08-1	10		FORM CM	S-2552-96		3690 (0	Cont.)
		red by law (42 USC 1395g; 42 CFR 4				FORM APPROVED	
		te the beginning of the cost reporting	1			OMB NO. 0938-005	0
		D HOSPITAL HEALTH CARE ST REPORT CERTIFICATION	1	PERIOD: FROM		WORKSHEET S, PARTS I & II	
		ENT SUMMARY		то			
Intern	iediary	[] Audited	Date Received:		[] Initial [] Reoper	ning	
use on		[] Desk Reviewed	Intermediary No		[]Final []MCR (Code	
		TIFICATION	N4 4			-	
Check	able box	[] Electronically	/ filed cost report unitted cost report	Date:	_	Time:	
	···	TATION OR FALSIFICATION	•	ONTAINED IN THIS COST	REPORT MAY BE PH	NISHARI F	
		CIVIL AND ADMINISTRAT					
		DENTIFIED IN THIS REPORT	•				
		CK OR WHERE OTHERWISE	ILLEGAL, CRIMINAL, CIVII	L AND ADMINISTRATIVE	ACTION, FINES AND/	OR	
IMPR	ISONMEN	IT MAY RESULT.					
		CERTIFICATION BY OF	FICER OR ADMINISTRATO	D OE DDOVIDED(S)			
		CERTIFICATION BT OF	TICER OR ADMINISTRATO	R OF TRO TIDER(B)			
	I HEREB	Y CERTIFY that I have read the	e above statement and that I ha	ve examined the accompanyir	ng electronically filed or		
	manually	submitted cost report and the Ba			-		
	h			vider Names(s) and Number(
	beginning	and end and complete statement prepared		id that to the best of my know			
		noted. I further certify that I am					
	-	he services identified in this cost	-			,	
				_			
			(Signed)				
			Officer or A	Administrator of Provider(s)			
			Title				
			Date				
PART	· II SET	FLEMENT SUMMARY					
IAKI	11-361	LEMENT SOMMAKI	1	TITLE XVI	П		$\overline{}$
			TITLE V	PART A	PART B	TITLE XIX	
			1	2	3	4	
							Т
1	HOSPITA	L					1
2	SUBPRO	VIINED	4			-	2
	SODI RO	VEDER					
3	SWING E	BED - SNF					3.
							<u> </u>
4	SWING E	BED - NF					4
5	CVB I EF	MI ID CIMIC TACH ITV					.
	SKILLEL	NURSING FACILITY					5
6	NURSING	FACILITY					6
						· · · · · · · · · · · · · · · · · · ·	
7	HOME H	EALTH AGENCY		•			7
- 8	OUTPAT	IENT REHABILITATION					8
	PROVIDI	ER (specify)					ـــــ
		OF WAY OF A STATE OF					
9	HEALTH	CLINIC (specify)					9
100	TOTAT		_				100
	TOTAL	its represent "due to" or "due for	m [#] the applicable progress for	the element of the above com	nley indicated		100
		its represent "due to" or "due fro perwork Reduction Act of 1995, no p				1 number The valid OMI	3 control
		mation collection is 0938-0050. The					
		irces, gather the data needed, and cor					
for impr	roving this fo	rm, please write to: CMS, 7500 Sec	nrity Boulevard, Attn; PRA Report	Clearance Officer, Mail Stop C4-2	6-05, Baltimore, Maryland 2	1244-1850,	

FORM CMS-2552-96 (4/2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 3603-3603.2)

3690 ((Cont.)	FURIVI	. CIVIS-2002	2.40					70-10
HOSPIT	AL AND HOSPITAL HEALTH CARE			PROVIDER N			WORKSH	EET S-2	
COMPL	EX IDENTIFICATION DATA				FROM	<u>.</u>	(CONT.)		
		*.			TO		<u> </u>		
Hospital	and Hospital Health Care Complex Add	ress:							1
1	Street:		P.O. Box:	-			-		1.01
1.01	City:	State:	Zip Code:	County:		T.	& Oncate		1.01
Hospital	and Hospital-Based Component Identific	cation:	T		1 5	-}	yment Syste		
			Provider	NPI	Date	V	P, T, O, or N XVIII	XIX	
	Component	Component Name	Number	Number	Certified		5	6	
	0	l	2	2.01	3	4	, , , , , , , , , , , , , , , , , , ,	U	2
_	Hospital		<u> </u>						3
3						 			4
4	Swing Beds-SNF	**				 			5
5	Swing Beds-NF								6
6	Hospital-Based SNF		4			 			7
7	Hospital-Based NF								8
8	Hospital-Based OLTC			4					9
9	Hospital-Based HHA					 		 	11
11	Separately Certified ASC		ļ						12
12	Hospital-Based Hospice								14
14	Hospital-Based Health Clinic (specify)	,,,				 	 	-	15
15	Outpatient Rehab. Clinic (specify)		 						16
16	Renal Dialysis	 .	<u> </u>						10
					T- :			L	17
17	Cost Reporting Period (mm/dd/yyyy)		From	:	To:	T 1	T"	2	1,
				***	***	1		<i>L</i>	18
	Type of Control (see instructions)				.		************		10
	hospital/subprovider (see instructions)		***			<u> </u>			19
	Hospital			***	**				20
20	Subprovider					<u> </u>	***************************************		
	formation (1)		1 - 6 1	ine period in col		т —	Т		21
21	Indicate if your hospital is either (1) ur	ban or (2) rural at the en	d of the cost report	ing period in cor	unith	1			
	If your hospital is geographically classif	ned or located in a rural	area, is your bed s.	NII for no	WILL	1			
21.01	CFR 42 412.105 less than or equal to 1	to beds, enter in column	diamenantianeta	hore bornital		+	-		21.01
21.01	Does your facility qualify and is current.								
	adjustment in accordance with 42 CFR								
	Is this facility subject to the provisions) (Pickle amendme	ent hospitals)?					
	Enter in column 2 "Y" for yes or "N" for					<u>.</u> j			21.02
21.02	Has your facility received a new geograp	phic reclassification state	is change after the	first day of the o	ost				21.02
	reporting period from rural to urban and		or yes and "N" for i	no. If yes, enter i	n column 2	1	1		1
	the effective date (mm/dd/yyyy) (See in	structions)				1			21.02
21.03	Enter in column 1 your geographic local	tion either (1) urban (2)	rural				1		21.03
	If you answered urban in column 1 inc	dicate if you received eit	her a wage or						l
	standard geographic reclassification to	a rural location, enter ir	column 2 "Y"	ŀ					l
	for yes and "N" for no. If column 2 is y	res enter in column 3 the	effective date						ļ
	(mm/dd/yyyy) (see instruction). Does	your facility contain 100	or fewer beds						1
	in accordance with 42 CFR 412.105?	Enter in column 4 "Y" fo	or yes and "N"	1					İ
	for no. Enter in column 5 the provider	rs actual MSA or CBSA				 		1	21.04
21.04	For standard Geographic classification (not wage), what is your	status at the begin	ming of the cost r	reporting				21.04
	period. Enter (1) urban and (2) rural.			64					21.05
21.05	For standard Geographic classification (not wage), what is your	status at the end o	or the cost reporti	ng period.				21.03
	Enter (1) urban and (2) rural.			. C . 111	1				21.06
21.06	Does this hospital qualifies for the three	e -year transition of hold	narmiess payment	s for small rural.	nospitai A \$3.479				21,00
	under the prospective payment system f		rvices under DKA	. gotto of MIPPA	w 8141;				
	(See instructions). Enter "Y" for yes, an	id "IN" for no.) (IDD / 61/470 F		VVI for you	+	<u> </u>	1	21.07
21.07	Does this hospital qualify as a SCH wit	n 100 or fewer beds und	et MIPPA§147? E	mer m commi !	1 101 yes		1		21.07
	or "N" for no (see instructions)	A 11 A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	77 t	:= 4014 %	nu 21212				
	Is this a SCH or EACH that qualifies j		normiess provisi	on in ACA Section	OB 31217				
	Enter in colun 2 "Y" for yes or "N" for	r no.(See instructions)	Tarl C Test	online 1 518:0"	it is based on det	+	 		21.08
21.08	Which method is used to determine Me	edicaid days on S-3, Part	1, COL 3 Enter in	roa Tathia math	n is vascu on uait ad different than				21.00
	of admission, "2" if it based on census	days, or "5" if it is based	ion date of dischar	for year or TATE for	og umorent man				
	the method used in the preceeding cos	a reporting period / Ente	п социял 2, Ү	TOT ACE OF 14 IOI	410.	 			22

HOSPIT.	AL AND HOSPITAL HEALTH CARE	PROVIDER NO	PERIOD:		WORKSI	EET S-2	
	EX IDENTIFICATION DATA		FROM		(CONT.)		
			то				
23	Does this facility operate a transplant center? If yes, enter certification date(s)	in column 2 and					23
	termination date(s) in column 3 (mm/dd/yyyy) below:						
23.01	If this is a Medicare certified kidney transplant center, enter the certification da	ate in col. 2 and term	ination in col. 3			<u> </u>	23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date	in col. 2 and termin	ation in col. 3				23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date	in col. 2 and termina	ation in col. 3.				23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date	in col. 2 and termina	ation in col. 3.				23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering cert	ification and termina	tion date.				23.05
23.06	If this is a Medicare certified intestinal transplant center, enter the certification	date in col. 2 and ter	m. in col. 3				23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date	in col. 2 and termina	ition in col. 3.				23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in o	ol.2 and termination	date in col 3.			<u> </u>	24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or	recertification date					24.01
	after (12/26/2007) in column 3 (mm/dd/yyyy).				1		
25	Is this a teaching hospital or affiliated with a teaching hospital and you are rece	iving payments for I	& R?				25
	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter						25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program	status in effect durii	ng				25.02
	the first month of the cost reporting period? If yes, complete Worksheet E-3, P	art IV. If no,					
	complete Worksheet D, Parts III and IV and D-2, Part II if applicable.						
25.03	As a teaching hospital, did you elect cost reimbursement for physicians' service	s as defined					25.03
	in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.						
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Workshee	et D-2, Part I.					25.04
	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2)	been reduced under		T			25.05
	42 CFR §413.79(c)(3) or42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and	l"N" for no in the ap	plicable				
	columns. (see instructions)						!
25.06	Has your facility received additional direct GME FTE resident cap slots or IME	EFTE residents cap	-				25.06
	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).	-					<u> </u>
26	If this is a sole community hospital (SCH), enter the number of periods SCH s	tatus in effect in the	C/R				26
	period. Enter beginning and ending dates of SCH status on line 26.01. Subscri]			
	of periods in excess of one and enter subsequent dates.						
26.01	Enter the applicable SCH dates: (see instructions) Beginning:	Ending:					26.01
	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	3 for swing					27
	beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.						<u> </u>
28	If this facility contains a hospital-based SNF, are all patients under managed car	re or there were no					28
	Medicare utilization enter "Y", if "N" complete lines 28.01 and 28.02.						<u> </u>
28.01	If hospital based SNF, enter appropriate transition period 1, 2, 3, or 100 in colu	ımn 1. Enter in colt	ımns 2			i	28.01
	and 3 the wage index adjustment factor before and on or after the October 1st (see instructions)		<u> </u>			ļ
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fisca	il intermediary)					28.02
	if you have not transitioned to 100% SNP PPS payment. In column 2 enter the	e facility					
	classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or	r two character					1
	state code if a Rural based facility. In column 4, enter the SNF CBSA code or	two character					1
	state code if a Rural based facility				<u> </u>	<u> </u>	
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003	provided for an incre	ease in the RUG	payments beg	inning 10/0	1/2003.	
	Congress expected this increase to be used for direct patient care and related ex	xpenses. Enter in co	olumn 1 the perc	entage of total	expenses f	or	l
	each category to total SNF revenue from Worksheet G-2, Part I, line 6, column	 Indicate in colu 	mn 2 "Y" for yes	or "N" for no			1
	if the spending reflects increases associated with direct patient care and related	l expenses for each c	ategory. (See ins	tructions)		-0	
28.03	Staffing			ļ	.		28.03
28.04	Recruitment				ļ		28.04
28.05	Retention of employees				<u> </u>		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	e aggregate for					29
	both components, using the swing bed optional method of reimbursement?			1	400000000000000000000000000000000000000	vsvisien (2000)	24

FORM CMS-2552-96 (01/2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3604)

Rev. 21 01-10

FORM CMS-2552-96 PROVIDER NO PERIOD:

36-504.1 3690 (Cont.)

COMPL	EX IDENTIFICATION DATA	,	FROM		(CONT.)		
	The state of the s	To amital /C ALD?	TO	T		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	30
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access I	nospitai (CAri):					50
20.03	(see 42 CFR 485.606ff) If so, is this the initial 12 month period for the facility operated as an RPCH/CAH?	See 42 CER 413	70				30.01
30.01	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method o	f navment					30.02
30.02	for outpatient services?(See instructions)	- F-9					
30.03	If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulan	ce services? If ye	s,				30.03
50.05	enter in column 2 the date of eligibility determination (date must be on or after 12/2						
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I &R train	ning programs? Er	iter "Y"				30.04
	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 I	Ц, if applicable.					
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See	42 CFR 412.113(c) .	•			31
Miscella	neous Cost Reporting information						22
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in	column 2.	1	ļ. <u> </u>	- E		33
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N"	Tor no in column	! I. ! et 1000/				- 33
	If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect	to be termomised	1 21 100%				
24	Federal capital payment? Enter "Y for yes and "N" for no in column 2.		**				34
34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1 Y i) ?		<u> </u>			35
33	Have you established a new subprovides (excitated with) under 42 of 10 113. 10(2)	- / (- / / / / / / / / / / / / / / / /		V	XVIII	XIX	
Prospec	tive Payment System (PPS)-Capital			1	2	3	
36	Do you elect fully prospective payment methodology for capital costs? (See instruc	tions)					36
36.01	Does your facility qualify and receive payment for disproportionate share in accord	ance with		1			36.01
	42 CFR 412.320 ? (see instructions)						
37	Do you elect hold harmless payment methodology for capital costs? (See instruction						37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal	eral rate?			<u> </u>		37.01
	X inpatient services			· · · · · ·	100000000000000000000000000000000000000		1 20
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 I	part?		<u> </u>			38.01 38.02
	Does the title XIX program reduce capital following the Medicare methodology?						38.03
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (se	e instructions)	.,,,,,	 			38.04
38.04	Do you operate an ICF/MR facility for purposes of title XIX? Are there any related organization or home office costs as defined in CMS Pub. 15	1 Chanter 102 I	free			*************	40
40							
40	Are there any related organization or notice costs as defined in Civis r do. 15	-1, Спария 10. 1 оббое сёлів вит	1 yes, her. (See inst.)				**
40	and this facility is part of a chain organization, enter in col. 2 the chain home	office chain num	ber. (See inst.)				40
	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon	office chain num ne office on lines	ber. (See inst.)	FI/Contracto	or's Number.		40.01
40.01	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: FI/Contractor's N	office chain num ne office on lines	ber. (See inst.)		or's Number:		
40.01 40.02	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon	office chain num ne office on lines	ber. (See inst.)	FI/Contracto	or's Number: Zip Code:		40.01
40.01 40.02	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: FI/Contractor's N Street: City:	office chain num ne office on lines	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41
40.01 40.02 40.03 41 42	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers?	office chain num ne office on lines	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42
40.01 40.02 40.03 41 42 42.01	and this facility is part of a chain organization; enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers?	office chain num ne office on lines	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01
40.01 40.02 40.03 41 42 42.01	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers?	office chain num ne office on lines	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02
40.01 40.02 40.03 41 42 42.01 42.02 43	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers?	office chain num ne office on lines Name:	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02 43
40.01 40.02 40.03 41 42 42.01 42.02 43 44	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient services	office chain num ne office on lines Name: ces only?	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02 43 44
40.01 40.02 40.03 41 42 42.01 42.02 43	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient servi Have you changed your cost allocation methodology from the previously filed cost	office chain num ne office on lines Name: ces only? report? See	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02 43
40.01 40.02 40.03 41 42 42.01 42.02 43 44	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient services you changed your cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in co	office chain num ne office on lines Name: ces only? report? See	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02 43 44
40.01 40.02 40.03 41 42 42.01 42.02 43 44 45	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient services you changed your cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in co Was there a change in the statistical basis?	office chain num ne office on lines Name: ces only? report? See	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.01 43 44 45 45.01
40.01 40.02 40.03 41 42 42.01 42.02 43 44 45	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are speech pathology services provided by outside suppliers? Are repsiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient servi Have you changed your cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in co Was there a change in the statistical basis? Was there a change in the order of allocation?	office chain num ne office on lines Name: ces only? report? See	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.02 43 44 45 45.01 45.02
40.01 40.02 40.03 41 42.01 42.02 43 44 45 45.01 45.02 45.03	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they impatient servi Have you changed your cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in co Was there a change in the statistical basis? Was there a change in the order of allocation? Was there change to the simplified cost finding method?	office chain num ne office on lines Name: ces only? report? See humn 2.	ber. (See inst.)	FI/Contractor P. O. Box			40.01 40.02 40.03 41 42 42.01 42.01 43 44 45 45.01
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40.01 40.02 40.03 41 42.01 42.02 43 44 45 45.01 45.03 46 If this f each co	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they inpatient services are compared by our cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in cowast there a change in the statistical basis? Was there a change in the order of allocation? Was there a change in the NHCMQ demonstration project (must have a hospital during this cost reporting period, enter the phase (see instructions). acility contains a provider that qualifies for an exemption from the application of the mponent and type of service that qualifies for the exemption. Enter "N" if not exem Hospital Subprovider SNF HHA Outpatient Rehab. Providers (specify) CMS-2552-96 (01/2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUB.)	ces only? report? See humn 2. lower of costs or pt. (See 42 CFR 4	charges, enter " 413.13.) Part B 2	FI/Contracto P. O. Box State: Y* for Outpatient ASC 3	Zip Code: Outpatient Radiology 4	Diagnostic 5	40.01 40.02 40.03 41 42.01 42.02 43 44 45 45.01 45.03 46
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40.01 40.02 40.03 41 42.02 43 44 45 45.01 45.02 45.03 46 If this fi each co	and this facility is part of a chain organization, enter in col. 2 the chain home If this facility is part of a chain organization enter the name and address of the hon Name: Street: City: Are provider based physicians' costs included in Worksheet A? Are physical therapy services provided by outside suppliers? Are occupational therapy services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? Are respiratory therapy services provided by outside suppliers? If you are claiming cost for renal services on Worksheet A, are they impatient servi Have you changed your cost allocation methodology from the previously filed cost CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in co Was there a change in the statistical basis? Was there a change in the order of allocation? Was there a change in the order of allocation? Was there a participating in the NHCMQ demonstration project (must have a hospital during this cost reporting period, enter the phase (see instructions). acility contains a provider that qualifies for an exemption from the application of the mponent and type of service that qualifies for the exemption. Enter "N" if not exem Hospital Subprovider SNF HHA Outpatient Rehab. Providers (specify) CMS-2552-96 (01/2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUB 21	ces only? report? See humn 2. al-based SNF) lower of costs or pt. (See 42 CFR 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	charges, enter " 413.13.) Part B 2	FI/Contracto P. O. Box State: Y* for Outpatient ASC 3	Zip Code: Outpatient Radiology 4	Diagnostic 5	40.01 40.02 40.03 41 42 42.01 42.02 43 44 45 45.01 45.02 45.03 46 47 48 49 50 51

