	Organ Acquisition Costs (col. 1 x col. 2) 3	
36	Adults & Pediatrics (General routine care)	2				36
37	Intensive Care Unit	3				37
38	Coronary Care Unit	4				38
39	Burn Intensive Care Unit	5				39
40	Surgical Intensive Care Unit	6				40
41	Other Special Care (specify)	7				41
42	TOTAL (sum of lines 36 through 41)					42

	Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program	Organ Charges (see instructions) 1	Ratio of Cost To Charges from Wkst. D-2, Part I, col. 4) D	2	Organ Acquisition Costs (col. 1 x col. 2) 3	
43	Clinic		20			43
44	Emergency		21			44
45	Observation Beds		22			45
46	Other Outpatient Service (specify)		23			46
47	TOTAL (sum of lines 43 through 46)					47

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

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES	PROVIDER NO.: _____ OPO NO.:	PERIOD: FROM _____ TO _____	WORKSHEET D-6, PARTS III & IV

Check Applicable Box	[ ] HEART	[ ] LIVER	[ ] PANCREAS	[ ] ISLET
	[ ] KIDNEY	[ ] LUNG	[ ] INTESTINE	[ ] OTHER (specify)

PART III - SUMMARY OF COSTS AND CHARGES

		Cost		Charges		
		Part A	Part B	Part A	Part B	
		1	2	3	4	
48	Routine and Ancillary from Part I					48
49	Interns and Residents (inpatient)					49
50	Interns and Residents (outpatient)					50
51	Direct Organ Acquisition (see instructions)					51
52	Cost of Services of Teaching Physicians (Wkst. D-9)					52
53	Total (sum of lines 48 thru 52)					53
54	Total Usable Organs (see instructions)					54
55	Medicare Usable Organs (see instructions)					55
56	Ratio of Medicare Usable Organs to Total Usable Organs (line 55 ÷ line 54)					56
57	Medicare Cost/Charges (see instructions)					57
58	Revenue for Organs Sold					58
59	Subtotal (line 57 minus line 58)					59
60	Organs Furnished Part B					60
61	Net Organ Acquisition Cost and Charges (see instructions)					61

PART IV - STATISTICS

		Living Related	Cadaveric	Revenue	
		1	2	3	
62	Organs Excised in Provider (1)				62
63	Organs Purchased from Other Transplant Hospitals (2)				63
64	Organs Purchased from Non-Transplant Hospitals				64
65	Organs Purchased from OPOs				65
66	Total (sum of lines 62 thru 65)				66
67	Organs Transplanted				67
68	Organs Sold to Other Hospitals				68
69	Organs Sold to OPOs				69
70	Organs Sold to Transplant Hospitals				70
71	Organs Sold to Military or VA Hospitals				71
72	Organs Sold Outside the U.S.				72
73	Organs Sent Outside the U.S. (no revenue received)				73
74	Organs Used for Research				74
75	Unusable/Discarded Organs				75
76	Total (sum of lines 67 thru 75 should equal line 66)				76

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

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

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS REASONABLE COMPENSATION EQUIVALENT COMPUTATION	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET D-9, PART I

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

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

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

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3626-3626.1)

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS	PROVIDER NO.:	PERIOD: FROM_____ TO_____	WORKSHEET D-9, PART II

Check Applicable Box: [ ] Hospital [ ] Subprovider

		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)	
		1	2	3	
1	Adjusted Cost of Physician's Direct Medical and Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days				2
3	Average Per Diem (line 1 ÷ line 2)				3
	HEALTH CARE PROGRAM REIMBURSABLE DAYS				
4	Title V - Inpatient				4
5	Title V - Outpatient				5
6	Title XVIII - Part A				6
7	Title XVIII - Part B				7
8	Title XIX - Inpatient				8
9	Title XIX - Outpatient				9
10	Inpatient and Outpatient Kidney Acquisition				10
11	Inpatient and Outpatient Liver Acquisition				11
12	Inpatient and Outpatient Heart Acquisition				12
13	Inpatient and Outpatient Lung Acquisition				13
13.01	Inpatient and Outpatient Pancreas Acquisition				13.01
13.02	Inpatient and Outpatient Intestine Acquisition				13.02
13.03	Inpatient and Outpatient Islet Acquisition				13.03
	HEALTH CARE PROGRAM REIMBURSABLE COST				
14	Title V - Inpatient (line 3 x line 4)				14
15	Title V - Outpatient (line 3 x line 5)				15
16	Title XVIII - Part A (line 3 x line 6)				16
17	Title XVIII - Part B (line 3 x line 7)				17
18	Title XIX - Inpatient (line 3 x line 8)				18
19	Title XIX - Outpatient (line 3 x line 9)				19
20	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)				20
21	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)				21
22	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)				22
23	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)				23
23.01	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 13.01)				23.01
23.02	Inpatient and Outpatient Intestine Acquisition (line 3 x line 13.02)				23.02
23.03	Inpatient and Outpatient Islet Acquisition (line 3 x line 13.03)				23.03

Transfer the amounts in column 3 as follows:
Add lines 14 and 15, and transfer to Worksheet E-3, Part III
Line 16 to Worksheet E, Part A, or Worksheet E-3, Part I or II as appropriate
Line 17 to Worksheet E, Part B
Add lines 18 and 19, and transfer to Worksheet E-3, Part III, as appropriate
Sum of lines 20 through 23.02 to Worksheet D-6, Part III, line 51