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52	Does this hospital claim expenditures for extraordinary circumstances in accordance	Land to the same of the same o					52
32	412.348(e)? (see instructions)	•					
52.01	If you are a fully prospective or hold harmless provider are you eligible for the spec	ial exceptions pay	ment pursuant to)			52.01
JZ.U1	42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV	, ,					
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MD	H status in effect	in this C/R perio	od.			53
. در	Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.0)1 for number	•				
	of periods in excess of one and enter subsequent dates.	or tet nameer					
C2 01			ending:				53.01
53.01			Citaling.				54
54	List amounts of malpractice premiums and paid losses: Premiums: Paid losses:	and/or Self insura	mea:				
54.01		4-44					54.01
54.01	Are malpractice premiums and paid losses reported in other than the Administrative		•				0
	center? If yes, submit supporting schedule listing cost centers and amounts contain						55
55	Does your facility qualify for additional prospective payment in accordance with 42	CFR 412.10).					33
	Enter "Y" for yes and "N" for no.	T 5.	Y 31	Limit	YorN	Fees	56
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit	Date	Y or N	2	3	4	50
	provided from your fiscal intermediary and the applicable dates for those limits	0	1	<u> </u>		4	
	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.		***************************************		*********		56.01
56.01	Enter subsequent ambulance payment limit as required. Subscript if more						36.01
	than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or			_			
	subsequent periods as applicable.	l					
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 subpre	ovider? Enter in co	olumn 1 "Y" for	yes and			58
	"N" for no. If yes have you made the election for 100% Federal PPS reimburseme	ent? Enter in colu	mn 2 °Y for yes	and "N"	1		
	for no. This option is only available for cost reporting periods beginning on or after	r 1/1/2002 and bet	fore 10/1/2002.				
58.01		t cost reporting pe	riod				58.0
	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 date	ed August 15, 200	5 pg 47929?				
	Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 responses	ectively in column	ı 3.				
	(see instructions). If the current cost reporting period covers the beginning of the	fourth enter 4 in c	olumn 3,				
	or if the subsequent academic years of the new teaching program in existence, enter	er 5 . (see instructi	ions)				
59	Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "	'N" for no. If yes h	ave you made a	1		-	59
• • •	election for 100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and	i "N" for no. (see i	nstructions)				ļ
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovid	ler? Enter in colun	nn 1 "Y" for yes	and "N"			60
•	for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y	for ves and "N" f	or no. (see instri	ictions)			
60.01	If line 60 column 1 is "Y", and the facility is an IPF subprovider, were residents tr	aming in this facil	ity in its most				60.0
00.01	recent cost reporting period filed before November 15, 2004? Enter "Y" for yes or	"N" for no. Is thi	s facility				1
	training residents in a new teaching programs in accordance with 42 CFR Sec. 41:						
	Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 resp						
	(see instructions). If the current cost reporting period covers the beginning of the	fourth enter 4 in c	olumn 3				
	(see instructions). If the current cost reporting period covers the degining of the	or 5 (see instr.)	orum, o,				
. i	or if the subsequent academic years of the new teaching program in existence, ent	er J. (See Histe.)	**	L			
fultica	mpus	CDCA2 Est	or #V# for you or	d "N" for no			6
61	Is this facility part of a Multicampus hospital that has one or more campuses in diff	eiem CBSA? Em	lei i idiyesai	IG IN TOTAG.	T	FTE/	, ·
	If line 61 is yes, enter the name in col. 0, County in col. 1,	G	8+-4-	Zin Cada	CBSA	Campus	ŀ
	state in col. 2, Zip in col 3, CBSA in col. 4 and	County	State	Zip Code			1
		1 1	2	3	4	5	1
	FTE/Campus in col. 5.						
	Name:	<u> </u>	<u> </u>				6:
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HOSI STA1	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	E COMP	LEX					፵	PROVIDER NO.:	NO:				н н Н	PERIOD FROM TO		_	,~ <u>514</u>	WORKSHEET S-3, PART I	EET S-3	
	i de la companya de l				I/P Da	Days / O/F	ys / O/P Visits / Trips	sdi				Interns 6	Interns & Residents FTEs	1	Full Time Equivalent	?quivalent		Discharges	rges	П	ļ
					i E	Total	Title XIX Obs.	Obs.	Total	Obs.	Obs.	JEN	Less I & R Replacing	<u> </u>	Employees	Monnoid		F.	11.H	Total	
	Component	Beds	Ava	Ħ	XVIII	XIX	AdmittedNot Adm		ŧŝ	귕	t_	Total Ar	Anesthetist	Set (Payroll	Workers	Title V	+	\neg	Patients	I
		-	2	e	4	ş	5.01	5.02	°	0.01	902	-	20	6	01	11	2	<u>~</u>	4	1	l
-	Hospital Adults & Peds. (columns 3, 4,									••••											-
	5 and 6, exclude Swing Bed,											••••									
	Observation Bed and Hospice days)						Ī			Ì		ľ		Ī							، ا
		Ĭ								İ								Ī	Í		4
ю																					m
	Swing Bed SNF									İ		1	Ī						Ī		1
4	Hospital Adults & Peds.								<u></u>	••••											4
	Swing Bed NF										1										l
Š	Total Adults and Peds. (exclude								*****												s,
	observation beds) (see instructions)																				1
9	Intensive Care Unit																				اه
7	Coronary Care Unit																				7
8	Bum Intensive Care Unit																				∞
6	Surgical Intensive Care Unit																				ം
10	Other Special Care																				10
11	Mursery																				=
12	Total (see instructions)																				12
13	RPCH/CAH visits																				13
14	Subprovider													1							4
15	Skilled Nursing Facility											1									15
16	Nursing Facility											1		1							16
17	Other Long Term Care											1									17
18	Home Health Agency																				18
20	ASC (Distinct Part)																				8
21	Hospice (Distinct Part)											_									21
23	Outpatient Rehab. Provider (specify)																				23
24	RHC/FQHC (specify)																				*
25	Total (sum of lines 12-24)																				25.
26	Observation Bed Days																				56
27					3320																27
28	Employee discount days (see instru.)																				88
29	29 Labor & delivery days (see instructions									***		***									29

FORM CMS-2552-96 (01-2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3605.1) Rev. 21

3690	(Cont.)	FOR	M CMS-253	32-96			U1-10		
HOSPT	AL WAGE INDEX INFORMATION		PROVIDER NO).:	PERIOD:		WORKSHEET S-3,		
					FROM		PART II		
				_	TO				
PART 1	I - WAGE DATA								
			Reclass.	Adjusted	Paid Hours	Average			
	•	Amount	of Salaries (from	Salaries (col. 1 ±	Related to Salaries	Hourly Wage (col. 3 ÷	Data		
		Reported	Wkst. A-6)	col. 1 ±	in col. 3	col. 4)	Source		
		1	2	3	4	5	б	\vdash	
	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)	Î						6	
6.01	Contract services, I&R (see instructions)							6.01	
7	Home office personnel						L	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	<u> </u>						9.01	
9.02	Laboratory services under contract	<u> </u>						9.02	
9.03	Management and administrative services							9.03	
10	Contract labor: physician-Part A					<u> </u>	ļ	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								12.01	
	WAGE-RELATED COSTS						av retablish	13	
	Wage-related costs (core)			****			CM\$ 339 CM\$ 339	14	
14	· · · · · · · · · · · · · · · · · · ·							15	
	Excluded areas						CMS 339 CMS 339	16	
	Non-physician anesthetist Part A		···				CMS 339	17	
17	Non-physician anesthetist Part B							18	
	Physician Part A						CMS 339 CMS 339	18.01	
	Part A teaching physicians (see instructions)						CM\$ 339	18.01	
	Physician Part B						CMS 339	19.01	
	Wage-related costs (RHC/FQHC)			.,,,,,,			CMS 339	20	
20	Interns & residents (in an approved program)	<u> </u>	ļ				LCTARGE OUN		

13 Total overhead costs (see inst.)

Rev. 10 36-506.3

13

	With a control of the	Full E	pisodes						
		Without	With	LUPA	PEP only	SCIC within	SCIC only	Total	
		Outliers	Outliers	Episodes	Episodes	a PEP	Episodes	(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		<u></u>	<u> </u>					38

ΔE	α

590 (Cont.)	FORM C	MS-2552-90	6			()5-0
SPITAL RENAL DIALYSIS DEPARTMENT		PROVIDER N	O.:	PERIOD:	•••	WORKSHEET	S-5
ATISTICAL DATA				FROM	<u>.</u>		
				TO			
RENAL DIALYSIS STATISTICS							
	Outpatio	ent	Traini	_~	Home		⊢
			Hemo-	CAPD	Hemo-	CAPD	l
DESCRIPTION	Regular	High Flux	dialysis	CCPD	dialysis	CCPD	⊢
	1	2	3	4	5	6	
l Number of patients in program at							
end of cost reporting period		ļ					⊢
Number of times per week patient						1	
receives dialysis		ļ					▙
3 Average patient dialysis time including setup			****************				<u> </u>
4 CAPD exchanges per day							
5 Number of days in year dialysis furnished							
6 Number of stations		<u> </u>	******	*******************			
7 Treatment capacity per day per station							<u> </u>
8 Utilization (see instructions)							<u>_</u>
Average times dialyzers re-used							
10 Percentage of patients re-using dialyzers		<u> </u>					
TRANSPLANT INFORMATION							
11 Number of patients on transplant list				······································			1
12 Number of patients transplanted during the cost re	porting period			***			
	<u> </u>				•		
EPOIETIN							
13 Net costs of Epoietin furnished to all maintenance		e provider.					
1.01 Epoietin amount from Worksheet A for Home Dia			**				13.0
14 Number of EPO units furnished relating to the ren							
Number of EPO units furnished relating to the hor	ne dialysis department	t					14.

INITIAL METHOD_

16 Net costs of Aranesp furnished to all maintenance dialysis patients by the provider.

18 Number of Aransep units furnished relating to the renal dialysis department 19 Number of Aransep units furnished relating to the home dialysis department

17 Aranesp amount from Worksheet A for Home Dialysis program

16

17

18

15 MCP

ARANESP

08-	10 FORM	1 CMS-2552-96	-	3690 (Co	ont.)
HOS	PITAL-BASED OUTPATIENT REHABILITATION VIDER STATISTICAL DATA	PROVIDER NO.:	PERIOD: FROM	WORKSHEET S-6	
rko	YIDEK STATISTICAL DATA	COMPONENT NO	1		
			<u> </u>		
OUT	PATIENT REHABILITATION PROVIDER - NUMBER OF EMPL	OYEES (FULL TIME EQUIVALEN	Т)	·	
Chec	k []CMHC []OOT	****			
Appl	icable [] CORF [] OSP				
Box	[] OPT		Out.	<u> </u>	
Enter	the number of hours in your normal workweek				
				Total	1
		Staff	Contract	(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
	Direct Nursing Service				4
	Nursing Supervisor				5
- 6	Physical Therapy Service		<u> </u>		6
7	Physical Therapy Supervisor		Ϊ		7
8	Occupational Therapy Service		1	•	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		<u> </u>		13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor		<u> </u>		15
16	Psychiatric/Psychological Service				16
17	Psychiatric/Psychological Service Supervisor				17
18	Other (specify)	L	<u> </u>		18
				·	1 10
19	Is this component paid 100% under established fee schedules? If yes	enter "Y" if no enter "N". If "Yes":	vou are not required	. 1	19

PROFESTION PROMESTIAN PROVIDER NO. PROMESTIAN P		ECTIVE PA	YMENT FO	R SNF		PROVIDER	NO.:		PERIOD:	· · ·		WORKSHEET S-7	
MGPI SURVICIS PRICE TO SURVICES ON CR AFTE Services trough (1) High Cost (2) Swing Held ROUTE Cooks Tax Swing Held A1/2001 - 393/2001 April 200 SWF TOTAL For A1/2001 - 393/2001 April 200 SWF TOTAL For A1/2001 - 393/2001 April 200 SWF TOTAL For A1/2001 - 393/2001 A				AC DIAI		1 RO (IDDA							
MAPP SIRA MURICA PRICE TO SERVICES NOR AFTE Services through (1) Half-Cost (2) Sirat Half-	SIMIL	HICAL DA	.1A										
RRVINIU Colobe Talk			M3PI	SERVICES	PRIOR TO	SERVICES O	ON OR AFTER	Services		High Cost (2)	Swing Bed		
RECUE CODE Rate Days Rate Days								4/1/2001	- 9/30/2001			TOTAL	1
1 XIC 2 XUB 3 XUA 3 3 XUA 3 3 XUA 3 3 XUA 3 3 3 XUA 3 3 3 XUA 3 3 3 XUA 4 XVC 4 4 4 4 4 4 4 4 4		GROUP	CODE.			Rate	Days	Rate	Days	Days	Days	(see instructions)	1
2 RUB 3 RUA 3 STAA 4 STAA 4 ST		1	2	3	3.01	4	4.01	4.02	4.03	4.05	4.06	5	
S RUA S S S S S S S S S	1	RUC											
301 RUX	2	RUB											
3.02		RUA											
A EVC	3.01	RUX							ļ				
S NYB	3.02						<u> </u>					···	
6 601 RVX 600 RVX 601 RVX 602 RVL 7 REC 7 REC 8 RIB 9 RIA 9 RIA 9 SIA 10 SIA 10 SIA 10 SIA 11 RMB 11 SIA 12 RMA 12 SIA 12 SIA 13 RIB 14 RIA 14 RIA 15 SE3 16 SE2 17 SIB 18 SSC 18 SIB 19 SSB 19 SIB 10 SIA 20 SSA 21 SSB 22 SSA 23 SSB 24 SSB 25 SSB 26 SSB 27 SSB 28 SSB 29 SSB 30 SSB 31 SSB 31 SSB 32 SSB 33 SSB 34 SSB 35 SSB 36 SSB 37 SSB 38 SSB 38 SSB 39 SSB 30 SSB 30 SSB 31 SSB 31 SSB 32 SSB 33 SSB 34 SSB 35 SSB 36 SSB 37 SSB 38 SSB 39 SSB 30 SSB 30 SSB 30 SSB 31 SSB 31 SSB 32 SSB 33 SSB 34 SSB 35 SSB 36 SSB 37 SSB 38 SSB 39 SSB 30 SSB 3							ļ					×****	4
601 RVX 602 RVL 7 RRC 9 RRC 9 RRC 9 RRC 9 RRC 9 RRC 9 RRC 9 RRC 10 PRC 10 RRC 110 RMC 111 RMB 111 RMB 111 RMB 111 RMB 112 RMA 112 RMA 113 RLB 13 RLB 14 RLA 140 RLX 15 SR3 15 SR3 15 SR3 16 SR2 17 SR1 18 SSC 18 SSC 18 SSC 18 SSC 19 SSB 19 SSB 10 SSC 20 CC1 21 CC2 22 CC1 23 CC2 24 CB1 25 CA2 26 CA1 27 RBC 28 RBC 38 RB 39 RRC 30 RBC 30 RBC 30 RBC 30 RBC 31 RBC 32 RBC 33 RBC 34 RBC 35 RBC 36 RBC 37 RBC 38 RBC					ļ		<u> </u>						3
6.00 7 RHC 7 RHC 7 7 RHC 8 8 9 RHA 9 RHA 9 9.01 RHX 9 9.01 RHX 9 9.02 RHL 9 9 9 9 9 9 9 9 9					-		 				•••		_
T	_						+ +						
RIB	-				<u> </u>	-	 		 				
9 RITA 9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					+		+ +		1				
Section Sect						<u> </u>	 		 				
9.02 RIL 9.02 10 11 RMB 11 11 12 RMA 12 12 12 12 12 12 12 1					-	<u> </u>	1		 	 			_
10 RMC 10 11 12 12 12 12 12 12						 			 	-			
11 RMB					 	+	1				***		
12 RMA					+	 	1			 	Lampia.	****	
120				•••	 	1							
1202 RML 12 13 RLB 15 15 14 RLA 14 14.0 RLX 14 14.0 RLX 15 SE3 15 15 16 SE2 16 16 17 SE1 17 SE1 17 18 SSC 18 SSC 19 19 19 19 19 19 19 1					 		 		 				
13 RLB 14 RLA 14 14 14 15 RLA 15 RES 15 15 15 15 15 16 RES 16 RES 17 RES 17 RES 18 RES 19							 		1				
14 RLA					<u> </u>	+	1				,	***	
1401 RLX 14 15 SE3 15 15 15 16 SE2 16 16 SE2 17 SE1 19 SEB 19	=					 	1	4 51177					
15 SE3						1	1		 				
16 SE2		·····						···	1				15
17 SEI 18 18 18 19 19 19 19 19					**								16
18 SSC 18 19 SSB 19 19 SSB 19 20 SSA 20 21 CC2 21 22 CC1 22 22											***		
20 SSA 20 21 CC2 22 22 22 23 CB2 22 23 CB2 24 CB1 24 25 CA2 25 CA2 26 CA1 26 CA1 26 CA1 27 CA1 28 IB1 28 29 IA2 29 IA2 29 IA2 29 IA2 30 IA1 31 32 BB1 32 BB1 32 BB1 33 BB2 33 BA2 33 BA2 33 BA2 33 BA2 33 BA1 34 BA1 34 BA1 34 BA1 34 BA1 35 PE2 35 36 PE1 36 37 PD2 37 38 PD1 38 39 PC2 39						T							
21 CC2 22 22 22 22 22 23 CB2 3 23 CB2 3 24 CB1 3 24 25 CA2 3 25 26 CA1 3 26 27 TB2 3 27 28 TB1 3 28 TB1 3 29 TA2 3 TBB2	19	SSB							<u> </u>	ţ			19
22 CCl 22 23 CB2 23 24 CB1 24 25 CA2 25 CA2 25 CA2 26 CA1 26 CA1 27 CA2 27 CA3 C	20	SSA											
23 CB2 23 24 CBI 24 25 CA2 25 26 CAI 26 27 IB2 27 28 IBI 28 29 IA2 29 30 IAI 30 31 BB2 31 33 BA2 33 34 BAI 34 35 FE2 35 36 PBI 36 37 PD2 37 38 PDI 38 39 PC2 39 40 PCI 40 41 PB2 40 42 PBI 42 43 PA2 43 44 PAI 44	21	CC2											
24 CBI 25 CA2 26 CAI 27 IE2 28 IBI 29 IA2 30 IAI 31 BB2 33 BA2 34 BAI 35 PE2 36 PBI 37 PD2 40 PCI 41 PB2 43 PA2 44 PAI 44 PAI	22	CC1					1						
25 CA2 25 26 CA1 26 27 EB2 27 28 EB1 28 29 IA2 29 30 IA1 30 31 BB2 31 32 BB1 32 33 BA2 31 34 BA1 32 35 PE2 32 36 PB1 36 37 PD2 37 38 PD1 38 39 PC2 39 40 PC1 41 41 PB2 41 42 PB1 41 44 PA1 44 44 PA1	23	CB2		****									
26 CAI 26 27 IB2 27 28 IB1 28 29 IA2 30 30 IAI 30 31 BB2 31 32 BB1 32 33 BA2 33 34 BAI 34 35 PE2 35 36 PEI 36 37 PD2 37 38 PDI 38 39 PC2 39 40 PCI 40 41 PB2 41 42 PBI 42 43 PA2 43 44 PAI 45	24					<u> </u>			<u> </u>				
27 B2 28 B1 28 29 IA2 29 IA2 30 IA1 30 31 BB2 31 32 BB1 32 BB1 32 BB1 33 BA2 33 BA2 33 BA2 34 BA1 35 PE2 36 PE1 36 37 PD2 37 38 PD1 38 PD1 39 PC2 39 40 PC1 40 41 PB2 42 PB1 42 PB1 42 PB1 44 PA1						<u> </u>			 	<u> </u>			
28 B1 28 29 IA2 29 30 IA1 30 31 BB2 31 32 BB1 32 33 BA2 33 34 BA1 34 35 PE2 35 36 PEI 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						<u> </u>			ļ				
29 IA2 29 30 IA1 30 31 BB2 31 32 BB1 32 33 BA2 33 34 BA1 34 35 PE2 35 36 PB1 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						1			<u> </u>	-			
30 IA1 30 31 31 32 32 32 33 34 34 34 35 PE2 35 36 PE1 36 37 PD2 37 38 PD1 38 PD1 39 40 PC1 40 41 PB2 41 42 PB1 42 43 PA2 44 PA1 44 P					+		1		 		· .	*****	
31 BB2 32 BB1 33 BAZ 34 BAI 35 PE2 36 PBI 37 PD2 38 PDI 39 PC2 40 PCI 41 PB2 42 PBI 43 PAZ 44 PAI					+				 	- 			_
32 BBI 32 33 BAZ 33 34 BAI 34 35 PE2 35 36 PBI 36 37 PD2 37 38 PDI 38 39 PC2 39 40 PCI 40 41 PB2 41 42 PBI 42 43 PA2 43 44 PAI 44 44 PAI 44						+							
33 BA2 34 BAI 35 PE2 36 PEI 37 PD2 38 PDI 39 PC2 40 PCI 41 PB2 43 PA2 44 PAI					+	 			 				
34 BAI 34 35 PB2 35 36 PEI 36 37 PD2 37 38 PDI 38 39 PC2 39 40 PCI 40 41 PB2 41 42 PBI 42 43 PA2 43 44 PAI 44 44 PAI 44					 	+	1		1				
35 PE2 35 35 36 PE1 36 36 37 PD2 37 38 PD1 38 PD1 38 PD1 39 PC2 39 39 PC2 39 40 PC1 40 40 41 PB2 41 42 PB1 42 PB1 42 43 PA2 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 44 PA1 45 PE PE PE PE PE PE PE PE PE PE PE PE PE					 	··\	 		 				34
36 PEI 36 36 36 37 PD2 37 37 PD2 38 PD1 38 PD1 38 PD1 39 PC2 39 40 PC1 40 40 41 PB2 41 42 PB1 42 43 PA2 44 PA1 44 PA1 44 PA1 44 PA1 45 PA1 44 PA1 45 PA1 44 PA1 45 PA1 PA1 PA1 PA1 PA1 PA1 PA1 PA1 PA1 PA1		} 			+	 	+ +			 			
37 PD2 38 PD1 38 38 39 PC2 39 40 PC1 40 41 PB2 41 42 PB1 42 43 PA2 44 PA1 44 PA1 44 44					 	1	 		 				
38 PD1 38 38 39 PC2 39 40 PC1 40 41 PB2 41 42 PB1 42 43 PA2 44 PA1 44 44 PA1 45 45 45 45 45 45 45 45 45 45 45 45 45						1	+ +		 				
39 PC2 39 40 PC1 40 41 PB2 41 42 PB1 42 43 PA2 43 44 PA1 44					†	1 -	- 				****		
40 PC1 40 41 PB2 41 42 PB1 42 43 PA2 43 44 PA1 44				***	1	1	 						
41 PB2 41 42 PB1 42 43 PA2 43 44 PA1 44					1	 	+ 1						
42 PB1 42 43 PA2 43 44 PA1 44						 						ſ	
43 PA2 43 44 PA1 44		·				-t	† †		<u> </u>				
44 PAI 44		•			"	 							
				***		1			T				

	ECTIVE PA	YMENT FO	OR SNF		PROVIDER	NO.:		PERIOD: FROM			WORKSHEET S-1 (CONT.)	7
								TO				
		M3PI	SERVICES I	PRIOR TO	SERVICES O	N OR AFTER		through (1)	High Cost (2)			
		REVENUE	Octobe	r 1st	Octob	er 1st	4/1/2001	- 9/30/2001	April 1, 2000		TOTAL	l
	GROUP	CODE	Rate	Days	Rate	Days	Rate	Days	Days	Days	(see instructions)	1
	1	2	3	3.01	4	4.01	4.02	4.03	4.05	4.06	5	
45.01	ES3							<u> </u>	1	_		45.01
45.02	ES2											45.92
45.03	ESI							1				45.03
45.04	HE2								1			45.04
45.05	HE1							1				45.05
45.06	HD2			^"								45.06
45.07	$H\!DI$		1					1				45.07
45.08	HC2											45.08
48.09	HC1							Ϊ				48.09
45.10	HB2				1							45.10
45.11	HBI											45,11
45.12	LE2											45.12
45.13	LE?		ŭ,									45.13
45.14	LD2				1						<u> </u>	45.14
45.15	LDI		- I									45.15
45.16	LC2											45.16
45.17	LC1				1	1						45.17
45.18	LB2											45.18
45.19	LB!				1							45.19
45.20	CE2											45.20
45.21	CE1										<u></u>	45.21
45.22	CD2			***								45.22
46	TOTAL										l	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 additional 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".

09-0	1				FO)RM	CMS-	2552	-96						369	90 (Co	nt.)
	IDER-BASED RU	RAL HEALT	H CLIN	IC/					DER NO).:	Ï	PERIO	D:		WORKS	SHEET S	5-8
	RALLY QUALIFE									_	ľ	FROM		_			
	IDER STATISTIC							СОМР	ONENT	NO.:		то		***			
Check		[] RHC															
Applica	able Box:	[]FQHC															
	Address and Identi	fication:	•														1
	Street:		a			ar: a :	1		.	a						\rightarrow	1.01
	City:		State:		1 97.70	Zip Coc				County	•						2
2	Designation (for F	QHCs only) - I	Enter "K	" for rur	al or "U"	for urba	n.						-				
~	CT 1 1F: 1-											Grant	Award		Da	ıte T	
Source	of Federal Funds:												Awaiu 1		2		
2	Community Healt	a Contar (Costi	on 22()/	4) Drid	A ot \						-				-		3
	Migrant Health Co							····			·						4
	Health Services fo					vet)											5
	Appalachian Regio			AI 5 10(d	<i>y</i> , 1 110 1	100)									 		6
	Look-Alikes	Har Collanda.	-								 						7
	Other (specify)	***************************************							-								8
	(CF112)				*****	-					•						
Physici	ian Information:										Physicia	n name		I	Billing No	5.	
	Physician(s) furnis	thing services a	at the cli	nic or w	nder agre	ement (s	see instru	ictions)			-				*		9
		<u> </u>															
											Physicia	n name	;		Hours		
10	Supervisory physic	cian(s) and hou	rs of su	pervision	n during j	period (s	ee instru	ections)									10
11	Does this facility	operate as other	than ar	RHC o	FQHC	If yes,	indicate	number	of other	operatio	ns in colu	ımı 2.					11
	(Enter in subscrip	ts of line 12 th	e type o	f other o	peration	(s) and t	ће орега	ting how	rs.)							I	
Facility	y hours of operation	ns (1)					,										
				nday	_	nday		sday	Wedn		Thur		Fri		Satu		
	Type Ope	ration	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	10
12	Clinic					<u> </u>							<u> </u>				12
									. 15.4		- 13	c	.41. \				
	nter clinic hours of																
L	ist hours of operati	on based on a	24 hour	clock. F	or exam	pie: 8:0	Oarn is U	800, 6:31	∪ pm is i≀	ssu, and	michigni	18 240	u.				
10	ler in	i1.6.			. 16			40							1	*******	13
	Have you received Is this a consolida								e enter	in colum	n 2 the					********	14
14	number of provide										Ht Z uic						- '
15		тѕ исписа и	uns repo	JII. LISI	це пап	es ur an	provider	2 atter no	IHOEIS OC		r number				1		15
13	Provider name				W-1"					110710	24 Hantitoer			v	XVIII	XIX	
16	Have you provide	d all ar eubeten	tialist all	GME ^	nete If s	ves enta	r in colu	mns 2 2	and 4+1	ւе որտե	er of pros	ram					16
10	visits performed b						. 11.00111	ل _و ط جمعیده	, was ru		or prog	,					
17	Has the hospitals'						vear for	cost ren	orting ne	riods ov	erlannino	7/1/20	01?		L		17
17	Enter "Y" for yes					ട വറ	. 101	3036 10p	True Po	-10-40-01		,					
	Lines 1 101 yes	14 101 110.	1 yes.	JUC HING	~~~~~~~.												

369	0 (Cont.)		FORM CMS	3-2552-96			09	-01
	SPICE IDENTIFICATION DATA		PROVIDER NO).:	PERIOD:		WORKSHEET	S-9,
					FROM		PARTS I & II	
			HOSPICE NO.;		то			
								•
PAR	TI-ENROLLMENT DAYS							
				Unduplio	cated Days			
				Title XVIII				
				Skilled	Title XIX		Total	
				Nursing	Nursing	All	(sum of	
	Enrollment Days	Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 & 5)	
	_	1	2	3	. 4	5	6	
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5
				, , , , , ,				
PAR	T II - CENSUS DATA							
				Title XVIII				
				Skilled	Title XIX		Total	
				Nursing	Nursing	All	(sum of	
		Title XVIII	Title XIX	Facility	Facility	Other	cols. 1, 2 & 5)	
	·	1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Countinuous							7
	Care Hours Billable to Medicare							
- 8	Average Length of Stay (line 5/line 6)							8

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

9 Unduplicated Census Count

05-04	•	FORM CMS	-2552-96		3690 (Cont.)
		1	PROVIDER NO.:	PERIOD:	WORKSHEET S-	
HOSPIT	TAL UNCOMPENSATED CARE DATA		THO TELL TO	FROM	1,0101011111111111111111111111111111111	
1103111	AL GIVEONI ENDATED CARE DATA		1	то		
Lincomn	ensated Care Information	1		110		
*****	Do you have a written charity care policy?					1
2	Are patients write-offs identified as charity? If yes an	ower lines 2 AI thro	2 04			2
2.01	Is it at the time of admission?	SWCI IIICS 2.01 UIIU	2,04	·		2.01
2.02	Is it at the time of first billing?					2.02
2.02	Is it after some collection effort has been made?					2.03
2.03	Other methods of write-offs (specify)					2.04
						3
4	Are charity write-offs made for partial bills? Are charity determinations based upon administrative	induced without G	annial data?			4
	<u> </u>		ianciai data:			5
	Are charity determinations based upon income data or	***************************************	•			6
	Are charity determinations based upon net worth (ass	•				7
-	Are charity determination based upon income and net		0 TC 9 O1			8
	Does your accounting system separately identify bad	<u>.</u>	7 II yes answer 8.01			8.01
8.01	Do you separately account for inpatient and outpat		0.01.00.0			9
	S 2		answer 9,01 thru 9.04			9.01
9.01	Is it because there is not enough staff to determine		11.0			
9.02	Is it because there is no financial incentive to separ		debt?			9.02
9.03	Is it because there is no clear directive policy on ch					9.03
9.04	Is it because your institution does not deem the dist	-				9.04
	If charity determinations are made based upon income		eximum income that ca	n be earned by patients		
10	(single without dependent) and still determined to be		·			10
	If charity determinations are made based upon incom	e data, is the income	directly tied to Federa	I poverty level?		
1i	If yes answer lines 11.01 thru 11.04					11
11.01	Is the percentage level used less than 100% of the					11.01
11.02	Is the percentage level used between 100% and 150					11.02
11.03	Is the percentage level used between 150% and 200					11.03
11.04	Is the percentage level used greater than or equal 2		poverty level?			11.04
	Are partial write-offs given to higher income patients					12
	Is there charity consideration given to high net worth			raordinary medical expen	ises?	13
	Is your hospital State or local government owned? If					14
14.01	Do you receive direct financial support from that go			guncompensated care?		14.01
14.02	What percentage of the amount on line 14.01 is from		<u>;? </u>			14.02
	Do you receive restricted grants for rendering care to					15
	Are other non-restricted grants used to subsidize char-	ty care?				16
	ensated Care Revenues					
	Revenues from uncompensated care					17
	Gross Medicaid Revenues				*******	17.01
	Revenues from State and local indigent care programs	i				18
	Revenues related to SCHIP (see instructions)					19
	Restricted grants		····			20
	Non-restricted grants					21
	Total Gross Uncompensated Care Revenues					22
	ensated Care Costs					
23	Total charges for patients covered by State and local i	ndigent care progran	1S			23
	Cost to Charge Ratio (Wkst C, Part I, column 3 line 1		ın 8, line 103)			24
	Total State and local indigent care program cost (line	23 x line 24)				25
	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 line	s 25 27 and 29\			l l	32

36-512.2 3690 (Cont.)

PROCEEDINGS PROCEDURE NO. 05-04				FORM CIV	FORM CMS-2552-96				3690 (Cont.)	ont.)	
COUNT CANADIA PROCESSIVE COUNTING SMAKES COU	RECLAS	SIFIC,	ATION AND ADJUSTMENT OF TRIAL BALANCE	OF EXPENSES		PROVIDER NO.:		PERIOD: FROM_ TO		WORKSHEET A	
CHENTELLY, SERVICES, CONTICENTIFIES OLDO, CLECCHER, MISSING STREAMS PROPERTY			COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI.	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
Old Clark Lab. Bark Cook of Clark Districts Old Clark Lab. Bark Cook of Clark Districts Old Old Crebe In Medical Cook of Districts Old Old Clark Districts Districts Districts District Districts District Districts District Distric				1	2	3	4	5	6	7	
2000 Colt Capital Related Coste-Movabile Equations			GENERAL SERVICE COST CENTERS								
2000 Clarc Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Light Lebted Coache Studinger and Externes 2000 Clarc Light Lebted Coache Studinger	0100									-	
Comparison Com	2	0200									7
Month Steam Care Capetal Beautifactor Cactors Adventible Equipment	e	0300									3
Commission of the part of th	4	0400					:				4
1900 Administrative and General 1900 Administrative and General 1900 Administrative and General 1900 Administrative and Repairs 1900 Caretair of Plant 1900 190	5										S
1000 Putationanco and Repairs 1000 Contributionanco and Repairs 1000 Contributionanco and Repairs 1000 Contribution of Plant 1000 Handselpering 1100 Contributional contribution 1000 Contributional contribution 1000 Contributional contributional	9										9
1000 Dienterly	7	_									7
(500) Laundry and Linen Service 1000 Houseleaping 1000 Carbon 1200 Carbon 1200 Carbon 1200 Carbon 1300 Carbon 1400 Number Services and Supply 1500 Permetal Services and Supply 1500 Permetal Services and Supply 1600 Permetal Services and Supply 1700 Modical Records of Supply 1600 Permetal Service and Supply 1600 Permetal Service (specify) 1600 Permetal Service (specify) 2001 Number Service (specify) 2001 Intent & Res. Orbor Program Costs (Approved) 2002 Intent & Res. Orbor Program Costs (Approved) 2003 Intent & Res. Orbor Program Costs (Approved) 2004 Adults and Pediatric (General Routine Care) 2005 Intent & Res. Orbor Care Unit 2006 Adults and Pediatric (General Routine Care) 2007 Coronary Care Unit 2008 District Special Care (care Care Unit <th< td=""><td>∞</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>∞</td></th<>	∞										∞
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1100 Dietary 1200 Calcachian 1	10										10
1300 Carteeria 1300 Carteeria 1300 Carteeria 1300 Maintenance 1400 Nussing Administration 1400 Nussing Administration 1400 Nussing Administration 1400 Nussing Administration 1500 Planman 1500 Planman 1500 Planman 1500 Planman 1500 Nussing Secords & Medical Records Library 1500 Nussing Secords & Medical Records 1500 Nussing Secords & Medical Records & Medical Records 1500 Nussing Secords & Medical Records & Me	:		Dietary								=
1300 Meintenance of Personnel 1400 Meintenance of Personne	12	1200	Cafeteria								12
1400 Nussing Administration 1500 Central Services and Supply 1500 Central Services and Supply 1600 Pentral Services and Supply 1700 Medical Records & Medical Records Library 1800 Social Services 1800 Social Service 1800 Social Service 1800 Nutsing School 2000 Nutsing School 2000 Intern & Ress Other Program Costs (Approved) 2400 Peramedical Ed Program Costs (Approved) 2400 Peramedical Ed Program Costs (Approved) 2500 Intern & Ress Other Program Costs (Approved) 2500 Interns (Service 2500 Interns (Service 2500 Interns (Service 2500 Service 2500 Supplead Internsive Care Unit 13	1300	Maintenance of Personnel								13	
1500 Central Services and Supply 1600 Pharmacy 1600 Pharmacy 1600 Pharmacy 1600 Pharmacy 1600 Pharmacy 1801 Social Service Records Library 1802 Social Service Salary & Fringes (Approved) 2000 Compulyacional Aresthetiss 2010 Musting Service-Salary & Fringes (Approved) 2020 Intern & Res. Other Program Copecity 2030 Intern & Res. Other Program C	14		Nursing Administration								4
1600 Pharmacy 1700 Abdalian Records Library 1700 Abdalian Records Library 1700 Abdalian Records Library 1700 Abdalian Records Library 1700 Cuber Centeral Service (apocify) 1700 Cuber Centeral Service Caperal 1700 Cuber Centeral Service Caperal 1700 Abdalian Caperal Caperal 1700 Abdalian Caperal Caperal Caperal 1700 Caperal Caperal Caper	15		Central Services and Supply								15
1700 Medical Records Library 1700 Medical Records Library 1800 Social Service 2000 Morphy Service (specify) 2001 Nurshing Service (specify) 2000 Morphy Service (specify) 2001 Intent & Res. Service-Salary & Finges (Approved) 2000 Intent & Res. Service-Salary & Finges (Approved) 2001 Intent & Res. Service-Salary & Finges (Approved) 2000 Intent & Res. Sorvice-Salary & Finges (Approved) 2400 Parametical Ed. Program Costs (Approved) 2000 Intent & Res. Sorvice-Salary & Finges (Approved) 2401 Parametical Ed. Program Costs (Approved) 2000 Intent & Res. Sorvice-Salary & Finges (Approved) 2500 Intensive Care Unit 2000 Intensive Care Unit 2500 Intensive Care Unit 2000 Intensive Care Unit 2500 Surgueal Intensive Care Unit 2000 Intensive Care Unit 2500 Intensive Care Unit 2000 Intensive Care Unit 2500 Intensive Care Unit 2000 Intensive Care Unit 2500 Intensive Care Unit 2000 Intensive Care Unit 2500 Intensive Care Unit 2500 Intensive Care Unit 2500 Intensive Sare Unit 2500 Intensive Care Unit 2500 Intensive Care Unit 2500 Intensive Care Unit 2500 Intensive Care Unit 2500 Intensive Care Unit	16		Pharmacy				***************************************				16
1800 Social Service	17		Medical Records & Medical Records Library								17
2000 Norpital Service (specify) Other General Service (specify) Company Central Service (specify) 2100 Numing School Norpital S	18										18
2000 Nonphysician Anesthetists 2000 Intent & Res. Service-Salary & Fringes (Approved) 2000 Intent & Res. Service-Salary & Fringes (Approved) 2000 Intent & Res. Service-Salary & Fringes (Approved) 2000 Intent & Res. Other Program (specify) 2000 Parametical Ed. Program (specify) 2000 <td>19</td> <td></td> <td>Other General Service (specify)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>19</td>	19		Other General Service (specify)								19
2100 Nursing School 24 (Nursing School Nursing Schoo	20										20
2200 Intern & Res. Service-Salary & Fringes (Approved) 200 Intern & Res. Other Program Costs (Approved) 200 Intern & Res. Other Program Costs (Approved) 200 Intern & Res. Other Program (specify) 2400 Paramedical Ed. Program (specify) 250 Anny ATHENT FOUTINE SERVICE COST CENTER 250 Internsive Care Unit 250 Internsive Care Unit <td>21</td> <td></td> <td>Nursing School</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>,</td> <td></td> <td>21</td>	21		Nursing School						,		21
2300 Intern & Res. Other Program Costs (Approved) Approved) Approved 2400 Paramedical Ed. Program (specify) Mach Ed. Program (specify) Mach Ed. Program (specify) 2500 Adults and Pediatrics (General Routine Care) Adults and Pediatrics (General Routine Care) Mach Ed. Program Care Unit 2500 Intersive Care Unit Man Intersive Care Unit Mach Ed. Program Care Unit 2500 Surgical Intensive Care Unit Mach Ed. Program Care Unit 310 Subgram Ed. Intensive Care Unit Mach Ed. Program Care Unit 3400 Skilled Nursing Facility Mach Ed. Program Care Unit 3500 Nursing Facility Mach Ed. Program Care Unit 3500 Nursing Facility Mach Ed. Program Care Unit	22	_									22
2400 Paramedical Ed. Program (specify) Adults and Pediatrics (General Routine Care) Adults and Pediatrics (General Routine Care) 2500 Adults and Pediatrics (General Routine Care) 2600 Intensive Care Unit 2700 Coronary Care Unit 2800 Burn Intensive Care Unit 2800 Burn Intensive Care Unit 2800 Surgical Intensive Care Unit 2900 Surgical Intensive Care Unit 3100 Subprovider (specify) 3100 Subprovider (specify) 3300 Nursing Pacility 3400 Skilled Nursing Pacility 3500 Nursing Pacility 3500 Other Long Term Care 3600 Other Long Term Care	23	2300								-	23
INPATIENT ROUTINE SERVICE COST CENTER 2500 Adults and Pediatrics (General Routine Care) Adults and Pediatrics (General Routine Care) 2600 Intersive Care Unit 700 2700 Coronary Care Unit 700 2800 Burn Intensive Care Unit 700 2900 Surgical Intensive Care Unit 700 3100 Subprovider (specify) 700 3300 Nursing Pacility 700 3400 Skilled Nursing Pacility 700 3500 Nursing Facility 700 3600 Other Long Term Care 700	24	_	Paramedical Ed. Program (specify)								24
2500 Adults and Pediatrics (General Routine Care) Adults and Pediatrics (General Routine Care) 2600 Intensive Care Unit Adults are Unit 2700 Coronary Care Unit Adults are Unit 2800 Burn Intensive Care Unit Adults are Special Tensive Care Unit 2800 Surgical Intensive Care Unit Adults are Special Care (specify) 3800 Subprovider (specify) Adults are Special Care (specify) 3800 Nursing Facility Adults are Care 3800 Other Long Term Care Adults are Care			NPATIENT ROUTINE SERVICE COST CEN								
2600 Intensive Care Unit 2700 Coronary Care Unit 8 2800 Burn Intensive Care Unit 8 8 2800 Sugical Intensive Care Unit 8 8 2900 Sugical Intensive Care Unit 8 8 3100 Subprovider (specify) 8 8 3300 Nursing Facility 8 8 3500 Nursing Facility 8 8 3600 Other Long Term Care 8 8	25		Adults and Pediatrics (General Routine Care)								25
2700 Coronary Care Unit 2800 Burn Intensive Care Unit 2800 Burn Intensive Care Unit 2800 Surgical Intensive Care Unit 2800 Surgical Intensive Care Unit 2800 Surgical Intensive Care Unit 3800 Subprovider (specify) 3800 Nursent 3800 Nursing Facility 3800 Nursing Facility 3800 Other Long Term Care 3800 Other Long Term Care	26		Intensive Care Unit								56
2800 Burn Intensive Care Unit 2900 Surgical Intensive Care Unit 2900 Surgical Intensive Care Unit 6 Cher Special Care (specify) 3100 Subprovider (specify) 8 3300 Nurseap 8 3500 Nursing Pacility 8 3600 Other Long Term Care 8	27		Coronary Care Unit								27
2900 Sugical Intensive Care Unit Other Special Care (specify) 100 3100 Subrovider (specify) 3300 Nursery 3400 Skilled Nursing Facility 3600 Other Long Term Care	28		Burn Intensive Care Unit								28
Other Special Care (specify) 3100 Subprovider (specify) 3300 Nursery 3400 Skilled Nursing Facility 3500 Nursing Facility 3500 Other Long Term Care	59		Surgical Intensive Care Unit								52
3100 Subprovider (specify) 3300 Nursery 3400 Skilled Nursing Facility 3500 Nursing Facility 3600 Other Long Term Care 3600 Other Long Term Care	30	L	Other Special Care (specify)								30
3300 Nursery 3400 Skilled Nursing Facility 3500 Nursing Facility 3500 Nursing Facility 3500 Other Long Term Care	31	-	Subprovider (specify)								31
3400 Skilled Nursing Facility 3500 Nursing Facility 3600 Other Long Term Care	33	_	Nursery								33
3500 Nursing Facility 3600 Other Long Term Care	34		Skilled Nursing Facility								34
3600 Other Long Term Care	35		Nursing Facility								35
	36		Other Long Term Care								36