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A

Check Applicable Box	[ ] Hospital [ ] Subprovider

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	DRG Amount		
1	Other Than Outlier Payments occurring prior to October 1		1
1.01	Other than Outlier Payments occurring on or after October 1 and before January 1.		1.01
1.02	Other than Outlier Payments occurring on or after January 1		1.02
	Managed Care Patients		
1.03	Payments prior to March 1st or October 1st.		1.03
1.04	Payments on or after October 1 and prior to January 1.		1.04
1.05	Payments on or after January 1st but before April 1st/October 1st.		1.05
1.06	Additional amount received or to be received (see instructions)		1.06
1.07	Payments for discharges on or after April 1, 2001 through September 30, 2001.		1.07
1.08	Simulated payments from the PS&R on or after April 1, 2001 through September 30, 2001.		1.08
2	Outlier payments for discharges occurring prior to October 1, 1997 (see instructions)		2
2.01	Outlier payments for discharges occurring on or after October 1, 1997 (see instructions)		2.01
3	Bed days available divided by number of days in the cost reporting period (see instructions)		3
	Indirect Medical Education Adjustment		
3.01	Number of Interns & Residents from Worksheet S-3, Part I		3.01
3.02	Indirect medical education percentage (see instructions)		3.02
3.03	Indirect medical education adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 3.02)		3.03
3.04	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		3.04
3.05	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with section 1886(d)(5)(B)(viii)		3.05
3.06	Adjusted FTE count for allopathic and osteopathic programs for affiliated programs in accordance with section 1886(d)(5)(B)(viii)		3.06
3.07	Sum of lines 3.04 through 3.06 (see instructions).		3.07
3.08	FTE count for allopathic and osteopathic programs in the current year from your records		3.08
3.09	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring prior to October 1.		3.09
3.10	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring on or after October 1.		3.10
3.11	FTE count for the period identified in line 3.09		3.11
3.12	FTE count for the period identified in line 3.10		3.12
3.13	FTE count for residents in dental and podiatric programs.		3.13
3.14	Current year allowable FTE (see instructions)		3.14
3.15	Total allowable FTE count for the prior year, if none but prior year teaching was in effect enter 1 here.....		3.15
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. If there was no FTE count in this period but prior year teaching was in effect enter 1 here.....		3.16
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines in excess of zero (see instructions).		3.17
3.18	Current year resident to bed ratio (line 3.17 divided by line 3).		3.18
3.19	Prior year resident to bed ratio (see instructions)		3.19
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19. (see instructions)		3.20
3.21	IME payments for discharges occurring prior to October 1 (see instructions)		3.21
3.22	IME payments for discharges occurring on or after October 1 but before January 1 (see instructions)		3.22
3.23	IME payments for discharges occurring on or after January 1 (see instructions)		3.23
3.24	Sum of lines 3.21 through 3.23 (see instructions).		3.24
	Disproportionate Share Adjustment		
4	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4
4.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I		4.01
4.02	Sum of lines 4 and 4.01		4.02
4.03	Allowable disproportionate share percentage (see instructions)		4.03
4.04	Disproportionate share adjustment (see instructions)		4.04

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A (Cont.)

Check Applicable Box	[ ] Hospital [ ] Subprovider

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	Additional payment for high percentage of ESRD beneficiary discharges		
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 or M S-DRG 652, 682 - 685. (see instructions)		5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, 317, or MS-DRGs 652 and 682 - 685 (see instructions)		5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)		5.02
5.03	Total Medicare ESRD inpatient days excluding DRGs 302, 316, 317, or MS-DRGs 652, 682 - 685 (see instructions)		5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)		5.04
5.05	Average weekly cost for dialysis treatments (see instructions)		5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)		5.06
6	Subtotal (see instructions)		6
7	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		7
7.01	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. See instructions FY beg. 10/1/00)		7.01
8	Total payment for inpatient operating costs SCH and MDH only (see instructions)		8
9	Payment for inpatient program capital (from Worksheet L, Parts I, II, or III, as applicable)		9
10	Exception payment for inpatient program capital (Worksheet L, Part IV, see instructions)		10
11	Direct graduate medical education payment (from Worksheet E-3, Part IV, see instructions).		11
11.01	Nursing and Allied Health Managed Care payment		11.01
11.02	Special add-on payments for new technologies		11.02
12	Net organ acquisition cost		12
13	Cost of teaching physicians		13
14	Routine service other pass through costs		14
15	Ancillary service other pass through costs		15
16	Total (sum of amounts on lines 8 through 15)		16
17	Primary payer payments		17
18	Total amount payable for program beneficiaries (line 16 minus line 17)		18
19	Deductibles billed to program beneficiaries		19
20	Coinsurance billed to program beneficiaries		20
21	Reimbursable bad debts (see instructions)		21
21.01	Adjusted reimbursable bad debts (see instructions)		21.01
21.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		21.02
22	Subtotal (line 18 plus line 21.01 minus lines 19 and 20)		22
23	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		23
24	Other adjustments (see instructions) (specify)		24
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		25
26	Amount due provider (line 22 plus or minus lines 24 and 25 minus line 23)		26
27	Sequestration adjustment (see instructions)		27
28	Interim payments		28
28.01	Tentative settlement (for fiscal intermediary use only)		28.01
29	Balance due provider (Program) (line 26 minus the sum of lines 27, 28, and 28.01)		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		30

	TO BE COMPLETED BY INTERMEDIARY		
50	Operating outlier amount from Worksheet E, Part A line 2.01		50
51	Capital outlier amount from Worksheet L, Part I line 3.01		51
52	Operating outlier reconciliation amount (see instructions)		52
53	Capital outlier reconciliation amount (see instructions)		53
54	The rate used to calculate the Time Value of Money		54
55	Operating Time Value of Money (see instructions)		55
56	Capital Time Value of Money (see instructions)		56

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART B

Check applicable box [ ] Hospital [ ] Subprovider [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	Medical and other services (see instructions)		1
1.01	Medical and other services rendered on or after April 1, 2001 (see instructions).		1.01
1.02	PPS payments received including outliers.		1.02
1.03	Enter the hospital specific payment to cost ratio.(see instructions)		1.03
1.04	Line 1.01 times line 1.03.		1.04
1.05	Line 1.02 divided by line 1.04.		1.05
1.06	Transitional corridor payment (see instructions)		1.06
1.07	Enter the amount from Worksheet D, Part IV, (sum of columns 9, 9.01 and 9.02) line 101.		1.07
2	Interns and residents		2
3	Organ acquisitions		3
4	Cost of teaching physicians		4
5	Total cost (see instructions)		5
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
6	Ancillary service charges		6
7	Interns and residents service charges		7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)		8
9	Charges of professional services of teaching physicians		9
10	Total reasonable charges (sum of lines 6 through 9)		10
	Customary charges		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)		13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)		16
17	Lesser of cost or charges (line 5 or line 14) (for CAH see instructions)		17
17.01	Total prospective payment (sum of lines 1.02, 1.06, and 1.07)		17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Deductibles and coinsurance (see instructions)		18
18.01	Deductibles and Coinsurance relating to amount on line 17.01 (see instructions)		18.01
19	Subtotal (lines 17 and 17.01 minus lines 18 and 18.01) (see instructions)		19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)		20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)		21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)		22
23	Subtotal (sum of lines 19 through 22)		23
24	Primary payer payments		24
25	Subtotal (line 23 minus line 24)		25
	Reimbursable bad debts (exclude bad debts for professional services)		
26	Composite rate ESRD (from Worksheet I-5, line 9)		26
27	Bad debts (see instructions)		27
27.01	Adjusted reimbursable bad debts (see instructions)		27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)		28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		29
30	Other adjustments (specify) (see instructions)		30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)		32
33	Sequestration adjustment (see instructions)		33
34	Interim payments		34
34.01	Tentative settlement (for fiscal intermediary use only)		34.01
35	Balance due provider/program (line 32 minus the sum of lines 33, 34, and 34.01)		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		36

FORM CMS-2552-96 (04/2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3630.2)

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART B

Check applicable box [ ] Hospital [ ] Subprovider [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

TO BE COMPLETED BY CONTRACTOR

50	*Original outlier amount (see instructions)*		50
51	*Outlier reconciliation amount (see instructions)*		51
52	*The rate used to calculate the Time Value of Money*		52
53	*Time Value of Money (see instructions)*		53
54	*Total (sum of lines 51 and 53)*		54

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART C
Check Applicable Box	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider	

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

1	Standard overhead amounts (ASC fees)		1
2	Deductibles		2
3	Subtotal (line 1 minus line 2)		3
4	Application of coinsurance (80% of line 3)		4
5	ASC portion of blend (for column 1, 58% of line 4, and column 1.01, 58% of line 1)		5
6	Outpatient ASC cost (from Worksheet D, Part V (see instructions))		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
7	Total charges		7
	CUSTOMARY CHARGES		
8	Aggregate amount actually collected from patients liable for payment for services on a charge basis		8
9	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)		9
10	Ratio of line 8 to line 9 (not to exceed 1.000000)		10
11	Total customary charges (see instructions)		11
12	Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 6) (see instru.)		12
13	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 11) (see instru.)		13
14	Lesser of cost or charges (see instructions)		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	Deductibles and coinsurance (see instructions)		15
16	Total (see instructions)		16
17	Hospital specific portion of blend (42% of line 16)		17
18	ASC blended amount (line 5 plus line 17)		18
19	Lesser of lines 16 or 18		19
20	Part B deductibles and coinsurance		20
21	ASC payment amount (column 1 amount from line 19, column 1.01, line 19 minus line 20)		21

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART D
Check Applicable Box	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider	

PART D - OUTPATIENT RADIOLOGY SERVICES

1	Prevailing charges (from PS&R or your records)		1
2	62 percent of line 1		2
3	Deductibles		3
4	Applicable of coinsurance (80% of the sum of line 2 minus line 3)		4
5	Blended charge proportion (for column 1, 58% of line 4, and column 1.01, 58% of line 2)		5
6	Cost of outpatient radiology (from Worksheet D, Part V (see instructions))		6
	COMPUTATION OF LESSER OF REASONABLE COST OR CHARGES		
7	Total charges		7
	CUSTOMARY CHARGES		
8	Aggregate amount actually collected from patients liable for payment for services on a charge basis		8
9	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)		9
10	Ratio of line 8 to line 9 (not to exceed 1.000000)		10
11	Total customary charges (see instructions)		11
12	Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 6) (see instru.)		12
13	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 11) (see instru.)		13
14	Lesser of cost or charges (see instructions)		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	Deductibles and coinsurance (exclude professional component) (see instructions)		15
16	Total (see instructions)		16
17	Cost proportion (column 1 enter 42% of line 16 and column 1.01 enter 42% of line 14)		17
18	Outpatient radiology blended amount (sum of line 5 plus line 17)		18
19	Lesser of lines 16 or 18		19
20	Part B deductibles and coinsurance		20
21	Radiology payment amount (column 1 amount from line 19, column 1.01, line 19 minus line 20)		21

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E, PART E
Check Applicable Box	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider	