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

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

PERIOD: FORM CMS-2552-96
PROVIDER NO.: Rev. 20 07-09 RECLASSIFICATION AND ADJUSTIMENT OF TRIAL BALANCE OF EXPENSES

36-513 3690 (Cont.) WORKSHEET A

			2	12		82	83	8	85	8	88	68	8	92	દ્ધ	8	8		8	16	88	8	100	101
	NET EXPENSES FOR ALLOCATION	(cot. 3 ± cot. 0) 7									-0-	-0-	-0-											
	Doda S. J. F. Wood Line V.	9 STATEMENTS																						
FROMTO	RECLASSIFIED TRIAL BALANCE	(coi. 3 # coi. 4) 5																						
	RECLASSIFI.	CALIONS 4																						-0-
·	TOTAL	3																						
	aarii	2																						
	CAI ADITO	1																						***************************************
	COST CENTER DESCRIPTIONS	(Sunc Cours)	7000 Intern-Resident Service (not appvd. tchng. prgm.)	7100 Home Health Agency	SPECIAL PURPOSE COST CENTERS	8200 Lung Acquisition	8300 Kidney Acquisition	8400 Liver Acquisition	8500 Heart Acquisition	Other Organ Acquisition (specify)	8800 Interest Expense	8900 Utilization Review-SNF	9000 Other Capital-Related Costs (see instructions)	9200 Ambulatory Surgical Center (Distinct Part)	9300 Hospice	Other Special Purpose (specify)	SUBTOTALS (sum of lines 1-94)	NONREIMBURSABLE COST CENTERS	9600 Gift, Flower, Coffee Shop, & Canteen	9700 Research	9800 Physicians' Private Offices	9900 Nonpaid Workers	Other Nonreimbursable (specify)	TOTAL (sum of lines 95-100)
									-			0068		9200						9700	0086		_	
			70	71		82	83	84	85	98	88	68	96	92	93	94	95		96	76	86	99	100	101

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

EXPLANATION OF RECLASSIFICATION(S) (1) 1 (2) (1) 1 (1) (2) (1) (1	11-96	96		FORM CMS-2552-96	552-96						369((Con	(;
EXPLANATION OF RECLASSIFICATION(8)	RECI	ASSIFICATIONS		A STATE OF THE STA	PROVID	ER NO.:		PERIOD: FROM			WORKSHEET	A-6	
CODIS CODI			_		INCREA	SES			DECRE,	ASES		Wkst.]
Total resultation to time 4 and 5 a 6 a 7 a 8 a 9 a 10 a 10 a 10 a 10 a 10 a 10 a 10		HXPLANATION OF RECLASSIFICATION(S)	CODE		LINE #		OTHER	COST CENTER	# EN 1		OTHER	A-7 Ref.	
The circle activations at and 5			-	2	3	1 1	5	9	7	1 [6	01	1 1
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Total reviewfictions (sum of columns 4 and 5	2	Light Michigan Control of the Contro											~
Total reclassifications (sum of columns 4 and 5)	3												m
The interactions (cum of columns 4 and 5)	4												4
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Tool reclassifications (sum of columns 4 and 5)	φ	William	4									1	ωl
Thoir reclassifustrose (sum of columns 4 and 5	7												<u>- </u>
Total reclassification (sum of columns 4 and 5	8												∞
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Total reclassifications (sum of columns 4 and 5	12												12
Total reclessifications (sum of columns 4 and 5	13												2
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Total reclassifications (sum of columns 4 and 5 Trust equal sum of columns 8 and 9)	15												15
Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)	16												16
Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)	17												17
Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)	18												<u>%</u>
Total reclassifications (arm of columns 4 and 5 must equal sum, of columns 8 and 9)	19												6]
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Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)	22												ß
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	23												23
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	24												72
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	25												52
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Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	27												27
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Total reclussifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	30												<u>۾</u>
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	31												31
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	32												32
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	33											1	33
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	34											1	34
Total reclassifications (sum of columns 4 and 5 must equal sum, of columns 8 and 9)	35												쑀
Imust equal sum of columns 8 and 9)	36	Total reclassifications (sum of columns 4 and 5											36
		must equal sum of columns 8 and 9)			******								1

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

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3611) Rev. 2

11-96 FORM CMS-2552-5	S-2552-96		3690 (Cont.)
ANAL YSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL	PROVIDER NO:	PERIOD:	WORKSHEET A-7,
ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE		FROM	PARTS I & II
COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS		ТО	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

			Acquisitions		Disposals		Fully	
	Beginning				pure	Ending	Depreciated	
Description	Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
	1	2	3	4	5	9	7	
I Land								1
2 Land Improvements								2
3 Buildings and Fixtures								3
4 Building Improvements								4
5 Fixed Equipment								5
6 Movable Equipment								9
7 Subtotal (sum of lines 1-6)								7
8 Reconciling Items								8
9 Total (line 7 minus line 8)								0

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

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

WORKSHEET A-7, PARTS III & IV PERIOD: FROM

PROVIDER NO. PART III - RECONCILIATION OF CAPITAL COSTS CENTERS RECONCILIATION OF CAPITAL COSTS CENTERS

cols. 5-7) Jo ums) Total OF OTHER CAPITAL Other Capital-Related Costs Taxes (see instru.) Ratio (col. 1 - col. 2) Gross Assets for Ratio Capitalized COMPUT Gross Assets New Capital Related Costs-Buildings and Fixtures Old Capital Related Costs-Movable Equipment New Capital Related Costs-Movable Equipment Description

Local (Julio 2 line)		SUMMARY OF OLD AND NEW CAPITAL	OLD AND NEW	CAPITAL			<u> </u>
					Other Capital-	Total (1)	
			Insurance	Taxes	Related Costs	Jo ums)	
Document	 						

						•	`
				Insurance	Taxes	Related Costs	Jo ums)
Description	Depreciation	Lease	Interest	(see instru.)	(see instru.)	(see instru.)	cols. 9-14)
*	6	10	11	12	13	14	15
1 Old Capital Related Costs-Buildings and Fixtures							
2 Old Capital Related Costs-Movable Equipment							
3 New Capital Related Costs-Buildings and Fixtures							
4 New Capital Related Costs-Movable Equipment							
5 Total (sum of lines 1-4)							
(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	et A, column 7, lines	1 thru 4. Columns	9 through 14 shou	ld include related			
Worksheet A-6 reclassificators, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)	-1 related organizati	ons and home office	costs. (See instru	ctions.)			
A CONTRACTOR MANAGEMENT OF THE PROPERTY OF THE							
PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4	LUMN 2, LINES 1	THRU 4					
Marie 14).			SUMMARY OF	SUMMARY OF OLD AND NEW CAPITAL	'CAPITAL		
						Other Capital-	Total (1)
				Insurance	Taxes	Related Costs	Jo tuns)

						Other Capital-	Total (I)	
				Insurance	Taxes	Related Costs	Jo tuns)	
Description	Depreciation	Lease	Interest	(see instru.)	(see instru.)	(see instru.)	cols. 9-14)	
*	9	10	11	12	13	14	15	
1 Old Capital Related Costs-Buildings and Fixtures								-
2 Old Capital Related Costs-Movable Equipment								ر ا
3 New Capital Related Costs-Buildings and Fixtures								m
4 New Capital Related Costs-Movable Equipment								4
5 Total (sum of lines 1-4)								ام ا

(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

 All lines numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers. which may have been included in Worksheet A, column 2, lines 1 thru 4.

FORM CMS-2552-96 (12/1999) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3612, 3612,2 AND 3612.3)

36-517

3690 (Cont.)	FORM CMS-		***			2-99
ADJUSTMENTS TO EXPENSES	PROVIDER NO).	PERIOD:	WORKS	HEET A-	8
			FROM	ŀ		
			TO	1		
			EXPENSE CLASSIFICATIO			
			WORKSHEET A TO/FROM		Wkst.	
, DESCRIPTION (1)	(2)		THE AMOUNT IS TO BE AI		A-7	
	BASIS/CODE	AMOUNT	COST CENTER	LINE#	Ref.	
	1	2	3	4	5	
1 Investment income - old buildings and fixtures (char			A Hidisani, 1345			
2 Investment income - old movable equipment (chapte			34234 × 3645 × 344358**			2
3 Investment income - new buildings and fixtures (cha			100 (-100)			3
4 Investment income - new movable equipment (chapt	ter 2)		Section was full record			
5 Investment income - other (chapter 2)					-	
6 Trade, quantity, and time discounts (chapter 8)				+		
7 Refunds and rebates of expenses (chapter 8)				-	1	
8 Rental of provider space by suppliers (chapter 8)						
9 Telephone services (pay stations excluded) (chapter	21)			+	 	
10 Television and radio service (chapter 21)						10
11 Parking lot (chapter 21)						1:
12 Provider-based physician adjustment	0000				\vdash	
13 Sale of scrap, waste, etc. (chapter 23)	***************************************					1;
14 Related organization transactions (chapter 10)					-	1-
15 Laundry and linen service					\vdash	1.
16 Cafeteria-employees and guests	***	· · · · · · · · · · · · · · · · · · ·		 		1
17 Rental of quarters to employee and others				_	\vdash	
18 Sale of medical and surgical						1
supplies to other than patients	····					1.0
19 Sale of drugs to other than patients		v=-		-		1:
20 Sale of medical records and abstracts					1	2
21 Nursing school (tuition, fees, books, etc.)			<u></u>		l	2
22 Vending machines						$-\frac{2}{2}$
23 Income from imposition of interest,					1 1	2
finance or penalty charges (chapter 21)			<u> </u>	+		
24 Interest expense on Medicare overpayments and						
borrowings to repay Medicare overpayments						2
25 Adjustment for respiratory therapy	XX85					2
costs in excess of limitation (chapter 14)	000000000000000000000000000000000000000		5.00			
26 Adjustment for physical therapy costs						2
in excess of limitation (chapter 14)	(3)************************************		990 03 307 07			2
27 Adjustment for HHA physical therapy						4
costs in excess of limitation	. 21)					2
28 Utilization review - physicians' compensation (chapt	ter 21)					2
29 Depreciation - old buildings and fixtures			365 (538) (548)			3
30 Depreciation - old movable equipment	*****		CONTRACTOR OF THE PROPERTY.			3
31 Depreciation - new buildings and fixtures			000000000000000000000000000000000000000		\vdash	3
32 Depreciation - new movable equipment			COLUMN TO A STATE OF THE STATE			3
33 Non-physician Anesthetist			Services Assesses			3
34 Physicians' assistant						3
35 Adjustment for occupational therapy costs						د ا
in excess of limitation (chapter 14)			CALLEGE COLUMN			3
36 Adjustment for speech pathology costs						د ا
in excess of limitation (chapter 14)	. Wikat ∧ 1 (CALCON CHARLES AND AND CO.			3
37 Other adjustments (specify) (3)		1000				5
50 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)				1		

⁽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.

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

A. C	l l	and adjustments required as a res	WIN OF WARRISH WARRIES WITH THE		Amount	Net		Г
				Amount of	included in	Adjustments	Wkst.	
	l			Allowable	Wkst. A,	(col. 4 minus	A-7	
	Line No.	Cost Center	Expense Items	Cost	column 5	col. 5) *	Ref.	
	1	2	3	4	5	6	7	
1	1							1
2								2
3		***************************************						3
4		···						4
5	TOTALS (su	m of lines 1-4) Transfer column 6, lir	ne 5 to Worksheet					5
	A-8, column	2, line 14.						Щ

^{*} The amounts on lines 1.4 and subscripts as appropriate are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related 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	
	·		Percentage		Percentage		- 1
	Symbol		σf		of	Type of Business	- 1
	(1)	Name	Ownership	Name	Ownership	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

										•
PROVIE	ER-BASED PHY:	PROVIDER-BASED PHYSICIANS ADJUSTMENTS			PROVIDER NO.:		PERIOD: FROM	,	WORKSHEET A-8-2	5
							OI			- 1
		Cost Center/					Physician/		5 Percent of	
	Wkst, A	Physician	Total	Professional	Provider	RCE	Provider		Unadjusted	
	Line#	Identifier	Remuneration	Component	Component	Amount	Component Hours	RCE Limit	RCE Limit	
	1	. 2	3	4	5	9	7	8	6	-
1										\vdash
2										-
3			7							-
4										1
5										+
9										-
7										⊢
8										-
6										_
10										+
11										1
101	TOTAL									-
			Cost of	Provider	Physician	Provider				1
		Cost Center/	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line#	Identifier	Education	col. 12	Insurance	col. 14	RCE Limit	Disallowance	Adjustment	
	10	11.	12	13	14	15	16	17	18	├
1										-
2				,						1
т										
4										┈
5										
9										 -
7										├-
8										├
6										┈
10										⊢
11										\vdash
[TOTAL									-

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11.	11-96			FORM	FORM CMS-2552-96	96-7					3	3690 (Cont.)	(t.)
RE/	REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Åd			<u>a</u>	PROVIDER NO.:		PERIOD; FROM			WORKSHEET A-8-3, PARTS I & II	8-3,	
								TO					1
 ਹੈ	Clieck applicable box:	() Physical The	rapy () Resp	herapy () Respiratory Therapy									١
PA!	PART I - GENERAL INFORMATION												
1	Total number of weeks worked (excluding aides) (see instuctions).	instuctions).											-
2	Line 1 multiplied by 15 hours per week												7
	Number of unduplicated days in which the following categories, as	ategories, as a	opropriate, are	appropriate, are on the provider's site and have the highest AHSEA, where applicable	s site and have	the highest AH	SEA, where ap	plicable.					١
۳	3 Supervisors or therapists												3
4	4 Therapy assistants and no supervisors or therapists.												4
5	Registered Therapists												5
9	Certified Therapists												9
7	Non-registered, non-certified therapists												7
×	8 Number of unduplicated HHA visits - supervisors or therapists (see	herapists (see ii	instructions)										8
6	9 Number of unduplicated HHA visits - therapy assistants (include only visits made by therapy assistant and in which	its (include only	y visits made b	y therapy assists	ant and in which	1							6
	supervisor and/or therapist was not present during the visit(s)) (see		instructions)										.
10	Standard travel expense rate												2
=	11 Optional travel expense rate per mile												=
			Supervisors				Therapists						
	•			Non-Reg.				Non-Reg.		-			
	•	Reg.	Cert.	Non-Cert.	Total	Reg.	Cert.	Non-Cert.	Total	Assistants	Aides	Trainees]
		1	2	3	4	5	9	7	8	6	10	11	1
12	12 Total hours worked												12
13	AHSEA (see instructions)												13
14	Standard travel allowance (enter 1/2 of the amounts												14
	from cols. 5-8, line 13, in cols. 1-4 and 5-8 and												
	enter 1/2 the amount from col. 9, line 13 in col. 9)												
15	Number of travel hours (HHA only)												15
19	16 Number of miles driven (HHA only)												16

PART II - SALARY EQUIVALENCY COMPUTATION

		۱
17	17 Supervisors total (column 4, line 12 times column 4, line 13)	17
28	8 Supervisory Registered Therapist (column 1, line 12 times column 1, line 13)	18
16	9 Supervisory Certified Therapists (column 2, line 12 times column 2, line 13)	61
20	0 Supervisory non-registered, non-certified therapists (column 3, line 12 times column 3, line 13)	20
77	Therapists total (column 8, line 12 times column 8, line 13)	21
22	22 Registered Therapists (column 5, line 12 times column 5, line 13)	77
	(6.213c 1.213c distributed if at mini also in citital finite facts before intermediations of some of second	

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.1-3616.2) Rev. 2

REASONABLE COST DETERMINATION FOR THERAPY		FORM CMS-2552-96 PROVIDER NO.:	S-2552-96	PERIOD:			WORKSHEET A-8-3,	3690 (Cont.)	nt.)
SERVICES FORNISHED BY OUTSIDE SOFF LIERS				TO			, tr, tr		İ
Check applicable box: [() Physical Therapy () Respiratory Therapy	1								
		Therapists							
	,	5	Non-registered	Total	\$ 000 to the	Aidoo	Trainper	Total	
PART V. OVERTIME COMPITATION	Kegistered	Certified 2	3 3	10tal 4	Assistants 5	9 9	7	8	
52 Overtime hours worked during cost reporting period (if column 8, line 52, is									\$2
zero or equal to or greater than 2,080, do not complete lines 53 through 60			~						
									5
53 Overtime rate (see instructions)									8 2
54 Total overtime (including base and overtime allowance) (line 32 times line 53)									5
55 Percentage of overtime hours by category (divide the hours in each column									55
on line 52 by the total overtime worked - column 8, line 52									
56 Allocation of provider's standard workyear for one full-time employee									26
times the percentages on line 55 (see instructions)									
Determination of Overtime Allowance									
57 Adjusted hourly salary equivalency amount (AHSEA) (see instructions)									24
58 Overtime cost limitation (line 56 times line 57)									58
Maximum overtime cost (enter the lesser of lines 54 or 58)									59
60 Portion of overtime already included in hourly computation at the AHSEA									09
(multiply line 52 times line 57)									
61 Overtime allowance (line 59 minus line 60. If negative, enter zero.)									61
(column 8, see instructions)									
ENGRADORY ALEGO SOCIONE GRA MORE STREET WAS ACTUAL OF MORE STREET, WAS ACTUAL OF THE STREET, WE SENT STREET	TATELLA								
FARI VI - COMPUTATION OF THEKAPY LIMITATION AND EACESS COST AN	O COLIMBINI								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)									8
67 Supplies (see instructions)									6
68 Total allowance (sum of lines 62-67)									ŝ
69 Total cost of outside supplier services (from your records)									3
70 Excess over limitation (line 69 minus line 68. If negative, enter zero. See instructions.)	(3								02
PART VIL. AT LOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES	R NONSHARE	D THERAPY I	DEPARTMENT	SERVICES					
71 Cost of outside supplier services - hospital (from your records)									71
72 Cost of outside supplier services - HHA (from your records)									72
	(6)								73
74 Ratio of hospital cost of outside supplier services to total cost (line 71 divided by line 73)	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 25, as applicable)	1-8, lines 25 or 20	6, as applicable)							92
77 HHA excess of cost over limitation (line 70 times line 75) (transfer to Worksheet A-8, line 27)	Ine 27)								:]
FORM CMS-2552-56 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-41, SECTIONS 3016.3-3016.7)	LED IN CMS FU	В. 13∗Щ МЕСТР	UNS 3010,3-3010	0.0					

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FORM CMS-2552-96		
FORM CMS-2552		

3690 (Cont.)

REA	REASONABLE COST DETERMINATION FOR THERAPY SERVICES		PROVIDER NO.:	PERIOD:	WORKSHEET A-8-4,	
FUR	FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998			FROM	PARTS I & II	
	- Control of the Cont			TO		I
Check	Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology					1
PAR	INFORMATION					I
F	Total number of weeks worked (excluding aides) (see instructions)					-1
2						7
т	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3
4		vider site (see instru	ctions)			4
S	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					2
9				-		9
	supervisor and/or therapist was not present during the visit(s)) (see instructions)					I
7	Standard travel expense rate					-
∞	Optional travel expense rate per mile					∞
	Supervisors	Therapists	Assistants	Aides	Trainees	١
		2	3	4	5	1
6	Total hours worked					م
10	AHSEA (see instructions)					2
11	Standard travel allowance (columns 1 and 2, one-half of column 2,					11
	line 10, column 3, one-half of column 3, line 10)					[
12	Number of travel hours (see instructions)					12
13	Number of miles driven (see instructions)					13
PAR	PART II - SALARY EQUIVALENCY COMPUTATION		Make transfer			ı
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)					92
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					17
182						18
19	Trainees (column 5, line 9 times column 9, line 10)					<u>6</u>
20	20 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					20
						l

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.

Weighted everage 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) 22 Weighted allowance excluding aides and trainees (line 2 times nine 21).

23 Total salary equivalency (see instructions)

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

12-99		FORM CMS-2552-96			3690 (Cont.)
REASONABLE FURNISHED B	REASONABLE COST DETERMINATION FOR THERAPY FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER A	SERVICES PRIL 10, 1998	PROVIDER NO.	PERIOD; FROM	WORKSHEET A-8-4, PARTS III & IV
				TO	
Check applicable box:	e box:	[] Occupational [] Physical [] Respiratory [] Speech Pathology			
PART III - STA	INDARD AND OPTIO	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
Standard Travel Allowance	el Allowance				
24 Therapists	Therapists (line 3 times column 2, line 11)	ine 11)			24
25 Assistants	Assistants (line 4 times column 3, line 11)	ine 11)	•		25
26 Subtotal (Subtotal (line 24 for respiratory therapy or sum of lines 24	rapy or sum of lines 24 and 25 for all others)			26
	ravel expense (line 7 tim	Standard travel expense (line 7 times line 3 for reslpiratory therapy or sum of lines 3 and 4 for all others)			27
	dard travel allowance and	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			28
Optional Travi	Optional Travel Allowance and Optional Travel Expense	l Travel Expense			
29 Therapists	Therapists (column 2, line 10 times the sum of columns 1	the sum of columns 1 and 2, line 12)			29
30 Assistants	Assistants (column 3, line 10 times column 3, line 12)	column 3, line 12)			30
31 Subtotal (line 29 for respiratory the	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			31
32 Optional t	ravel expense (line 8 tim	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
_	ravel allowance and stan	Standard travel allowance and standard travel expense (line 28)			33
	ravel allowance and stank	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	-		34
35 Optional t	ravel allowance and optic	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			35
PART IV - ST	ANDARD AND OPTIO	PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE	E PROVIDER SITE		
Standard Travel Expense	el Expense				
36 Therapist	36 Therapists (line 5 times column 2, line 11)	ine 11)			36
37 Assistants	Assistants (line 6 times column 3, line 11)	ine 11)			37
	Subtotal (sum of lines 36 and 37)				38
39 Standard t	ravel expense (line 7 tim	Standard travel expense (line 7 times the sum of lines 5 and 6)			39
Optional Trav	Optional Travel Allowance and Optional Travel Expense	ıl Travel Expense			
40 Therapist	s (sum of columns 1 and	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			40
	Assistants (column 3, line 12.01 times column 3, line 10)	nes column 3, line 10)			41
	Subtotal (sum of lines 40 and 41)				42
	Optional travel expense (line 8 times the sum of columns	es the sum of columns 1-3, line 13.01)			43
Total Travel	Ulowance and Travel Exp	Total Travel Allowance and Travel Expense - Offsite Services, Complete one of the following			-
three lines 44,	three lines 44, 45, or 46, as appropriate.	The second secon			
44 Standard	travel allowance and stan	44 Standard travel allowance and standard travel, expense (sum of lines 38 and 39 - see instructions)			44
45 Optional t	ravel allowance and stan-	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			45
46 Optional	ravel allowence and optiv	46 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)			46
FORM CMS-2:	.52-96 (12/1999) (INST.	XUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-11, SECTIONS 3616.8, 3616.11-361	5.12)		

12 EE	12-99 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	FORM CMS-2552-96	96-29	PROVIDER NO.:	PERIOD: FROMTO	3690 (Cont.) Worksheet A-8-4, Parts V-VII	nt.)
Che	Check applicable box: [] Occupational [] Physical [] Respiratory [] Speech Pathology PARTY - OVERTME COMPLIFICATION	athology		:			
Š.		Therapists	Assistants	Aides	Trainees	Total	l
		1	2	8	. 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
84	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
	CALCULATION OF LIMIT						
20							20
ŀ	column on line 4/ by the total overtime worked - column 4, line 4/)						:
21	Allocation of provider's standard workyear for one full-time						7
	DETERMINATION OF OVERTIME ALLOWANCE						
25	Adjusted hourly salary equivalency amount (see instructions)						25
53	Overtime cost limitation (line 51 times line 52)						53
\$	Maximum overtime cost (enter the lessor of line 49 or line 53)						34
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						25
56							26
PA.	PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT	ENT				+	
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
8	Overtime allowance (from column 5, line 56)						8
9	_						19
62							62
63	Total allowance (sum of lines 57-62)						83
8	Total cost of outside supplier services (from your records)						R
65	65 Excess over limitation (line 64 minus line 63 - if negative, enter zero) PADT VII. ALLI OCATION OF THER ADV PYCESS COST, OVER I PAGTATION FOR NONSHAREN THER ADV DRIVATIONS SERVICES	T VGA THER LEADY I	REPARTMENT SE	PVICES			65
99	Cost of cutside sumulier services ((see instructions) (from voir records)						99
29	Total cost (sum of line 66 and subscripts) (this line must agree with line 64)						22
89	Ratio of cost of outside supplier services to total cost (line 66 and subscripts divided by line 67)						89
69	Excess of cost over limitation (see instructions) (transfer to Wkst. A-8, lines as indicated in instructions)	uctions)					69
70	Total excess of cost over limitation (sum of line 69 and subscripts of line 69) (this line must agree with line 65)	e with line 65)					70
PO PO	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)	PUB. 15-11, SECTIONS	3616.8 and 3616.13-3	3616.15)		-	

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NECONTINES NEC	COST ALLOCATION - GENERAL SERVICE COSTS											ł
ADMINIS. MAIN. E BAPLOYEE SUBTOTAL TRAITYE& TENANCE & OPERATION S SA GENERAL SEPAIRS OF PLANT S SA GENERAL SEPAIRS OF PLANT S SA GENERAL SEPAIRS OF PLANT 1 1						-	PROVIDER N	:: O	PERIOD: FROMTO		WORKSHEET PART I	
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		NET EXPENSES FOR COST	OLD CAPITAL RELATED COSTS	PITAL COSTS	NEW CAPITAL RELATED COSTS	APITAL) COSTS							
	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst. A, col. 7)	BLDGS. & FIXTURES	MOVABLE	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	ا	
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47	Blood Storing, Processing, & Trans,											47 47	7
48			*****									48 48	∞
49	Respiratory Therapy												0,
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51	Occupational Therapy											51 51	,
52	Speech Pathology												2
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55	Medical Supplies Charged to Patients											55 55	'n
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28	ASC (Non-Distinct Part)												∞
59	Other Ancillary (specify)											59 59	6
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70	Intern-Resident Service (not approd. tchng. prgm.)											70 70	0
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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET B, PART I	COST
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3690 (Cont.) 08-9 WORKSHEET B, COST PART I	SOCIAL	18		_1			_1_		_1_	1		1		_!		1																						
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	HOUSE- KEEPING	10																																				ARE PUBLIS
	LAUNDRY & LINEN SERVICE	6																																				WORKSHEET
39 ALLOCATION - GENERAL SERVICE COSTS	COST CENTER DESCRIPTIONS	GENERAL SERVICE COST CENTERS	Old Capital Related Costs-Buildings and Fixtures	Old Capital Related Costs-Movable Equipment	New Capital Related Costs-Buildings and Fixtures	New Capital Related Costs-Movable Equipment	Employee Benefits	Administrative and General	Maintenance and Repairs	Operation of Plant	Laundry and Linen Service	Housekeeping	Dietary	Cafeteria	Maintenance of Personnel	Nursing Administration	Central Services and Supply	Pharmacy	Medical Records & Medical Records Library	Social Service	Other General Service (specify)	Nonphysician Anesthetists	Nursing School	Intern & Res. Service-Salary & Fringes (Approved)	Intern & Res. Other Program Costs (Approved)	Paramedical Ed. Program (specify)	A 4-th and Dadiotalian (Consum Datation Care)	Intensive Care Thit	Coronary Cara Unit	Rum Intensive Care Unit	Surgical Intensive Care I hit	Other Special Care Unit (specify)	Submovider (sneeify)	Vinserv	Skilled Nursing Facility	Nursing Facility	Other Long Term Care	J CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617)

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COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL	
	6	10	11	12	13	14	15	16		18	1
ANCILLARY SERVICE COST CENTERS											.
Operating Room											ı
Recovery Room	*										- 1
Delivery Room and Labor Room											- 1
Anesthesiology											-1
Radiology-Diagnostic											- 1
Radiology-Therapeutic											- 1
Radioisotope											43 43
aboratory											44 44
PBP Clinical Laboratory Services-Program Only											
Whole Blood & Packed Red Blood Cells											1
Blood Storing Processing & Trans.											47 47
Intravenous Therapy											ı
and average Thomas											ı
Description Thereses											50 50
IICIADY											1
Occupational Inerapy											ı
Speech Pathology											1
Electrocardiology											1
Electroencephalography											1
Medical Supplies Charged to Patients											S
mplantable Devices Charged to Patients											7
Drugs Charged to Patients											- 1
Renal Dialysis											57 57
ASC (Non-Distinct Part)											58 \$
Other Ancillary (specify)											59 59
OUTPATIENT SERVICE COST CENTERS											
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Other Outpatient Service (specify)											1
OTHER REIMBURSABLE COST CENTERS											1
Home Program Dialysis											ļ
Ambulance Services											65
Durable Medical Fournment, Rented											99 99
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		LAUNDRY & LINEN	SERVICE	ζ.					;															
37 : ALLOCATION - GENERAL SERVICE COSTS	The annual control of the control of	COST CENTER DESCRIPTIONS			Home Health Agency	SPECIAL PURPOSE COST CENTERS	Lung Acquisition	Kidney Acquisition	Liver Acquisition	Heart Acquisition	Other Organ Acquisition (specify)	Ambulatory Surgical Center (Distinct Part)	Hospice	Other Special Purpose (specify)	SUBTOTALS (sum of lines 1-94)	NONREIMBURSABLE COST CENTERS	Giff, Flower, Coffee Shop, & Canteen	Research	Physicians' Private Offices	Nonpaid Workers	Other Nonreimbursable (specify)	Cross Foot Adjustments	Negative Cost Centers	TOTAL (sum of lines 95-102)

J CMS-2552-36 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 3617)

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	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS		
		19	20	21	22	23	24	25	26		
	ENERAL SERVICE COST CENTERS										
	d Capital Related Costs-Buildings and Fixtures										
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	onphysician Anesthetists										8
	ursing School										7
	tern & Res. Service-Salary & Fringes (Approved)										22
	tem & Res. Other Program Costs (Approved)										23
	ramedical Ed. Program (specify)										24
	PATIENT ROUTINE SERVICE COST CENTERS										
	hults and Pediatrics (General Routine Care)										X3
	tensive Care Unit										56
	ronary Care Unit										27
	un Intensive Care Linit										8
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	ner special Care Unit (specify)										₹
	bprovider (specify)										31
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	illed Nursing Facility										34
	ırsing Facility										35
	her Long Term Care										3
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RAL SERVICE COSTS NON- OTHER PHYSICIAN GENERAL ANES- SERVICE THETISTS 19 20 COST CENTERS 19 20 Room Red Blood Cells 2, & Trans. 4 to Patients 2 10 20 21 22 24 24 25 26 26 27 28 28 28 28 28 28 28 28 28 28 28 28 28	INTERNS & RESIDENTS STANDENTS SALARY & SALARY & FRINGES 21 22 22	PROVIDER NO: INTERNS & RESIDENTS PROGRAM EI COSTS 23 23	PARA- MEDICAL EDUCATION (specify) 24 24	PERIOD: FROM TO 25	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 26 26	WORKSHEET B. PART I TOTAL 27	23 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
Only Only	┠╼╼╧╼═╂═╬╬═╂╼╂═╂═╂═╂═╂═╫╬═╂╌╂╌╂╌╂		PARA- MEDICAL EDUCATION (specify) 24	SUBTOTAL 25	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 26 26		4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
Conly	╀╫┼┼┼┼┼┼┼	23	24	25	26		44 44 44 44 44 44 44 44 44 44 44 44 44
Only							38 33 33 44 44 45 47 47 47 47 47 47 47 47 47 47 47 47 47
Becovery Room Recovery Room Delivery Room Delivery Room Anesthesiology Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Radiology-Diagnostic Respiratory Therapy Respiratory Therapy Respiratory Therapy Respiratory Therapy Respiratory Therapy Respiratory Diagnostic Blectroencephalogy Electroencephalogy Ele							38 38 38 38 44 44 45 46 47 47 47 47 47 47 47 47 47 47 47 47 47
Recovery Room Delivery Room Anesthesiology Radiology-Therapostic Radiology-Therapoutic Radiology Respiratory Services-Program Only Whole Blood & Pasked Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Physical Therapy Speech Pathology Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged to Patients Engestreadillogy Renal Dialysis Renal Dialysis							45 44 44 44 44 44 44 44 44 44 44 44 44 4
Delivery Room and Labor Room Anesthesiology Radiology-Diagnostic Radiology-Therapeutic Respiratory Therapy Respiratory Therapy Physical Therapy Cocupational Therapy Speech Pathology Electrocardiology Electrocardiology Relectrocardiology Relectroc							44 44 44 44 44 44 44 44 44 44 44 44 44
Anesthesiology Radiology-Diagnostic Radiology-Diagnostic Radiology-Therapoutic Radiology-Therapoutic Radiosotope Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells Blood & Packed Red Blood Cells Blood & Spacked Red Blood Cells Lintavenous Therapy Respiratory Therapy Physical Therapy Respiratory Therapy Speech Pathology Electrocardiology Electrocardiology Relectrocardiology Relectrocardiology Andicioal Supplies Charged to Patients Lintamatch's Charged to Patients Longs Charged to Patients Renal Dialysis Renal Dialysis							04 14 24 24 44 44 44 44 44 44 44 44 44 44 44
Radiology-Diagnostic Radiology-Therapeutic Radiology-Therapeutic Radiosotope Laboratory BBP Clinical Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Occupational Therapy Speech Pathology Electrocardiology Electrocardiology Electrocardiology Electrocardiology Rejorics Charged to Patients Armidiantable Devices Charged in Patients Drugs Charged to Patients Renal Dialysis Renal Dialysis							45 44 44 47 47 48 48 48 48 48 48 48 48 48 48 48 48 48
Radiology-Therapeutic Radiosotope Laboratory Pab Clinical Laboratory Services-Program Only Whole Blood & Pasked Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Physical Therapy Speech Pathology Electrocardiology Electrocardiology Electrocardiology Electrocardiology Aredical Supplies Charged to Patients Implantable Devices Charged to Patients Charge Charged to Patients Renal Dialysis Renal Dialysis							44 44 45 44 44 45 45 45 45 45 45 45 45 4
Radioisotope Laboratory PBP Clinical Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Speech Pathology Speech Pathology Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged to Patients Brigs Charged to Patients Renal Dialysis Renal Dialysis							\$ 4 4 4 8
Laboratory PBP Clinical Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Occupational Therapy Speech Pathology Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged to Patients Engisted to Patients Englished to Patients							4 8 8 8
PBP Clinical Laboratory Services-Program Only Whole Blood & Packed Red Blood Cells Blood Storing, Processing, & Trans. Intravenous Therapy Respiratory Therapy Physical Therapy Occupational Therapy Speech Pathology Electroencephalography Medical Supplies Charged to Patients Inpliantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							2 4 4 8
Whole Blood & Padvatory Detrices Ingrain City Whole Blood & Padvatory Detrices Ingran City Blood Storing, Processing, & Trans. Intervenous Therapy Physical Therapy Cocupational Therapy Speech Pathology Electrocardiology Electrocardiology Medical Supplies Charged to Patients Implantable Devices Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients Charge Charged to Patients							3 4 4 8
Blood Storing, Processing, & Trans. Blood Storing, Processing, & Trans. Interactory Therapy Physical Therapy Cocupational Therapy Speech Pathology Electrocardiology Electrocardiology Medical Supplies Charged to Patients Implicates Charged to Patients Interactory Medical Supplies Charged to Patients Interactory Renal Dialysis Renal Dialysis						-	4 4 4
Intravenous Therapy Respiratory Therapy Respiratory Therapy Occupational Therapy Spector Pathology Electrocardiology Electrocardiology Addical Supplies Charged to Patients Implantable Devices Charged to Patients Brougs Charged to Patients Renal Dialysis	West-1444-144						1 64
Intravendus I netapy Respiratory Therapy Physical Therapy Occupational Therapy Speech Pathology Electrocardiology Aledical Supplies Charged to Patients Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							2 4
Respuratory Therapy Physical Therapy Cocupational Therapy Speech Pathology Electrocardiology Alexical Supplies Charged to Patients Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							3
Physical Therapy Occupational Therapy Speech Pathology Electrocardiology Electrocardiology Additional Supplies Charged to Patients Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis		_					49
Occupational Therapy Speech Pathology Electrocardiology Medical Supplies Charged to Patients Implantable Devices Charged to Patients Introduction Supplies Charged to Patients Implantable Devices Charged to Patients Renal Dialysis		1					50
Speech Pathology Electrocardiology Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							51
Electrocardiology Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged in Panents Drugs Charged to Patients Renal Dialysis							52
Electroencephalography Medical Supplies Charged to Patients Implantable Devices Charged in Panents Drugs Charged to Patients Renal Dialysis							53
Medical Supplies Charged to Patients Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							24
Implantable Devices Charged to Patients Drugs Charged to Patients Renal Dialysis							55
Drugs Charged to Patients Renal Dialysis						8	55.30
Renal Dialysis							86
							57
ASC (Non-Distinct Part)							28
Other Ancillary (specify)							65
OUTPATIENT SERVICE COST CENTERS							
Clinic							8
Emergency							5
Observation Beds							3
Other Outnatient Service (specify)							Ę
OTHER REIMBIRSABLE COST CENTERS							3
Home Program Dialysis							2
Amhri Inno Nerrina							t d
Prince In Sodies I Described To Describe							3
Durable Medical Equipment-Kented							9
L'urable Medical Equipment-Sold							67
Other Reimbursable (specify)							88
Outpatient Rehabilitation Provider (specify)							69
Intern-Resident Service (not appvd. tchng. prgm.)						,	2

96			FORM CN	FORM CMS-2552-96					3690 (Cont.)	nt.)
: ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.	,	PERIOD: FROM TO		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (specify)	SUBTOTAL	RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTTAT	
	19	20	21	22	23	72	25	26	27	
Home Health Agency										=
SPECIAL PURPOSE COST CENTERS										1
Lung Acquisition										٤
Kidney Acquisition										:
Liver Acquisition										2
Heart Acquisition										158
Other Organ Acquisition (specify)										3 8
Ambulatory Surgical Center (Distinct Part)										8
Hospice										8
Other Special Purpose (specify)										12
SUBTOTALS (sum of lines 1-94)										: %
NONREIMBURSABLE COST CENTERS										1
Giff, Flower, Coffee Shop, & Canteen										8
Research										8
Physicians' Private Offices									-	ő
Nonpaid Workers										ls
Other Nonreimbursable (specify)		-								<u>6</u>
Cross Foot Adjustments										101
Negative Cost Centers										102
TOTAL (sum of lines 95-102)										103

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

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

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71	71 Home Health Agency											7.1	11
	SPECIAL PURPOSE COST CENTERS												
82	Tung Acquisition											82	82
83	Kidnev Acquisition											83	83
7.5	Liver Acquisition			·								84	84
85	85 Heart Acquisition											8.5	85
98	86 Other Organ Acquisition (specify)											98	98
92	92 Ambulatory Surgical Center (Distinct Part)											62	92
93	93 Hosnice											93	93
8	94 Other Special Purpose (specify)											8	8
95	SUBTOTALS (sum of lines 1-94)											95	95
	NONREIMBURSABLE COST CENTERS												
98	Giff, Flower, Coffee Shop, & Canteen											8	g
76	97 Research											97	24
86	98 Physicians' Private Offices											86	86
66	99 Nonpaid Workers											66	66
100	100 Other Nonreimbursable (specify)											100	100
101	Cross Foot Adjustments											101	101
	102 Negative Cost Centers											102	102
103	TOTAL (sun lines 95-102)											103	103