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

1	Prevailing charges (from PS&R or your records)		1
2	42 percent of line 1		2
3	Deductibles		3
4	Application of coinsurance (80% of the sum of line 2 minus line 3)		4
5	Blended charge proportion (for column 1, 50% of line 4, and column 1.01, 50% of line 2)		5
6	Cost of other outpatient diagnostic procedures (from Worksheet D, Part V (see instructions))		6
	COMPUTATION OF LESSER OF REASONABLE COST OR CHARGES		
7	Total charges		7
	CUSTOMARY CHARGES		
8	Aggregate amount actually collected from patients liable for payment for services on a charge basis		8
9	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)		9
10	Ratio of line 8 to line 9 (not to exceed 1.000000)		10
11	Total customary charges (see instructions)		11
12	Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 6) (see instructions)		12
13	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 11) (see instructions)		13
14	Lesser of cost or charges (see instructions)		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	Deductibles and coinsurance (exclude professional component) (see instructions)		15
16	Total (see instructions)		16
17	Cost proportion (50% of line 16)		17
18	Other outpatient diagnostic blended amount (line 5 plus line 17)		18
19	Lesser of lines 16 or 18		19
20	Part B deductibles and coinsurance		20
21	Diagnostic payment amount (column 1 amount from line 19, column 1.01, line 19 minus line 20)		21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-1

Check Applicable Box: [ ] Hospital [ ] Swing-Bed SNF [ ] Subprovider [ ] SNF

	Description			Inpatient Part A mm/dd/yyyy 1	Inpatient Part A Amount 2	Part B mm/dd/yyyy 3	Part B Amount 4	
1	Total interim payments paid to provider							1.00
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							2.00
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)		.01					3.01
			.02					3.02
		Program to Provider	.03					3.03
			.04					3.04
			.05					3.05
			.50					3.50
			.51					3.51
		Provider to Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)							4.00
	TO BE COMPLETED BY INTERMEDIARY							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
			.50					5.50
		Provider to Program	.51					5.51
			.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98)		.99					5.99
6	Determined net settlement amount (balance 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)							7.00

Name of Intermediary	Intermediary Number	Signature of Authorized Person	Date (Mo/Day/Yr)

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

CALCULATION OF REIMBURSEMENT SETTLEMENt - SWING BEDS	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-2

Check Applicable Boxes	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Swing Bed - SNF [ ] Swing Bed - NF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	Inpatient routine services - swing bed-SNF (see instructions)			1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-4, column 3, line 101 for Part A, and sum of Wkst. D, Part V, columns 9 and 11, line 104 and Wkst. D, Part VI, line 3 for Part B). For CAH (see instructions)			3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days			5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)			10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			15
16	Other adjustments (see instructions) (specify)			16
17	Reimbursable bad debts (see instructions)			17
17.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			17.01
18	Total (title XVIII, Part A - sum of lines 15 and 17, plus/minus line 16; Part B - sum of lines 15 and 17 plus/minus line 16) (titles V or XIX - sum of lines 15 and 17, plus/minus line 16)			18
19	Sequestration adjustment (see instructions)			19
20	Interim payments			20
20.01	Tentative settlement (for fiscal intermediary use only)			20.01
21	Balance due provider/program (line 18 minus the sum of lines 19, 20, and 20.01)			21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			22

CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA, IRF PPS, LTCH PPS AND IPF PPS	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART I

Check Applicable Box	[ ] Hospital [ ] Subprovider

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS

1	Inpatient hospital services (see instructions)		1
1.01	Hospital specific amount (see instructions)		1.01
1.02	Net Federal PPS Payments (see instructions)		1.02
1.03	Medicare SSI ratio (IRF PPS only) (see instructions)		1.03
1.04	Inpatient Rehabilitation LIP Payments (see instructions)		1.04
1.05	Outlier Payments		1.05
1.06	Total PPS Payments {sum of lines 1.01, (1.02, 1.04, ***1.42*** for columns 1 and 1.01), ***and 1.05***}		1.06
1.07	Nursing and Allied Health Managed Care payment (see instruction)		1.07
	Inpatient Psychiatric Facility (IPF)		
1.08	Net Federal IPF PPS Payments (excluding outlier, ECT, stop-loss, and medical education payments)		1.08
1.09	Net IPF PPS Outlier Payments		1.09
1.10	Net IPF PPS ECT Payments		1.10
1.11	Unweighted intern and resident FTE count for latest cost report filed prior to November 15, 2004. (see instructions)		1.11
1.12	New Teaching program adjustment. (see instructions)		1.12
1.13	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		1.13
1.14	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		1.14
1.15	Intern and resident count for IPF PPS medical education adjustment (see instructions)		1.15
1.16	Average Daily Census (see instructions)		1.16
1.17	Medical Education Adjustment Factor {((1 + (line 1.15/line 1.16)) raised to the power of .5150 -1}.		1.17
1.18	Medical Education Adjustment (line 1.08 multiplied by line 1.17).		1.18
1.19	Adjusted Net IPF PPS Payments (sum of lines 1.08, 1.09, 1.10 and 1.18)		1.19
1.20	Stop Loss Payment Floor (line 1 x 70%).		1.20
1.21	Adjusted Net Payment Floor (line 1.20 x the appropriate Federal blend percentage)		1.21
1.22	Stop Loss Adjustment (If line 1.21 is greater than line 1.19 enter the amount on line 1.21 less line 1.19 otherwise enter -0-)		1.22
1.23	Total IPF PPS Payments (sum of lines 1.01, 1.19 and 1.22)		1.23
	Inpatient Rehabilitation Facility (IRF)		
1.35	Unweighted intern and resident FTE count for cost report periods ending on/or prior to November 15, 2004. (see inst.)		1.35
1.36	New Teaching program adjustment. (see instructions)		1.36
1.37	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		1.37
1.38	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		1.38
1.39	Intern and resident count for IRF PPS medical education adjustment (see instructions)		1.39
1.40	Average Daily Census (see instructions)		1.40
1.41	Medical Education Adjustment Factor *(see instructions).*		1.41
1.42	Medical Education Adjustment (line 1.02 multiplied by line 1.41).		1.42
2	Organ acquisition		2
3	Cost of teaching physicians (from Worksheet D-9, Part II, column 3, line 16) (see instructions)		3
4	Subtotal (see instructions)		4
5	Primary payer payments		5
6	Subtotal (line 4 less line 5).		6
7	Deductibles		7
8	Subtotal (line 6 minus line 7)		8
9	Coinsurance		9
10	Subtotal (line 8 minus line 9)		10
11	Reimbursable bad debts (exclude bad debts for professional services) (see instructions)		11
11.01	Adjusted reimbursable bad debts (see instructions)		11.01
11.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		11.02
12	Subtotal (sum of lines 10 and 11.01)		12

CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER TEFRA, IRF PPS, LTCH PPS AND IPF PPS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART I (Cont.)