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

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

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0	ATTON OF OLD CAPITAL RELATED COSTS		COST CENTER DESCRIPTIONS		Home Health Agency	SPECIAL PURPOSE COST CENTERS	Lung Acquisition	Kidney Acquisition	Liver Acquisition	Heart Acquisition	Other Organ Acquisition (specify)	Ambulatory Surgical Center (Distinct Part)	Hospice	Other Special Purpose (specify)	SUBTOTALS (sum of lines 1-94)	NONREIMBURSABLE COST CENTERS	Gift, Flower, Coffee Shop, & Canteen	Research	Physicians' Private Offices	Nonpaid Workers	Other Nonreimbursable (specify)	Cross Foot Adjustments	Negative Cost Centers	TOTAL (sum lines 95-102)

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

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GENERAL SERVICE COST CENTERS										
Old Capital Related Costs-Buildings and Fixtures								-		-
Old Capital Related Costs-Movable Equipment										73
New Capital Related Costs-Buildings and Fixtures										8
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Employee Benefits										5
Administrative and General										9
Maintenance and Repairs							***			~
Operation of Plant										∞
Laundry and Linen Service										6
Housekeeping										10
Dietary										Ξ
Cafeteria										12
Maintenance of Personnel	··									13
Nursing Administration										4
Central Services and Supply										15
Pharmacy										16
Medical Records & Medical Records Library										17
Social Service										18
Other General Service (specify)			·							19
Nonphysician Anesthetists										8
Nursing School										[7]
Intern & Res. Service-Salary & Fringes (Approved)										52
Intern & Res. Other Program Costs (Approved)										23
Paramedical Education Program (specify)										24
INPATIENT ROUTINE SERVICE COST CENTER	П									
Adults and Pediatrics (General Routine Care)										3
Intensive Care Unit										5 2
Coronary Care Unit										77
Burn Intensive Care Unit										78
Surgical Intensive Care Unit									***************************************	59
Other Special Care Unit (specify)										æ
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)

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COST CENTER DESCRIPTIONS	OTHER GENERAL eed vioes	NON- PHYSICIAN ANES-	NURSING	INTERNS & RESIDENTS SALARY & TRINGES	INTERNS & RESIDENTS PROGRAM	PARA- MEDICAL EDUCATION	14 TOTOTA	INTERN & RESIDENT COST & POST STEPDOWN	T-C-T	
	JENVICE 19	20	21	22	23	24	25	26	27	
ANCILLARY SERVICE COST CENTERS										
Operating Room										LE
Recovery Room										38
Delivery Room and Labor Room										39
Anesthesiology										성
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										7
Physical Therapy										20
Occupational Therapy										Ľ
Speech Pathology										52
Electrocardiology										23
Electroencephalography										
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										55.30
Drugs Charged to Patients										99
Renal Dialysis										LS
ASC (Non-Distinct Part)										85
Other Ancillary (specify)										65
OUTPATIENT SERVICE COST CENTERS										L
Clinio										8
Emergency										19
Observation Beds										62
Other Outpatient Service (specify)										63
OTHER REIMBURSABLE COST CENTERS										L
Home Program Dialysis										2
Ambulance Services										65
Durable Medical Equipment-Rented										99
Durable Medical Equipment-Sold										29
Other Reimbursable (specify)										89
Outpatient Rehabilitation Provider (specify)										69
The state of the s										

9			FORM CN	FORM CMS-2552-96					3690 (Cont.)	nt.)
CATION OF OLD CAPITAL RELATED COSTS					PROVIDER NO.:		PERIOD:		WORKSHEET B,	
							FROM		PART II	
							TO			
-								INTERN &		
		NON-		INTERNS &	INTERNS &	PARA-		RESIDENT		
	OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	MEDICAL		COST & POST		
COST CENTER DESCRIPTIONS	GENERAL	ANES-	NURSING	SALARY &	PROGRAM	EDUCATION		STEPDOWN		
	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	ADJUSTMENTS	TOTAL	
	19	20	21	7.7	23	24	25	26	27	
Home Health Agency										71
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition										84
Heart Acquisition										82
Other Organ Acquisition (specify)										98
Ambulatory Surgical Center (Distinct Part)										93
Hospice										93
Other Special Purpose (specify)										24
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Giff, Flower, Coffee Shop, & Canteen										%
Research										62
Physicians' Private Offices										86
Nonpaid Workers										66
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)

FORM	Rev.
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DESCRIPTION PRINCIPLE PR	ALLOCATION OF NEW CAPITAL RELATED COSTS		·				PROVIDER NO		PERIOD: FROM TO		WORKSHEET B, PART III	ALLOC,
COST CENTER DESCRIPTIONN NEW CAPAILING BALLOSS & MOVABILE BLDOSS	DIRECTLY ASSIGNED	OLD CAPIT RELATED O	TAL	NEW CA RELATED	PITAL							
Columb C	COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED COSTS		OVABLE		MOVABLE SQUIPMENT	SUBTOTAL (sum of (cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
Control Extract & Control Court Library & Control Co		0	1	2	Н	4	4A	5	9	7	8	
1 1 2 2 2 2 2 3 3 3 3 3	GENERAL SERVICE COST CENTERS											
Acquaint Related Course, brightings and Figures 2	1 Old Capital Related Costs-Buildings and Fixtures										J	1
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A												3 3
Administration Research	-											
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Conference of Personnel Conference of Personnel Conference of Personnel Conference of Personnel Control Administration Control Adminis	11 Dietary											
Maintenance of Personnel 14												
Contract Administration 14					_							
Control Services and Supply 16 16 17 18 19 19 19 19 19 19 19										-		
Department of the Property of the Property of the Property of the Control Library 17 17 18 19 19 19 19 19 19 19												15 15
Sund like Records & Medical Records & Medical Records & Medical Records & Medical Records & Medical Records & Medical Records 118 118 Stand Like Stand (specify) 18 18 Nonphreician Auschleitst 20 21 Intern & Res. Service-Salary & Fringes (Approved) 22 22 Intern & Res. Service-Salary & Fringes (Approved) 22 24 Intern & Res. Service-Salary & Fringes (Approved) 24 24 Intern & Res. Service-Salary & Fringes (Approved) 24 24 Intern & Res. Service-Salary & Fringes (Approved) 24 24 Intern & Res. Service-Salary & Fringes (Approved) 24 24 Intern & Res. Service-Salary & Fringes (Approved) 24 24 Intern & Res. Service-Salary & Fringes (Approved) 25 26 Adults and Pediatrics (General Routine Care) 26 26 Coccounty Care Unit 27 26 Coccounty Care Unit 27 27 Coccounty Care Unit 28 29 Sulprovider (specify) 28 29 Sulprovider (specify) 28 29 Sulprovider (spec												
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Other Geneal Service (specify) 19 Numbring School 20 Intern & Res. Service-Salaty & Fringes (Approved) 21 Intern & Res. Service-Salaty & Fringes (Approved) 22 Intern & Res. Cuber Program Coasts (Approved) 23 Peramedical Industric (Part Start (Specify) 24 Peramedical Industric (Approved) 25 Internsive Care Unit 26 Coronary Care Unit 26 Coronary Care Unit 26 Surgical Intensive Care Unit 26 Coronary Care Unit 26 Surgical Intensive Care Unit 27 Bun Intensive Care Unit (specify) 30 Surgical Intensive Care Unit (specify) 31 Surgical Intensive Care Unit (specify) 33 Surgical Intensive Care Unit (specify) 34 Number Special Care Unit (specify) 34 Number Special Care Unit (specify) 34 Number Special Care Unit (specify) 34 Number Special Care Unit (specify) 34 Number Special Care Unit (specify) 34 Number Special Care Unit (specify) 34												
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Intern & Res. Service-Salary & Fringes (Approved) 23 Intern & Res. Other Program Costs (Approved) 24 Parameter Bacetion Program (specify) 25 Parameter Bacetion Program (specify) 25 Parameter Bacetion Program (specify) 26 Parameter Bacetion Program (specify) 26 Parameter Bacetion Bacetion Care Unit Care Unit Bacetion Care Unit Bacetion Baceti	_											
Intern & Res. Other Program Coats (Approved) 23 Paramedical Education Program (specify) 24 Paramedical Education Program (specify) 24 Adults and Pediatrics (General Routine Carc) 26 Intensive Carc Unit 26 Coronary Cace Unit 27 Burn Intensive Carc Unit 27 Burn Intensive Carc Unit 27 Burn Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Burn Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 28 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27 Surgical Intensive Carc Unit 27<	_											
Paramedical Education Program (specify) Paramedical Education Program (specify) 24 INPATIENT ROUTINE SERVICE COST CENTERS 4 Adults and Pediatrics (General Routine Care) 25 Adults and Pediatrics (General Routine Care) 26 Adults and Pediatrics (General Routine Care) 27 Coronary Care Unit 28 Sumplical Intensive Care Unit 29 Other Special Care Unit (specify) 30 Subprovider (specify) 31 Mursery 31 Skilled Mursing Facility 34 Nursing Facility 34 Other Long Term Care 35	_										-	
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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 Mussing Facility 34 Mussing Pacility 34 Nursing Pacility 35 Other Long Term Care 36	_											
Coronary Care Unit 27 Burn Intensive Care Unit 28 Surgical Intensive Care Unit 29 Other Special Care Unit (specify) 30 Subprovider (specify) 31 Mussery 31 Skilled Mvrsing Facility 34 Musing Facility 34 Other Long Term Care 36	_											Ì
Burn Intensive Care Unit 28 Surgical Intensive Care Unit 29 Other Special Care Unit (specify) 30 Subprovider (specify) 31 Nursery 33 Skilled Mursing Facility 34 Mursing Facility 34 Other Long Term Care 36												
Surgical Intensive Care Unit 29 Other Special Care Unit (specify) 30 Subprovider (specify) 31 Nursery 33 Skilled Mursing Facility 34 Nursing Facility 34 Other Long Term Care 35												
Other Special Care Unit (specify) 30 Subprovider (specify) 31 Nansery 33 Skilled Nursing Facility 34 Nansing Facility 34 Other Long Term Care 36												
Subprovider (specify) Subprovider (specify) 31 Mursery Skilled Mursing Facility 33 Natising Pacility 34 Mursing Facility 35 Other Long Term Care 36												
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Other Long Term Care												
	36 Other Long Term Care											

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 3618)

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FORM CMS-2552-96

3690 (Cont.) 07-09

ALLOCATION OF NEW CAPITAL RELATED COSTS					1	PROVIDER NO.		PERIOD: FROM	***************************************	WORKSHEET B,	, ALLOC
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										PAKI III	
								2			
	DIRECTLY ASSIGNED	OLD CAPITAL RELATED COSTS	VPITAL O COSTS	NEW CAPITAL RELATED COSTS	PITAL COSTS						
COST CENTER DESCRIPTIONS	NEW CAPITAL RELATED	BLDGS. &	MOVABLE	BLDGS, &	MOVABLE	SUBTOTAL (sum of	EMPLOYEE	ADMINIS- TRATIVE &	MAIN- TENANCE &	OPERATION	
	COSIS	FIXIUKES	EQUIPMENT 2	FIXIUKES 3	EQUIPMENT 4	(cols. 0-4)	SENEFLIS 5	GENERAL 6	KEPAIKS 7	OF PLANI	
ANCILLARY SERVICE COST CENTERS											
ating Room											37
very Room											38
very Room and Labor Room											39
thesiology											9
ology-Diagnostic											41
ology-Therapeutic											42
oisotope											43
ratory											44
PBP Clinical Laboratory Services-Program Only											45
Whole Blood & Packed Red Blood Cells											46
d Storing, Processing, & Trans.									,		47
venous Therapy											48
iratory Therapy											49
Physical Therapy											50
Occupational Therapy											51
ch Pathology											52
Electrocardiology											53
roencephalography											54
Medical Supplies Charged to Patients											55
Implantable Devices Charged to Pattents											55.30 55.30
Drugs Charged to Patients											56
Renal Dialysis											S7
ASC (Non-Distinct Part)											58
Other Ancillary (specify)											59
PATIENT SERVICE COST CENTERS											
ic									***************************************		99
Emergency											19
Observation Beds											62
Other Outpatient Service (specify)											63
OTHER REIMBURSABLE COST CENTERS											
Home Program Dialysis											\$
wlance Services											65
ible Medical Equipment-Rented											99
Durable Medical Equipment-Sold											29
Other Reimbursable (specify)											89
natient Rehabilitation Provider (specify)											69
m-Resident Service (not appyd. tchng. prgm.)											20
	ANCILI,ARY SERVICE COST CENTERS Operating Room Recovery Room Delivery Room Anesthesiology Radiology-Diagnostic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapeutic Radiology-Therapy Physical Therapy Physical Therapy Respiratory Therapy Physical Therapy Speech Pathology Recent Pathology Recent Pathology Recent Pathology Recent Pathology Medical Supplies Charged to Patients Implantable Devices Charged to Patients Renal Devices Charged to Patients ASC (Non-Distinct Part) Outre Ancillary (specify) OUTPATIENT SERVICE COST CENTERS Clinic Emergency Observation Beds Other Coupatient Service (specify) OTHER REIMBURSABL B COST CENTERS Home Program Dialysis Ambulance Services Outher Reimbursable (specify) Other Reimbursable (specify) Outher Reimbursable (specify) Outher Reimbursable (specify) Outher Reimbursable (specify) Outher-Resident Service (not appvd. tohug. prgm.)		ANCILIARY SERVICE COST CENTERS rg Room ry Room ry Room ry Room read Labor Room read Labor Room read Labor Room read Labor Room read Labor Room read Labor Room rical Laboratory Services-Program Culy rical Laboratory Services-Program Culy rical Laboratory Services-Program Culy rical Laboratory Services-Program Culy rical Laboratory Services-Program room rical Laboratory Services-Program room rical Laboratory Services-Program room rical Laboratory Services-Program room rical Laboratory Services-Program room room room rical Laboratory Services room room room rical Laboratory Services recephalography re								

FORM CMS-2552-96 (107-09) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618) Rev. 20

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ALIC	ALLOCATION OF NEW CAPITAL RELATED COSTS		****				PROVIDER NO.:		PERIOD: FROMTO		WORKSHEET B, PART III	ALLOC.
	**************************************	DIRECTLY	OLD CAPITAL	TAL	NEW CAPITAL	PITAL						
		ASSIGNED	RELATED COSTS	COSTS	RELATED COSTS	COSTS				1		
		NEW CAPITAL					SUBTOTAL		ADMINIS-	MAIN-	:	
	COST CENTER DESCRIPTIONS	RELATED	BLDGS. & N	MOVABLE FOUIPMENT	BLDGS, & FIXTURES I	MOVABLE EQUIPMENT	(sum of (cols, 0.4)	EMPLOYEE BENEFITS	TRATIVE & GENERAL	TENANCE & REPAIRS	OPERATION OF PLANT	
		0	_	ᆫ	+	4	44	s	9	7	8	ı
7	Home Health Agency										1.	71
	SPECIAL PURPOSE COST CENTERS											
82	82 Lung Acquisition										82	2 82
83	Kidney Acquisition										83	-
84	Liver Acquisition										84	4 84
85	85 Heart Acquisition										85	5 85
98	Other Organ Acquisition (specify)										8	
92	92 Ambulatory Surgical Center (Distinct Part)										56	2 92
83	Hospice										6	3 93
8	Other Special Purpose (specify)										6	94 94
8	95 SUBTOTALS (sum of lines 1-94)					****					6	95 95
	NONREIMBURSABLE COST CENTERS											
8	96 Giff, Flower, Coffee Shop, & Canteen										6	96 96
97	97 Research										76	7 97
86	98 Physicians' Private Offices									0	6	86 86
99	99 Nonpaid Workers										6	99 99
001	Other Nonreimbursable (specify)										100	0 100
101	101 Cross Foot Adjustments										101	1 101
[02	102 Negative Cost Centers										102	2 102
103	103 [TOTAL (sum lines 95-102)										103	3 103

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

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3690 (Cont.) 10-9	WORKSHEET B, PART III	SOCIAL SERVICE 18		J				•	•								•																					
		MEDICAL RECORDS & LIBRARY 17																																-				
	PERIOD: FROM TO	PHARMACY 16											2.0																									
	lO::	CENTRAL SERVICES & SUPPLY 15													_																							
	PROVIDER NO.	NURSING ADMINIS- TRATION 14																																				
		MAIN- TENANCE OF PERSONNEL 13																																				
FORM CMS-2552-96		CAFETERIA 12																							-													
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		HOUSE- KEEPING								1																												
		LAUNDRY & LINEN SERVICE	,	_			· T	_																														
-	ATION OF NEW CAPITAL RELATED COSTS	COST CENTER DESCRIPTIONS	GENERAL SERVICE COST CENTERS	Old Capital Related Costs-Buildings and Fixtures Old Coate Delated Costs Moveble Fanisment	New Capital Related Costs-Buildings and Fixtures	New Capital Related Costs-Movable Equipment	Employee Benefits	Administrative and General	Maintenance and Repairs	Operation of Flant	Laundry and Linen Service	Housekeeping	Dietary	Cafeteria	Maintenance of Personnel	Nursing Administration	Central Services and Supply	Pharmacy	Medical Records & Medical Records Library	Social Service	Other General Service (specify)	Nonphysician Anesthetists	Nursing School	Intern & Res. Service-Salary & Fringes (Approved)	Intern & Res. Other Program Costs (Approved)	Paramedical Education Program (specify)	INPATIENT ROUTINE SERVICE COST CENTERS	Adults and Pediatrics (General Routine Care)	Intensive Care Unit	Coronary Care Unit	Burn Intensive Care Unit	Surgical Intensive Care Unit	Other Special Care Unit (specify)	Subprovider (specify)	Nursero	Skilled Nursing Facility	Nursing Facility	Other Long Term Care

:MS-2552-96 (09/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3618)

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ATION OF NEW CAPITAL RELATED COSTS						PROVIDER NO.		FEROM TO	1	WOKKSHEET	1
COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NG VIS-	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL	
ANCH LARY SERVICE COST CENTERS	6	10	11	12	13	14	15	16	17	18	
Onarating Room											37 37
Operating two in											1
Delivery Room and Labor Room											
Anesthesiology											
Radiology-Diagnostic											41 41
Radiology-Therapeutic			-								
Radioisotone											
ahoratory											44 44
PBP Clinical Laboratory Services-Program Only											
Whole Blood & Packed Red Blood Cells											
Blood Storing, Processing, & Trans.											ı
intravenous Therapy											1
Respiratory Therapy											
Physical Therapy											
Occupational Therapy											١
Speech Pathology											52 52
Electrocardiology											-
Electroencephalography		-									١
Medical Supplies Charged to Patients											55 55
Implantable Devices Charged to Patients											Ş
Drugs Charged to Patients											56 56
Renal Dialysis											1
ASC (Non-Distinct Part)											58 58
Other Ancillary (specify)											1
OUTPATIENT SERVICE COST CENTERS											
WARREST TO THE PARTY OF THE PAR											1
Emergency											1
Observation Beds											
Other Outpatient Service (specify)											63 63
OTHER REIMBURSABLE COST CENTERS											
Home Program Dialysis											42 42
Ambulance Services											
Durable Medical Equipment-Rented											
Durable Medical Equipment-Sold											67 67
Other Reimbursable (specify)					-						89 89
Outnotient Rehabilitation Provider (specify)											09 09

ALTON OF NEW CAPITAL RELATED COSTS ALTON OF NEW CAPITAL RELATED COSTS				FORM CIV	FORM CMS-2552-96						3690 (Cont.) 07-0	nt.) 07
TIONS & LAUNDRY REPLY CARETERIA PERSONNEL TRATION SUPPLY PHARMACY LIBRARY SERVICE S & SOCIAL TRATION SUPPLY PHARMACY LIBRARY SERVICE S & SOCIAL SERVICE S & SERVIC	PITAL RELATED COSTS	· · · · · · · · · · · · · · · · · · ·	***************************************				PROVIDER NO		PERIOD: FROM TO		WORKSHEET I PART III	, ALLO
10 11 12 13 14 15 16 17 18 71 11 12 13 14 15 16 17 18 71 11 12 13 14 15 16 17 11 71 12 13 14 15 16 16 16 17 103 13 103	CENTER DESCRIPTIONS	LAUNDRY & LINEN	HOUSE-		CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL	
The control of the		6	10	_	12	13	14	15	16	17	18	
Color Colo	AS											71 7
1	SE COST CENTERS											
Second Color												82 82
Section												١
Inter-Party												84 84
Innot Part) Incertify												85 85
Innot Party Innot Innot Party Innot Innot Party Innot Innot Innot Party Innot I	sition (specify)											١
4) CENTERS CENTERS Inferior Infer	al Center (Distinct Part)											١
4) CENTERS CENTERS Mattern												-1
4). CENTERS	ose (specify)											94
ENTERS Cent <	n of lines 1-94)											95 95
Company Company <t< td=""><td>ABLE COST CENTERS</td><td></td><td></td><td></td><td></td><td>#</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	ABLE COST CENTERS					#						
Total Control of the control	e Shop, & Canteen											96
becify) Pecify) Pecify Pecif												97 97
becify) Pecify) Pecify Pecif	Offices											86 86
100 100												1
101	able (specify)											Ĺ
102 103	nents											ı
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	(501-102)											103 103