Check Applicable Box	[ ] Hospital [ ] Subprovider

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS

13	Direct graduate medical education payments (from Worksheet E-3, Part IV, line 24)		13
13.01	Other pass through costs (see instructions)		13.01
14	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		14
15	Other adjustments (see instructions) (specify)		15
16	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		16
17	Total amount payable to the provider (see instructions)		17
18	Sequestration adjustment (see instructions)		18
19	Interim payments		19
19.01	Tentative settlement (for fiscal intermediary use only)		19.01
20	Balance due provider/program (line 17 minus the sum of lines 18 , 19, and 19.01)		20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		21

TO BE COMPLETED BY INTERMEDIARY

50	Operating outlier amount from Worksheet E-3, Part I line 1.05 or line 1.09		50
51	Operating Outlier reconciliation amount (see instructions)		51
52	The interest rate used to calculate the Time Value of Money		52
53	Operating Time Value of Money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART II

Check Applicable Box	[ ] Hospital [ ] Subprovider [ ] SNF

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services		1
1.01	Nursing and Allied Health Managed Care payment (see instruction)		1.01
2	Organ acquisition		2
3	Cost of teaching physicians (from Worksheet D-9, Part II, column 3, line 16) (see instructions)		3
4	Subtotal (sum of lines 1 through 3)		4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) . For CAH (see instructions)		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Teaching physicians		10
11	Total reasonable charges		11
	Customary charges		
12	Aggregate amount actually collected from patients liable for payment for services on a charge basis		12
13	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)		13
14	Ratio of line 12 to line 13 (not to exceed 1.000000)		14
15	Total customary charges (see instructions)		15
16	Excess of customary charges over reasonable cost (complete only if line 15 exceeds line 6) (see instructions)		16
17	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 15) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments (from Worksheet E-3, Part IV)		18
19	Cost of covered services (sum of lines 6 and 18)		19
20	Deductibles (exclude professional component)		20
21	Excess reasonable cost (from line 17)		21
22	Subtotal (line 19 minus sum of lines 20 and 21)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Reimbursable bad debts (exclude bad debts for professional services) (see instructions)		25
25.01	Adjusted reimbursable bad debts (see instructions)		25.01
25.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		25.02
26	Subtotal (sum of lines 24 and 25 or 25.01(line 25.01 hospital and subprovider only))		26
27	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization		27
28	Other adjustments (see instructions) (specify)		28
29	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		29
30	Subtotal (line 26, plus or minus lines 28 and 29, minus line 27)		30
31	Sequestration adjustment (see instructions)		31
32	Interim payments		32
32.01	Tentative settlement (for fiscal intermediary use only)		32.01
33	Balance due provider/program (line 30 minus the sum of lines 31, 32, and 32.01)		33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III
Check Applicable Boxes	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/MR	[ ] PPS [ ] TEFRA [ ] Other

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

		Title V or Title XIX	Title XVIII SNF PPS	
		1	2	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Interns and residents (see instructions)			3
4	Organ acquisition (certified transplant centers only)			4
5	Cost of teaching physicians (see instructions)			5
6	Subtotal (sum of lines 1 through 5)			6
7	Inpatient primary payer payments			7
8	Outpatient primary payer payments			8
9	Subtotal (line 6 less sum of lines 7 and 8)			9
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
10	Routine service charges			10
11	Ancillary service charges			11
12	Interns and residents service charges			12
13	Organ acquisition charges, net of revenue			13
14	Teaching physicians			14
15	Incentive from target amount computation			15
16	Total reasonable charges (sum of lines 10 through 15)			16
	CUSTOMARY CHARGES			
17	Amount actually collected from patients liable for payment for services on a charge basis			17
18	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)			18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)			19
20	Total customary charges (see instructions)			20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)			21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)			22
23	Cost of covered services (line 9)			23
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
24	Other than outlier payments			24
25	Outlier payments			25
26	Program capital payments			26
27	Capital exception payments (see instructions)			27
28	Routine service other pass through costs			28
29	Ancillary service other pass through costs			29
30	Subtotal (sum of lines 23 through 29)			30
31	Customary charges (title XIX PPS covered services only)			31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter amount from line 30			32
33	Deductibles (exclude professional component)			33

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III (CONT.)

Check Applicable Boxes	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/MR	[ ] PPS [ ] TEFRA [ ] Other

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	COMPUTATION OF REIMBURSEMENT SETTLEMENT	Title V or Title XIX 1	Title XVIII SNF PPS 2	
34	Excess of reasonable cost (from line 22)			34
35	Subtotal (line 32 minus sum of lines 33 and 34)			35
36	Coinsurance			36
37	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19			37
38	Reimbursable bad debts (see instructions)			38
38.01	Adjusted reimbursable bad debts for periods ending before 10/01/05 (see instructions)			38.01
38.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			38.02
38.03	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)			38.03
39	Utilization review			39
40	Subtotal (see instructions)			40
41	Inpatient routine service cost (Wkst. D-1, Part III, line 70)			41
42	Medicare inpatient routine charges (from your records)			42
43	Amount actually collected from patients liable for payment for services on a charge basis (see instructions)			43
44	Amounts that would have been realized from patients liable for payment of Part A services (see instructions)			44
45	Ratio of line 43 to line 44 (not to exceed 1.000000)			45
46	Total customary charges (see instructions)			46
47	Excess of customary charges over reasonable cost (see instructions)			47
48	Excess of reasonable cost over customary charges (see instructions)			48
49	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization			49
50	Other adjustments (see instructions) (specify)			50
51	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			51
52	Subtotal (line 40 ± lines 50 and 51, minus line 49)			52
53	Indirect medical education adjustment (PPS only) (see instructions)			53
54	Direct graduate medical education payments (from Wkst. E-3, Part IV)			54
55	Total amount payable to the provider (sum of lines 52, 53, and 54)			55
56	Sequestration adjustment (see instructions)			56
57	Interim payments			57
57.01	Tentative settlement (for fiscal intermediary use only)			57.01
58	Balance due provider/program (line 55 minus the sum of lines 56, 57, and 57.01)			58
59	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			59

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER NO.:	PERIOD: FROM_____ TO	WORKSHEET E-3, PART IV

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1	Number of FTE residents for OB/GYN and primary care (see instructions)		1
1.01	Number of FTE residents for all other (see instructions)		1.01
2	Updated per resident amount for OB/GYN and primary care (see instructions)		2
2.01	Updated per resident amount for all other (see instructions)		2.01
3	Aggregate approved amount (line 1 x line 2 plus line 1.01 x line 2.01)		3
3.01	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.		3.01
3.02	Unweighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an add on to the cap for new programs in accordance with 42 CFR 413.86(g)(6).		3.02
3.03	Unweighted resident FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.86(g)(4).		3.03
3.04	FTE adjustment cap (sum of lines 3.01 through 3.03). For cost reporting periods ending on or after 7/1/2005 see instructions		3.04
3.05	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instru.)		3.05
3.06	Lesser of line 3.04 or line 3.05		3.06
3.07	Weighted FTE count for primary care physicians in an allopathic and osteopathic program for the current year in column 1. If current year is zero and teaching program was in existence in prior year enter count here..		3.07
3.08	Weighted FTE count for all other physicians in an allopathic and osteopathic program for the current year in column 1. If current year is zero and teaching program was in existence in prior year enter count here..		3.08
3.09	Sum of lines 3.07 and 3.08		3.09
3.10	See instructions		3.10
3.11	Weighted dental and podiatric resident FTE count for the current year in column 1. If current year is zero and teaching program was in existence in prior year enter count here.....		3.11
3.12	See instructions		3.12
3.13	Total weighted resident FTE count for the prior cost reporting year (see instructions) If none, enter 1 here:		3.13
3.14	Total weighted resident FTE count for the penultimate cost reporting year (see instructions) If none, enter 1 here:		3.14
3.15	Rolling average FTE count (see instructions)		3.15
3.16	Weighted number of FTE residents in the initial years of the primary care program that meet the exception. (see instructions)		3.16
3.17	Weighted number of FTE residents in the initial years of an other program that meet the exception. (see instructions)		3.17
3.18	FTE resident count (see instructions)		3.18
3.19	Primary care physician per resident amount (see instructions)		3.19
3.20	Other program per resident amount.(see instructions)		3.20
3.21	Primary care unadjusted approved amount (see instructions).		3.21
3.22	Other unadjusted approved (see instructions).		3.22
3.23	See instructions depending on the cost reporting periods beginning prior to 10/01/2001 or on or after 10/01/2001		3.23
3.24	See instructions depending on the cost reporting periods beginning prior to 10/01/2001 or on or after 10/01/2001		3.24
3.25	See instructions depending on the cost reporting periods beginning prior to 10/01/2001 or on or after 10/01/2001		3.25
	COMPUTATION OF PROGRAM PATIENT LOAD		
4	Program Part A inpatient days (see instructions)		4
5	Total inpatient days (from Worksheet S-3, Part I, column 6, sum of lines 1, 6 thru 10, and 14)		5
6	Ratio of program inpatient days to total inpatient days (line 4 ÷ line 5)		6
6.01	Total GME payment for non-managed care days (line 6 x line 3.25).		6.01
6.02	Program managed care days occuring on or after January 1 of this cost reporting period (see instructions)		6.02
6.03	Total inpatient days from line 5 above		6.03
6.04	Appropriate percentage for inclusion of the managed care days (see instructions)		6.04
6.05	Graduate medical education payment for managed care days on or after January 1 through the end of the cost reporting period (line 6.02 divided by line 6.03 x line 6.04 x line 3.25) (See instructions prior to October 1, 1997)		6.05
6.06	Program managed care days occurring before January 1 of this cost reporting year (see instructions)		6.06
6.07	Appropriate percentage using the criteria identified on line 6.04 above (see instructions)		6.07
6.08	Graduate medical education payment for managed care days prior to January 1 of this cost reporting period (line 6.06 divided by line 6.03 x line 6.07 x line 3.25)		6.08

FORM CMS-2552-96 (08/2006) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 3633.4)

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	PROVIDER NO.:	PERIOD: FROM_____ TO_____	WORKSHEET E-3, PART IV (Cont.)

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX

	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
7	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 21 and 24, lines 57 and 64)		7
8	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 57 and 64)		8
9	Ratio of direct medical education costs to total charges (line 7 ÷ line 8)		9
10	Medicare outpatient ESRD charges (see instructions)		10
11	Medicare outpatient ESRD direct medical education costs (line 9 x line 10)		11
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
12	Reasonable cost (see instructions)		12
13	Organ acquisition costs (Worksheet D-6, Part III, column 1, line 61)		13
14	Cost of teaching physicians (Worksheet D-9, Part II, column 3, line 16)		14
15	Primary payer payments (see instructions)		15
16	Total Part A reasonable cost (sum of lines 12 through 14 minus line 15)		16
	Part B Reasonable Cost		
17	Reasonable cost (see instructions)		17
18	Primary payer payments (see instructions)		18
19	Total Part B reasonable cost (line 17 minus line 18)		19
20	Total reasonable cost (sum of lines 16 and 19)		20
21	Ratio of Part A reasonable cost to total reasonable cost (line 16 ÷ line 20)		21
22	Ratio of Part B reasonable cost to total reasonable cost (line 19 ÷ line 20)		22
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
23	Total program GME payment (line 3 x line 6)		23
23.01	For cost reporting periods ending on or after January 1, 1998 (sum of lines 6.01, 6.05, and 6.08)		23.01
24	Part A Medicare GME payment (lines 21 x 23 or 23.01) (title XVIII only) (see instructions)		24
25	Part B Medicare GME payment (lines 22 x 23 or 23.01) (title XVIII only) (see instructions)		25

CALCULATION OF NHCMQ DEMONSTRATION REIMBURSEMENT SETTLEMENT	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART V

PART A - INPATIENT SERVICES: PROVIDER COMPUTATION OF REIMBURSEMENT

	INPATIENT DAYS		
1	Total title XVIII days (from Worksheet S-3, Part I, column 4, line 15)		1
2	Demonstration program days (from Worksheet S-7, sum of columns 3.01 and 4.01, line 46)		2
	INPATIENT ANCILLARY SERVICES - PART A - NON-DEMONSTRATION		
3	Total Part A ancillary program costs (from Worksheet D-4, column 3, line 101)		3
4	Less physical, occupational, and speech therapy (from Worksheet D-4, column 3, sum of lines 50-52)		4
5	Net Non-NHCMQ Demonstration Ancillary Services (line 3 less line 4)		5
	NHCMQ DEMONSTRATION INPATIENT/ANCILLARY SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
6	Inpatient routine/ancillary PPS amount paid (from Worksheet S-7, column 5, line 46)		6
	PROGRAM INPATIENT CAPITAL COSTS		
7			7
8	Per diem capital related costs (from Worksheet D-1, line 72)		8
9	Program capital related cost (line 8 times line 1)		9
	NHCMQ DEMONSTRATION ANCILLARY SERVICES: INDIRECT COST COMPONENT		
	Total General Service Cost Allocation (lines 10 through 24 are completed only for phase 3)		
10	Physical Therapy (from Worksheet B, Part I, column 27, line 50)		10
11	Occupational Therapy (from Worksheet B, Part I, column 27, line 51)		11
12	Speech Therapy (from Worksheet B, Part I, column 27, line 52)		12
	Direct Cost		
13	Physical Therapy (from Worksheet B, Part I, column 0, line 50)		13
14	Occupational Therapy (from Worksheet B, Part I, column 0, line 51)		14
15	Speech Therapy (from Worksheet B, Part I, column 0, line 52)		15
	Indirect Cost		
16	Physical Therapy (line 10 less line 13)		16
17	Occupational Therapy (line 11 less line 14)		17
18	Speech Therapy (line 12 less line 15)		18
	Charge to Charge Ratio		
19	Physical Therapy (from Worksheet D-4, column 2, line 52 divided by Worksheet C, column 8, line 50)		19
20	Occupational Therapy (from Worksheet D-4, column 2, line 51 divided by Worksheet C, column 8, line 51)		20
21	Speech Therapy (from Worksheet D-4, column 2, line 52 divided by Worksheet C, column 8, line 52)		21
	Demonstration Indirect Cost		
22	Physical Therapy (line 16 times line 19)		22
23	Occupational Therapy (line 17 times line 20)		23
24	Speech Therapy (line 18 times line 21)		24
	Total Reimbursed NHCMQ Demonstration		
25	NHCMQ Demonstration Inpatient/Ancillary Services - Part A - PPS Provider Computation of Reimbursement. (see instructions) (transfer this amount to Worksheet E-3, Part III, line 24)		25

CALCULATION OF GME AND IME PAYMENTS FOR REDISTRIBUTION OF UNUSED RESIDENCY SLOTS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM TO	WORKSHEET E-3 PART VI

Check Applicable Box	[ ] Title V [ ] Title XVIII [ ] Title XIX

PART A - INPATIENT HOSPITAL

Calculation of Reduced Direct GME Cap Under Section 422 of MMA			
1	Ratio of days occurring on or after 7/1/2005 to total days in the cost reporting period (see instructions)		1
2	Reduced Direct GME FTE Cap (see instructions)		2
3	Unadjusted Direct GME FTE Cap (Wkst E-3, Part IV, sum of lines 3.01 and 3.02)		3
4	Prorated Reduced Direct GME FTE Cap (see instructions)		4
Calculation of Additional Direct GME Payment Attributable to Section 422 of MMA			
5	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79 (c) (4)		5
5.01	Prorated additional unweighted direct GME FTE resident cap slots (cost reporting periods overlapping 7/1/2005 only)		5.01
6	*Direct* GME FTE Resident count over Cap (see instructions)		6
7	*Section 422 Allowable Direct GME FTE Resident Count (see instructions)*		7
8	Enter the locality adjustment national average per resident amount (see instructions)		8
9	Multiply line 7 time line 8		9
10	Medicare program patient load from Wkst E-3 Part IV, line 6.		10
11	Direct GME payment for non-managed care days (multiply line 9 times line 10)		11
12	Direct GME payment for managed care days (multiply line 9 by Wkst E-3, Part IV[(line 6.02 +6.06)/line 5]		12
Calculation of Reduced IME Cap Under Section 422 of MMA			
13	Reduced IME FTE Cap (see instructions)		13
14	Unadjusted IME FTE Cap (Wkst E, Part A, sum of lines 3.04 and 3.05)		14
15	Prorated Reduced allowable IME FTE Cap		15
Calculation of Additional IME Payments Attributable to Section 422 of MMA			
16	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		16
17	IME FTE Resident Count Over Cap (see instructions)		17
18	If the amount on line 17 is greater than -0-, then enter the lower of line 16 or line 17 (see instructions for cost reporting periods overlapping 7/1/2005)		18
19	Resident to bed ratio (divide line 18 by line 3 of Wkst E, Part A)		19
20	IME Adjustment Factor (see instructions)		20
21	DRG other than outlier payments for discharges on or after July 1, 2005.		21
22	Simulated Medicare managed care payments for discharges on or after July 1, 2005		22
23	Additional IME payments attributable to section 422 of MMA		23

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET G

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		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	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
13.01	Accumulated depreciation					13.01
14	Buildings					14
14.01	Accumulated depreciation					14.01
15	Leasehold improvements					15
15.01	Accumulated depreciation					15.01
16	Fixed equipment					16
16.01	Accumulated depreciation					16.01
17	Automobiles and trucks					17
17.01	Accumulated depreciation					17.01
18	Major movable equipment					18
18.01	Accumulated depreciation					18.01
19	Minor equipment depreciable					19
19.01	Accumulated depreciation					19.01
20	Minor equipment-nondepreciable					20
21	Total fixed assets (sum of lines 12-20)					21
	OTHER ASSETS					
22	Investments					22
23	Deposits on leases					23
24	Due from owners/officers					24
25	Other assets					25
26	Total other assets (sum of lines 22-25)					26
27	Total assets (sum of lines 11, 21, and 26)					27

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER NO.: | PERIOD: FROM _____ TO _____ | WORKSHEET G (CONT.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT LIABILITIES					
28	Accounts payable					28
29	Salaries, wages, and fees payable					29
30	Payroll taxes payable					30
31	Notes and loans payable (short term)					31
32	Deferred income					32
33	Accelerated payments					33
34	Due to other funds					34
35	Other current liabilities					35
36	Total current liabilities (sum of lines 28 thru 35)					36
	LONG TERM LIABILITIES					
37	Mortgage payable					37
38	Notes payable					38
39	Unsecured loans					39
40	Loans from owners .01 Prior to 7/1/66					40.01
	.02 On or after 7/1/66					40.02
41	Other long term liabilities					41
42	Total long term liabilities (sum of lines 37 thru 41)					42
43	Total liabilities (sum of lines 36 and 42)					43
	CAPITAL ACCOUNTS					
44	General fund balance					44
45	Specific purpose fund					45
46	Donor created - endowment fund balance - restricted					46
47	Donor created - endowment fund balance - unrestricted					47
48	Governing body created - endowment fund balance					48
49	Plant fund balance - invested in plant					49
50	Plant fund balance - reserve for plant improvement, replacement, and expansion					50
51	Total fund balances (sum of lines 44 thru 50)					51
52	Total liabilities and fund balances (sum of lines 43 and 51)					52

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER NO.: | PERIOD: FROM _____ TO | WORKSHEET G-1

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

STATEMENT OF PATIENT REVENUES AND OPERATING REVENUES	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET G-2, PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital				1
2	Subprovider				2
4	Swing bed - SNF				4
5	Swing bed - NF				5
6	Skilled nursing facility				6
7	Nursing facility				7
8	Other long term care				8
9	Total general inpatient care services (sum of lines 1-8)				9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	Intensive care unit				10
11	Coronary care unit				11
12	Burn intensive care unit				12
13	Surgical intensive care unit				13
14	Other special care (specify)				14
15	Total intensive care type inpatient hospital services (sum of of lines 10-14)				15
16	Total inpatient routine care services (sum of lines 9 and 15)				16
17	Ancillary services				17
18	Outpatient services				18
19	Home health agency				19
20	Ambulance				20
21	Outpatient rehabilitation providers				21
22	ASC				22
23	Hospice				23
24					24
25	Total patient revenues (sum of lines 16-24) (transfer column 3 to Wkst. G-3, line 1)				25

PART II - OPERATING EXPENSES

		1	2	
26	Operating expenses (per Wkst. A, column 3, line 101)			26
27	Add (specify)			27
28				28
29				29
30				30
31				31
32				32
33	Total additions (sum of lines 27-32)			33
34	Deduct (specify)			34
35				35
36				36
37				37
38				38
39	Total deductions (sum of lines 34-38)			39
40	Total operating expenses (sum of lines 26 and 33 minus line 39) (transfer to Wkst. G-3, line 4)			40

STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET G-3

	Description		
1	Total patient revenues (from Wkst. G-2, Part I, column 3, line 25)		1
2	Less contractual allowances and discounts on patients' accounts		2
3	Net patient revenues (line 1 minus line 2)		3
4	Less total operating expenses (from Wkst. G-2, Part II, line 40)		4
5	Net income from service to patients (line 3 minus line 4)		5
	OTHER INCOME		
6	Contributions, donations, bequests, etc		6
7	Income from investments		7
8	Revenues from telephone and telegraph 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, flowers, coffee shops, and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
25	Total other income (sum of lines 6-24)		25
26	Total (line 5 plus line 25)		26
27	Other expenses (specify)		27
28			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