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NON- PHYSICIAN ANES- THETISTS
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(CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 3618)

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CATION OF NEW CAPITAL RELATED COSTS					PROVIDER NO.:		PERIOD: FROM		WORKSHEET B, PART III	
							TO			
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING	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										
Onerating Room										37
Весичету Ворт										38
Delivery Room and Labor Room										39
Anesthesiology										40
Radiology-Diamostic										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										20
Occupational Therapy										52
Speech Pathology										22
Electrocardiclogy										23
Electroencephalography										잧
Medical Supplies Charged to Patients										55
Implantable Devices Charged to Patients										55.30
Drugs Charged to Patients							****			35
Renal Dialysis										م
ASC (Non-Distinct Part)										٦
Other Ancillary (specify)										8
OUTPATIENT SERVICE COST CENTERS										
Clinic										8
Emergency										[S
Observation Beds										5
Other Outpatient Service (specify)							***			63
OTHER REIMBURSABLE COST CENTERS							1			
Home Program Dialysis							***			2
Ambulance Services							***			65
Durable Medical Equipment-Rented										99
Durable Medical Equipment-Sold										19
Other Reimbursable (specify)										89
Outpatient Rehabilitation Provider (specify)							588			69
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CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 3618) 20

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CATION OF NEW CAPITAL RELATED COSTS				<u>a</u>	PROVIDER NO.:		PERIOD: FROM		WORKSHEET B, PART III	
							1	1		
- And the second								INTERN &		
		NON-		INTERNS &	INTERNS &			RESIDENT		
	OTHER	PHYSICIAN		RESIDENTS	RESIDENTS	PARAMEDICAL		COST & POST		
COST CENTER DESCRIPTIONS	GENERAL	ANES.	NURSING	SALARY AND	PROGRAM	EDUCATION		STEPDOWN		
	SERVICE	THETISTS	SCHOOL	FRINGES	COSTS	(SPECIFY)	SUBTOTAL	ADJUSTMENTS	TOTAL	
	19	20	21	22	23	24	25	26	27	
Home Health Agency										11
SPECIAL PURPOSE COST CENTERS										
Lung Acquisition										82
Kidney Acquisition										83
Liver Acquisition				•						84
Heart Acquisition										85
Other Organ Acquisition (specify)										98
Ambulatory Surgical Center (Distinct Part)										23
Hospice										93
Other Special Purpose (specify)										8
SUBTOTALS (sum of lines 1-94)										95
NONREIMBURSABLE COST CENTERS										
Giff, Flower, Coffee Shop, & Canteen										%
Research										76
Physicians' Private Offices										86
Nonpaid Workers										8
Other Nomeimbursable (specify)										100
Cross Foot Adjustments										101
Negative Cost Centers										102
TOTAL (sum lines 95-102)										103

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

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3690 (Cont.) 08-97	WORKSHEET B-1	OPERATION OF PLANT (SQUARE FEET)	×									***************************************																														
		MAIN- TENANCE & REPAIRS (SQUARE FEET)	1																																							
	PERIOD; FROMTO	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	Q																							-																
		RECONCIL. IATION	θA																***************************************						***************************************		-															
	PROVIDER NO:	EMPLOYBE BENEFITS (GROSS SALARIES)	C											***************************************																											į	
3-2552-96		NEW CAPITAL RELATED COST BLDGS. & MOVABLE FIXTURES EQUIPMENT (SQUARE (DOLLAR FEET) VALUE)	4																***************************************																							
FORM CMS-2552-96		NEW CAPITAL BLDGS, & FIXTURES (SQUARE FEET)	5																				775 H. L. L. L. L. L. L. L. L. L. L. L. L. L.																			
		RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	7																																							
		OLD CAPITAL RELA BLDGS. & Mo FIXTURES EQI (SQUARE FEET)	1																																							
	COST ALLOCATION - STATISTICAL BASIS	COST CENTER DESCRIPTIONS	CENTER AL SERVICE COST CENTERS	CENERAL SERVICE COST CENTERS	Old Capital Related Costs-Buildings and Fixtures	Old Capital Related Costs-Movable Equipment	New Capital Related Costs-Buildings and Fixtures				-		-			Dietary	Cafeteria		-					Other General Service (specify)			_			INPATIENT ROUTINE SERVICE COST CENTERS	Adults and Pediatrics (General Routine Care)			Bum Intensive Care Unit				Supplied (Special)	Nursery	Skilled Nursing Facility	35 Nursing Facility	Other Long Term Care
07-09	COSTA					2	3	4	5	9	7	8		2	10	11	12	13	14	15	16	17		2 2	20	21	22	23	42		25	26	27	28	83	8	2 2	15	55	34	33	8

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

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			FORM CMS-2552-96	3-2552-96					3690 (Coi	3690 (Cont.) 07-09
COST ALLOCATION - STATISTICAL BASIS		A SA A SA A SA A SA A SA A SA A SA A S			PROVIDER NO:		PERIOD: FROM_ TO		WORKSHEET B-1	COST /
COST CENTER DESCRIPTIONS	OLD CAPITAL REL. BLDGS. & N FIXTURES E (SQUARE FEET)	ATED COST AOVABLE QUIPMENT (DOLLAR VALUE)	NEW CAPITAL RELATED COST BLDGS. & MOVABLE FIXTURES EQUIPMENT (SQUARE (DOLLAR FBET) VALUE) 3 4	MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYBE BENEFITS (GROSS SALARIES) 5	RECONCIL- IATION 6A	ADMINIS- TRATIVE & GENERAL (ACCUM COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
ANCILLARY SERVICE COST CENTERS										
Operating Room								***************************************		
Recovery Room										-
Delivery Room and Labor Room			10000							39 39
Anesthesiology										1
Radiology-Diagnostic										1
Radiology-Therapeutic										1
Radioisotope										1
Laboratory										ļ
PBP Clinical Laboratory Services-Program Only										45 45
Whole Blood & Packed Red Blood Cells										١
Blood Storing, Processing, & Trans.										
Intravenous Therapy										-
Respiratory Therapy										49 49
Physical Therapy										1
Occupational Therapy										١
Speech Pathology										-
Electrocardiology										1
Electroencephalography										1
Medical Supplies Charged to Patients										
Implantable Devices Charged to Patients									55	3
Drugs Charged to Patients										56 56
Renal Dialysis										1
ASC (Non-Distinct Part)										58 58
Other Ancillary (specify)										1
OUTPATIENT SERVICE COST CENTERS										9
Cimilist The second of the sec										61 61
Observation Rade										62 62
Other Output Service (specify)										
OTHER REIMBURSABLE COST CENTERS										
Home Program Dialysis										
Ambulance Services			=							65 65
Durable Medical Equipment-Rented										99 99
Durable Medical Equipment-Sold										١
Other Reimbursable (specify)										
Outpatient Rehabilitation Provider (specify)										69 69
V										

FORM CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) Rev. 20

26-90			FORM CMS-2552-96	3-2552-96					3690 (Cont.) 07-09	nt.) 070
COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO:		PERIOD: FROM TO		WORKSHEET B-1	COST
	OLD CAPITAL REI BLDGS. &	ATED COST MOVABLE	NEW CAPITAL RELATED COST	RELATED COST MOVABLE	EMPLOYBE		ADMINIS- TRATIVE &	MAIN- TENANCE &	OPERATION	
COST CENTER DESCRIPTIONS	FIXTURES (SQUARE FEET)	EQUIPMENT (DOLLAR VALUE)	FIXTURES (SQUARE FEET)	EQUIPMENT (DOLLAR VALUE)	BENEFITS (GROSS SALARIES)	RECONCIL- IATION	GENERAL (ACCUM. COST)	REPAIRS (SQUARE FEET)	OF PLANT (SQUARE FEET)	
Home Health Aconou		2	3	4	0	6A	9	7	8	
SPECIAL PURPOSE COST CENTERS										/1 /1
82 Lung Acquisition										82 82
83 Kidney Acquisition										83 83
84 Liver Acquisition										
85 [Heart Acquisition										
86 Other Organ Acquisition (specify)										
92 Ambulatory Surgical Center (Distinct Part.) 93 Hospice										92 92
94 Other Special Purpose (specify)										
95 SUBTOTALS (sum of lines 1-94)										
NONREIMBURSABLE COST CENTERS										
96 Giff, Flower, Coffee Shop, & Canteen										96 96
97 Research										76 76
98 Physicians' Private Offices										86 86
99 Nonpaid Workers										66 66
100 Other Noureimbursable (specify)										100 100
Cross foot adjustments										101 101
Negative cost centers										102 102
Cost to be allocated (per Wkst. B, Part I)										
Unit cost multiplier (Wkst. B, Part I)										
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
108 Unit cost multiplier (Wkst. B, Part III)										108 108

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

it.) 07-05	COST				1 1	2 2	3	4					∞ ∞	6	10		1	12 12	13 13		l	ı	16 16	17 17		l	l	l	Ì	22 20	l	24 24		25 25	26 26	27 27		000	20 20		31 31	33 33			36 36	
3690 (Cont.) 07-09	WORKSHEET B-1	SOCIAL SERVICE (TIME SPENT)	18				<u></u>	<u> </u>	<u> </u>	<u>l</u>	1		į		1		i			1_	<u> </u>																		1							-
		MEDICAL RECORDS & LIBRARY (TIME SPENT)	17													•				-																										
	PERIOD: FROM	PHARMACY (COSTED REQUIS.)	16																																											
	Ö	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	15																																				The state of the s							
	PROVIDER NO	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	14																																											
		MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	13																																											
FORM CMS-2552-96		CAFETERIA (MEALS SERVED)	12			***************************************	*******			-					•	-															-															
FORM CN		DIETARY (MEALS SERVED)	11																																											
		HOUSE- KEEPING (HOURS OF SERVICE)	10																																											
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	6																																											
7	ALLOCATION - STATISTICAL BASIS	COST CENTER DESCRIPTIONS		GENERAL SERVICE COST CENTERS	Old Capital Related Costs-Buildings and Fixtures	Old Capital Related Costs-Movable Equipment	New Capital Related Costs-Buildings and Fixtures	New Capital Related Costs-Movable Equipment	Employee Benefits	Administrative and General	Maintenance and Denoine	Tyranicality alic typolis	Operation of Flant	Laundry and Linen Service	Housekeeping	Diefary	L. L. L. L. L. L. L. L. L. L. L. L. L. L	Careteria	Maintenance of Personnel	Nursing Administration	Central Services and Sunnly	N	Fnarmacy	Medical Records & Medical Records Library	Social Service	Other General Service (specify)	Nonphysician Anesthetists	Nursing School	Intern & Res. Service-Salary & Fringes (Approved)	Intern & Res. Other Program Costs (Approved)	Doromodical Education Descreen (accorde)	I a a missing i concatoli riogiani (specify) INDATIBNIT BOI ITINE SEBVICE COST CENTERS	THE WITHING THE SEN VIOLOGIA COLUMN STATE	Adults and Pediatrics (General Routine Care)	Intensive Care Unit	Coronary Care Unit	Burn Intensive Care Unit	Surgical Intensive Care Unit	Other Special Care Unit (specify)	Colombia and American Colombia and Colombia	Supprovider (specify)	Nursery	Skilled Nursing Facility	Nursing Facility	Other Long Term Care	

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

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.70	COST	l ,		37 37				41 41			44			47 47	48 48	l	l						55		57 57		59 59	П	9 09			63 63			65 6	l	67 6		69 69	
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3690 (Cont.) 07-05	WORKSHEET B-1	SOCIAL SERVICE (TIME SPENT)																																						
		MEDICAL RECORDS & LIBRARY (TIME SPENT)																																						
	PERIOD: FROM TO	PHARMACY (COSTED REQUIS.)																																						
	Õ	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)																																						
	PROVIDER NO	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)																																						
9		PERS (NL																																						
FORM CMS-2552-96		CAFETERIA (MEALS SERVED)																																						
FORM C		DIETARY (MEALS SERVED)																																						
		HOUSE- KEEPING (HOURS OF SERVICE)																																						
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)																																						
6	ALLOCATION - STATISTICAL BASIS	COST CENTER DESCRIPTIONS	ANCILLARY SERVICE COST CENTERS	Operating Room	Recovery Room	Delivery Room and Labor Room	Anesthesiology	Radiology-Diagnostic	Radiology-Therapeutic	Radioisotope	Laboratory	PBP Clinical Laboratory Services-Program Only	Whole Blood & Packed Red Blood Cells	Blood Storing, Processing, & Trans.	Intravenous Therapy	Respiratory Therapy	Physical Therapy	Occupational Therapy	Speech Pathology	Electrocardiology	Electroencephalography	Medical Supplies Charged to Patients	Implantable Devices Charged to Patients	Drugs Charged to Patients	Renal Dialysis	ASC (Non-Distinct Part)	Other Ancillary (specify)	OUTPATIENT SERVICE COST CENTERS	Clinic	Emergency	Observation Beds	Other Outpatient Service (specify)	OTHER REIMBURSABLE COST CENTERS	Home Program Dialysis	Ambulance Services	Durable Medical Equipment-Rented	Durable Medical Equipment-Sold	Other Reimbursable (specify)	Outpatient Rehabilitation Provider (specify)	Intern-Resident Service (not appvd. tchug. prgm.)

CMS-2552-% (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3617) 20

nt.) บว-บะ	1 COST 4		71 71		82 82	83 83	84 84	85 85	98 98	92 92			95 95		96 96		86 86	66 66	Γ	101 101		103 103	104 104	105 105	106 106	107 107	108 108
3690 (Cont.) 05-08	WORKSHEET B-1	SOCIAL SERVICE (TIME SPENT)																									
		MEDICAL RECORDS & LIBRARY (TIME SPENT)																									
	PERIOD: FROM TO	PHARMACY (COSTED REQUIS.)	:																								
		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 15																									
	PROVIDER NO:	NURSING ADMINIS- TRATION (DIRECT NURS, HRS)																									
		MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)																									
FORM CMS-2552-96		CAFETERIA (MEALS SERVED)																									
FORM CA		DIETARY (MEALS SERVED)																									
		HOUSE- KEEPING (HOURS OF SERVICE)																									
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)																									
	ALLOCATION - STATISTICAL BASIS	COST CENTER DESCRIPTIONS	Home Health Agency	SPECIAL PURPOSE COST CENTERS	Lung Acquisition	Kidney Acquisition	Liver Acquisition	Heart Acquisition	Other Organ Acquisition (specify)	Ambulatory Surgical Center (Distinct Part)	Hospice	Other Special Purpose (specify)	SUBTOTALS (sum of lines 1-94)	NONREIMBURSABLE COST CENTERS	Giff, Flower, Coffee Shop, & Canteen	Research	Physicians' Private Offices	Nonpaid Workers	Other Noureimbursable (specify)	Cross foot adjustments	Negative cost centers	Cost to be allocated (per Wkst. B, Part I)	Unit cost multiplier (Wkst. B, Part I)	Cost to be allocated (per Wkst. B, Part II)	Unit cost multiplier (Wkst. B, Part II)	Cost to be allocated (per Wkst. B, Part III)	Unit cost multiplier (Wkst. B, Part III)

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

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3690 (Cont.)	WORKSHEET B-1						TOTAL	27																																					
			INTERN &	RESIDENT	COST & POST	STEPDOWN	ADJUSTMENTS	26																																					
	PERIOD;	FROM					SUBTOTAL	25																																					
			PARA.	MEDICAL	EDUCATION	(ASSIGNED	TIME)	24																																					
	PROVIDER NO:		INTERNS & RESIDENTS	PROGRAM	COSTS	(ASSIGNED	TIME)	23																																					
S-2552-96			NATERNS &	SALARY AND	FRINGES	(ASSIGNED	TIME)	22																																					
FORM CMS-2552-96				NURSING	SCHOOL	(ASSIGNED	TIME)	21																																					
			NON	PHYSICIAN	ANES-	THETISTS	(ASGND TIME)	20																					-																
				OTHER	GENERAL	SERVICE	(SPECIFY)	19																																					
	LLOCATION - STATISTICAL BASIS		***************************************			COST CENTER DESCRIPTIONS			GENERAL SERVICE COST CENTERS	Old Capital Related Costs-Buildings and Fixtures	Old Capital Related Costs-Movable Equipment	New Capital Related Costs-Buildings and Fixtures	New Capital Related Costs-Movable Equipment	nefits	Administrative and General	and Repairs	Plant	Laundry and Linen Service	50			of Personnel	inistration	Central Services and Supply		Medical Records & Medical Records Library		Other General Service (specify)	Nonphysician Anesthetists	lo	Intern & Res. Service-Salary & Fringes (Approved)	Intern & Res. Other Program Costs (Approved)	Paramedical Education Program (specify)	INPATIENT ROUTINE SERVICE COST CENTER	Adults and Pediatrics (General Routine Care)	e Unit	e Unit	e Care Unit	Surgical Intensive Care Unit	Other Special Care Unit (specify)	specify)		ng Facility	fai	
•	LLOCATIO					COS			GENERAL 5	Old Capital B	Old Capital F	New Capital	New Capital	Employee Benefits	Administrativ	Maintenance and Repairs	Operation of Plant	Laundry and	Housekeeping	Dietary	Cafeteria	Maintenance of Personnel	Nursing Administration	Central Servi	Pharmacy	Medical Reco	Social Service	Other Genera	Nonphysician	Nursing School	Intern & Res	Intern & Res	Paramedical.	INPATIENT	Adults and P	Intensive Care Unit	Coronary Care Unit	Burn Intensive Care Unit	Surgical Inter	Other Specia	Subprovider (specify)	Nursery	Skilled Nursing Facility	Nursing Facility	6 6

CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-11, SECTION 3617)

Sont.)			Ş	£ 8	8	4	41	42	43	4	45	94	4	48	49	20	51	52	23	54	55	55.30	99	57	58	29		99	19	53	63		64	65	99	29	89	9	20
3690 (Cont.) WORKSHEET B-1	TOTAL	27																																					
	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	26																																					
PERIOD: FROM	SUBTOTAL	25																																					
	PARA- MEDICAL EDUCATION (ASSIGNED TIME)	24																																					
PROVIDER NO:	INTERNS & RESIDENTS LARY AND PROGRAM FRINGES COSTS ASSIGNED (ASSIGNED TIME) TIME)	23						***************************************	***************************************				***************************************																										
3-2552-92	SALARY AND FRINGES (ASSIGNED TIME)	22																																					
FORM CMS-2552-92	NURSING SCHOOL (ASSIGNED TIME)	21																																					
	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	20																																					
	OTHER GENERAL SERVICE (SPECIFY)	19																																					
) ALLOCATION - STATISTICAL BASIS	COST CENTER DESCRIPTIONS		ANCILLARY SERVICE COST CENTERS	Operating Koom Recovery Room	Delivery Room and Labor Room	Anesthesiology	Radiology-Diagnostic	Radiology-Therapeutic	Radioisotope	Laboratory	PBP Clinical Laboratory Services-Program Only	Whole Blood & Packed Red Blood Cells	Blood Storing, Processing, & Trans.	Intravenous Therapy	Respiratory Therapy	Physical Therapy	Occupational Therapy	Speech Pathology	Electrocardiology	Electroencephalography	Medical Supplies Charged to Patients	Implantable Devices Charged to Patients	Drugs Charged to Patients	Renal Dialysis	ASC (Non-Distinct Part)	Other Ancillary (specify)	OUTPATIENT SERVICE COST CENTERS	Clinic	Emergency	Observation Beds	Other Outpatient Service (specify)	OTHER REIMBURSABLE COST CENTERS	Home Program Dialysis	Ambulance Services	Durable Medical Equipment-Rented	Durable Medical Equipment-Sold	Other Reimbursable (specify)	Outpatient Rehabilitation Provider (specify)	Intern-Resident Service (not appyd. tchng. prgm.)

CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 361 7) $20\,$

3690 (Cont.)	WORKSHEET B-1					OI			TOTAL 27		TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 37	TOTAL 37	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 27	TOTAL 37
		INTERN &	COST & POST	STEPDOWN	26																									
	PERIOD: FROM TO			STRTOTAL	25																									
		PARA.	EDUCATION	(ASSIGNED	24																									
	PROVIDER NO;	INTERNS & RESIDENTS	COSTS	(ASSIGNED TIME)	23																									
5-2552-96		INTERNS &	FRINGES	(ASSIGNED	22																									
FORM CMS-2552-96		MIRSING	SCHOOL	(ASSIGNED	21																									
		NON- PHYSICIAN	ANES-	THETISTS	20																									
		OTHER	GENERAL		T																									
	ALOCATION - STATISTICAL BASIS	AFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFFF		COST CENTER DESCRIPTIONS		Home Health Agency	SPECIAL PURPOSE COST CENTERS	Lung Acquisition	Kidney Acquisition	Liver Acquisition	Heart Acquisition	Other Organ Acquisition (specify)	Ambulatory Surgical Center (Distinct Part)	Hospice	Other Special Purpose (specify)	SUBTOTALS (sum of lines 1-94)	NONREIMBURSABLE COST CENTERS	Giff, Flower, Coffee Shop, & Canteen	Research	Physicians' Private Offices	Nonpaid Workers	Other Nonreimbursable (specify)	Cross foot adjustments	Negative cost centers	Cost to be allocated (per Wkst. B, Part I)	Unit cost multiplier (Wkst. B, Part I)	Cost to be allocated (per Wkst. B, Part II)	Unit cost multiplier (Wkst. B, Part II)	Cost to be allocated (per Wkst. B, Part III)	Unit cost multiplier (Wkst. B, Part III)

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

07-09	FOR	M CMS-2552-	·96			3690 (0	Cont.)
COMP	UTATION OF RATIO OF COSTS TO CHARGES	PROVIDER N	O.:	PERIOD:		WORKSHEE"	TC,
J - 1-11				FROM		PART I	-
				TO			
		Total Cost	<u> </u>				1
					D.CE		
		(from Wkst.	Therapy		RCE		
	COST CENTER DESCRIPTIONS	B, Part I,	Limit	Total	Dis-	Total	
		col. 27)	Adj.	Costs	allowance	Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
25							25
	Intensive Care Unit						26
	Coronary Care Unit						27
	Burn Intensive Care Unit						28
	Surgical Intensive Care Unit						29
30	Other Special Care (specify)						30
31	Subprovider						31
	Nursery						33
	Skilled Nursing Facility				.	ļ	34
	Other Nursing Facility					<u> </u>	35
36	Other Long Term Care						. 36
	ANCILLARY SERVICE COST CENTERS						4
	Operating Room						37
	Recovery Room						38
39	Delivery Room and Labor Room						39
	Anesthesiology						40
	Radiology-Diagnostic				, Name :		41
	Radiology-Therapeutic						42
43	Radioisotope						43
	Laboratory						44
	PBP Clinical Laboratory Services-Prgm. 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			ļ			51
	Speech Pathology						52
	Electrocardiology					.	53
	Electroencephalography					w	54 55
	Medical Supplies Charged to Patients						55,30
	Implantable Devices Charged to Patients					 	
	Drugs Charged to Patients						56 57
	Renat Dialysis					 	58
	ASC (Non-Distinct Part)						59
39	Other Ancillary (specify)						8 32
Zn.	OUTPATIENT SERVICE COST CENTERS						60
60	Clinic				1		61
	Emergency Observation Beds (see instructions)						62
	Other Outpatient Service (specify)	-				1 	63
03	OTHER REIMBURSABLE COST CENTERS						* ***
61	Home Program Dialysis		1				64
65					 	1	65
	Durable Medical Equipment-Rented				†	 	66
	Durable Medical Equipment-Sold	-				 	67
	Other Reimbursable (specify)				1		68
	Subtotal (sum of lines 25 thru 68)	- 		1		 	101
	Less Observation Beds						102
	Total (line 101 minus line 102)					1	103
103	ON OR OSSO DO (07/0000) (PROTECTION FOR THE WO	NDIZGIEDET ADE DIT	DI TOTTED DI C	MODID 1S I	PECITIONS 24	20 8 2620 1)	, .,,,

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

COMP	UTATION OF RATIO OF COSTS TO CHARGES	<u> </u>	PROVIDER N	O.:	PERIOD: FROM TO		WORKSHEET PART I (CON	
	COST CENTER DESCRIPTIONS	Inpatient 6	Charges Outpatient 7	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio 11	
	INPATIENT ROUTINE SERVICE COST CENTE	i						
25	Adults and Pediatrics (General Routine Care)	1						25
***************************************	Intensive Care Unit							26
27	Coronary Care Unit							27
28	Burn Intensive Care Unit							28
	Surgical Intensive Care Unit							29
30	Other Special Care (specify)							30
	Subprovider							31
33	Nursery							33
34	Skilled Nursing Facility							34
_	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	1						42
43	Radioisotope			-				43
	Laboratory							44
	PBP Clinical Laboratory Services-Prgm. Only							45
	Whole Blood & Packed Red Blood Cells							46
47	Blood Storing, Processing, & Trans.							47
	Intravenous Therapy	<u> </u>						48
	Respiratory Therapy							49
	Physical Therapy							50
	Occupational Therapy				<u> </u>			51
_	Speech Pathology	<u> </u>						52
	Electrocardiology	<u> </u>			<u> </u>			53
	Electroencephalography	<u> </u>						54
	Medical Supplies Charged to Patients				<u> </u>			55
	Implantable Devices Charged to Patients	1			-			55.30
	Drugs Charged to Patients	-			 		-	56 57
	Renal Dialysis	 			 			58
	ASC (Non-Distinct Part)	 			 		-	_
59	Other Ancillary (specify) OUTPATIENT SERVICE COST CENTERS							59
								60
60		 						61
	Emergency Observation Beds (see instructions)				1			62
	Other Outpatient Service (specify)							63
	OTHER REIMBURSABLE COST CENTERS							<u> </u>
64	Home Program Dialysis							64
	Ambulance Services			-				65
	Durable Medical Equipment-Rented				-		 	66
	Durable Medical Equipment-Sold				İ			67
	Other Reimbursable (specify)	1					——	68
	Subtotal (sum of lines 25 thru 68)							101
	Less Observation Beds							102
	Total (line 101 minus line 102)	1						103
	CM 49 2552 96 (07/2009) (INSTRICTIONS FOR T	THE WORKS	TEPT AND DID	OLIGITED DIL	NACOTIO 15 II	CENTRONIC 26	20 P 2420 1)	

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

09-01	01		FORM	FORM CMS-2552-96	9(3690 (Cont.)	π.)
CALC	CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS					PROVIDER NO.		PERIOD: FROM TO		WORKSHEET C, PART II	
		Total Cost	Capital Cost (Wkst. B, sum	Operating Cost Net of		Operating Cost	Cost Net of Capital and	Total Charges	Outpatient Cost	I/P Part B Cost	
	Cost Center Descriptions	(Wkst. B,	of Parts II &	Capital Cost	Capital	Reduction	Operating Cost	(Wkst. C,		to Charge Ratio	
		Part I, col. 27)	III, col. 27)	(col. 1 - col. 2)	Reduction	Amount	Reduction	Part I, col. 8)	(col. 6 + col. 7)	(see instruc.)	1
	ANCILLARY SERVICE COST CENTERS	-1	7	c	t	6	0	,	o	7	
37											37
38											38
39	39 Delivery Room and Labor Room										39
49	40 Anesthesiology										9
41	Radiology-Diagnostic										-
42	Radiology-Therapeutic										42
43	43 Radioisotope										43
4	44 Laboratory										4
45	45 PBP Clinical Laboratory Services-Prgm, Only										45
46	46 Whole Blood & Packed Red Blood Cells										94
47	Blood Storing, Processing, & Trans.										47
48	48 Intravenous Therapy										48
49	49 Respiratory Therapy										64
50	50 Physical Therapy										80
51	Occupational Therapy										51
52	Speech Pathology										52
53	53 Electrocardiology										23
\$	54 Electroencephalography										4
55	55 Medical Supplies Charged to Patients										55
56	Drugs Charged to Patients										88
57	Renal Dialysis										23
58	58 ASC (Non-Distinct Part)										28
59	59 Other Ancillary (specify)										59
											[

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

3690 (Cont.)	WORKSHEET C,	PART II (CONT.)		'art B Cost	to Charge Ratio	(see instruc.)	6		09	61	79	63		22	65	99	19	89	101	102	103
•	WOR	- PART		Outpatient Cost I/P Part B Cost	to Charge Ratio to Ch		80														
	PERIOD	FROM:	Total	Charges	(Wkst. C.	Part I, col. 8)	7														
	.;. G		Cost Net of		Operating Cost	Reduction	9														
	PROVIDER NO.:			Operating Cost	Reduction	Amount	5														
52-96			Sost		sst Capital	1	4														
FORM CMS-2552-96			ost Operating Cost		Ü	\dashv	3				-										
FO			Capital Cost	$\overline{}$. 27) III, col. 27)	2														
	TO			Total Cost	(Wkst. B,	Part I, 001. 27)	1														
	CALCULATION OF OUTPATIENT SERVICE COST TO	CHARGE RATIOS NET OF REDUCTIONS			Cost Center Descriptions			OUTPATIENT SERVICE COST CENTERS	inic	61 Emergency	62 Observation Beds (see instructions)	63 Other Outpatient Service (specify)	OTHER REIMBURSABLE COST CENTERS	64 Home Program Dialysis	65 Ambulance Services	66 Durable Medical Equipment - Rented	67 Durable Medical Equipment - Sold	68 Other Reimbursable (specify)	101 Subtotal (sum of lines 37-68)	102 Less Observation Beds	103 Total (sum of line 101 minus line 102)
09-01	CALCUL	CHARGE						O.	60 Clinic	61 Err	62 Ob	63 Off	TO	64 Ho	65 An	96 Du	67 Du	99 04	101 Sul	102 Le	103 To

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

9 Total program swing-bed inpatient routine costs (line 7 plus line 8)

9

76-80	7	FORM CMS-2552-96	\$-2552-96					3690 (Cont.)	ont.)
COMP	COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL	OSPITAL		PROVIDER NO.:		PERIOD:		WORKSHEET C,	
						FROM		PART V	
			Provider-based		Total Ancillary	Total	Ratio of Out-	Total	
		Total Cost	Physician		Charges	Outpatient	patient Charges	Outpatient	
		(from Wkst. B,	Adjustment	Total Costs	(from Wkst. C.	Charges	to Total Charges	Costs	
	COST CENTER DESCRIPTIONS	Part I, col. 27)	(see instructions)	(col. 1 + col. 2)	Part III, col. 2)	(see instructions) (col. 5 + col. 4)	(col. 5 + col. 4)	(col. 3 x col. 6)	
		1	2	3	4	5	9	7	
	ANCILLARY SERVICE COST CENTERS								
37	Operating Room								37
38	38 Recovery Room								. 38
36	39 Delivery Room and Labor Room								39
8	40 Anesthesiology								40
41	Radiology-Diagnostic								41
42	Radiology-Therapeutic								42
43	43 Radioisotope								43
4	44 Laboratory								4
45	45 PBP Clinical Laboratory Services-Prgm. Only								45
4	46 Whole Blood & Packed Red Blood Cells								46
47	Blood Storing, Processing, & Transfusion								47
48	Intravenous Therapy								48
9	49 Respiratory Therapy								49
20	50 Physical Therapy								20
51	51 Occupational Therapy								51
52	Speech Pathology								52
53	53 Electrocardiology								53
52	Electroencephalography								54
55	55 Medical Supplies Charged to Patients								55
36	56 Drugs Charged to Patients								ξ.
53	57 Renal Dialysis								S7
28	58 ASC (Non-Distinct Part)								28
59	59 Other Ancillary (specify)								59

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

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

08-97			FOR	FORM CMS-2552-96	52-96		-				(°)	3690 (Cont.)	ıt.)
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	臣				PROVIDER NO.:	::		PERIOD: FROM: TO:			WORKSHEET D. PART I	std,	
Check	[] Title V			Sdd[]									
applicable boxes	[] Title XVIII, Part A	, Part A		[]TEFRA									
		Old Capital			New Capital				Old Capital	pital	New Capital	apital	
			Reduced			Reduced				Inpatient		Inpatient	
	Capital		Capital	Capital Poleted Cost		Capital			ģ	Program	Š	Program	
	(from Wkst.	Swing	Cost	(from Wkst.	Swing	Cost	Total	Inpatient	Diem	Cost	Diem	Cost	
	B, Part II,	Bed	(col. 1.	B, Part III,	Bed	(col. 4-	Patient	Program	(col. 3 [–]	(col. 9 x	(co). 6 ⁻	(col. 11	
Cost Center Description	col. 27)	Adj.	col. 2)	col. 27)	Adjustment	col. 5)	Days	Days	col. 7)	col. 8)	col. 7)	x col. 8)	
	1	2	3	4	5	9	7	8	6	10	11	12	
(A) INPATIENT ROUTINE SERVICE COST CENTERS													
25 Adults & Pediatrics													22
(General Routine Care)]
26 Intensive Care Unit													92
27 Coronary Care Unit									:				27
28 Burn Intensive Care Unit													28
29 Surgical Intensive Care Unit			•										29
30 Other Special Care Unit (specify)												:	8
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)

07-09				FORM CMS-2552-96	-2552-96				3690 (Cont.)	ont.)
APPORTIONMENT OF INPASERVICE CAPITAL COSTS	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				PROVIDER NO.		PERIOD: FROM		WORKSHEET D, PART II	
Check		[] Title V		[] Hospital	COMPONENT NO.	0:	TO [] PPS			
applicable boxes		Title XVIII, Part A Title XIX	Part A	[] Subprovider			[] TEFRA			
		Old Capital	New Capital			Old Capital	apital	New Capital	apital	
		Related Cost	Relatod Cost			Ratio of Cost	Capital	Ratio of Cost	Capital	
		(from Wkst.	(from Wkst.	Total Charges	Inpatient	to Charges	Costs	to Charges	Costs	
Cost Center Description	aription	B, Part II, col. 27)	B, Part III, col. 27)	(from Wkst. C, Part I. col. 8)	Program Charges	(col. 1 ⁻	(col. 4 x	(col. 2 ⁻	(col. 4 x	
		1	2	3	4	5	9	7	8	
(A) ANCILLARY	ANCILLARY SERVICE COST CENTERS									
37 Operating Room										37
38 Recovery Room										38
39 Delivery Room 6	Delivery Room and Labor Room									89
40 Anesthesiology										8
41 Radiology-Diagnostic	nostic									4
42 Radiology-Therapeutic	peutic							-		42
43 Radioisotope										54
44 Laboratory										4
45 PBP Clinical Lai	45 PBP Clinical Laboratory Services-Prgm, Only									45
46 Whole Blood &	46 Whole Blood & Packed Red Blood Cells									8
47 Blood Storing, P.	Blood Storing, Processing, & Transfusing									47
48 Intravenous Therapy	rapy									84
49 Respiratory Therapy	rapy									6
	γ									80
51 Occupational Therapy	erapy									51
52 Speech Pathology	AS .									52
53 Electrocardiology	A									53
54 Electroencephalography	ography									22
55 Medical Supplie	Medical Supplies Charged to Patients									55
55.30 [Implantable De	55.30 [Implantable Devices Charged to Patients									55.30
56 Drugs Charged to Patients	o Patients									8
57 Renal Dialysis	***************************************									23
58 ASC (Non-Distinct Part)	inct Part)									58
59 Other Ancillary (specify)	(specify)									85

(A) Worksheet A line numbers

07-09	6			FORM CMS 2552-96	3 2552-96				3690 (Cont.)	nt.)
APPOR	APPORTIONMENT OF INPATIENT ANCILLARY				PROVIDER NO.:		PERIOD:		WORKSHEET D,	
SERVI	SERVICE CAPITAL COSTS						FROM		PART II (CONT.)	
					COMPONENT NO.	5.;	TO			
Check		[] Title V		[] Hospital			sdd []			
applicable	ble	[] Title XVIII, Part A	Part A	[] Subprovider			[] TEFRA			
boxes		[] Title XIX								
		Old Capital	New Capital			Old Capital	apital	New Capital	apital	
		Related Cost	Related Cost			Ratio of Cost	Capital	Ratio of Cost	Capital	
		(from Wkst.	(from Wkst.	Total Charges	Inpatient	to Charges	Costs	to Charges	Costs	
	Cost Center Description	B, Part II,	B, Part III,	(from Wkst. C,	Program	(col. 1	(col. 4 x	(col. 2 ⁻	(col. 4 x	
		col. 27)	col. 27)	Part I, col. 8)	Charges	col. 3)	col. 5)	col. 3)	col. 7)	
		1	2	3	4	5	9	7	8	
09	Clinic									8
19	61 Emergency									61
62	62 Observation Beds									62
63	Other Outpatient Service (specify)								-	63
	OTHER REIMBURSABLE COST CENTERS									
4	64 Home Program Dialysis									2
65	65 Ambulance Services									65
99	66 Durable Medical Equipment-Rented									99
67	67 Durable Medical Equipment-Sold									67
89	68 Other Reimbursable (specify)									89
101	101 Total (sum of lines 37 through 68)									101

(A) Worksheet A line numbers

07-09	60		FORM (FORM CMS-2552-96					3690 (Cont.)	nt.)
APP(SER	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				PROVIDER NO.:		PERIOD: FROM TO	-	WORKSHEET D, PART III	
Check		Title V		Sdd[]						
applice boxes	ble	[] Title XVIII, Part A [] Title XIX		[] TEFRA						
				Swing-Bed					Inpatient	
				Adjustment	Total Costs		Per		Program	
		Nonphysician		Amount	(sum of cols.	Total	Diem	Inpatient	Pass thru	
	Cost Center Description	Anesthetist Cost	t Education Cost	(see instructions)	1+2, minus col. 3)	Patient Days	(col. 4 ÷ col. 5)	Program Days	Cost (col. 6 x col. 7)	
		1	2	3	4	\$	9	7	. 8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics									52
36										%
27	Coronary Care Unit									27
28										28
29										59
30	Other Special Care Unit (specify)									30
31										31
33	Nursery									33
34	34 Skilled Nursing Facility									½
35	Nursing Facility									35
101	Total (sum of lines 25-35)									101

(A) Worksheet A line numbers

07-09	6			FORM C	FORM CMS-2552-96					3690 (Cont.)	nt.)
APPOF	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	LLARY				PROVIDER NO.		PERIOD: FROM		WORKSHEET D. PART IV	
						COMPONENT NO.:	0.:	TO			
Check applicable	əlq	[] Title V [] Title XVIII, Part	art A	[] Hospital [] Subprovider	[]NF []ICFMR	() pps () tefra					
poxes		[] Title XIX		[] SNF							
			*		E C			Treation			
		N	1 (4.4)		10121	Datio of Cast	Tampfinet	Designation Designation	***************************************	Outpanent	
	Onet Center Description	Nonpnysician Apesthetist	Medical	Total Coste	Charges (from West C	to Chames	Inpatient	Through Costs	Program	Through Costs	,
	COSE COSTON TO THE COSTON TO T	Cost	Cost	(col. 1 + col. 2)	Part I, col. 8)	(col. 3 ÷ col. 4)	Charges	(col. 5 x col. 6)	Charges	(col. 5 x col. 8)	
		1	2	3	4	5	9	L	8	6	
€	ANCILLARY SERVICE COST CENTERS										
37	Operating Room										37
38	38 Recovery Room										38
39	39 Delivery Room and Labor Room	,									39
40	40 Anesthesiology										6
41	Radiology-Diagnostic										41
42	Radiology-Therapeutic										42
43	Radioisotope										43
4											4
45	_										45
46	Whole Blood & Packed Red Blood Cells										4
47	Blood Storing, Processing, & Tranfusing										47
48	Intravenous Therapy										48
49	49 Respiratory Therapy										69
50	50 Physical Therapy										50
51	Occupational Therapy									•	51
52	Speech Pathology										52
53	53 Electrocardiology										53
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
55.30											55.30
56	Drugs Charged to Patients										99
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59	59 Other Ancillary (specify)										59

(A) Worksheet A line numbers

60-//0				FORM CI	FORM CMS-2552-96					3690 (Cont.)	nt.)
APPORT	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	LLARY			I	PROVIDER NO.:		PERIOD:	1	WORKSHEET D,	
SERVICE	SERVICE OTHER PASS THROUGH COSTS							FROM	<u> </u>	PART IV (CONT.)	
)	COMPONENT NO.:		TO			
Check		[] Title V		[] Hospital	₩[]	[] PPS					
applicable boxes	0	[] Title XVIII, Part A	1.4	[] Subprovider	[]ICFMR	[]Tefra					
					Total			Inpatient		Outpatient	
		Nonphysician	Medical		Charges	Ratio of Cost	Inpatient	Program Pass	Outpatient	Program Pass	
Ü	Cost Center Description	Anesthetist	Education	Total Costs	(from Wkst. C,	to Charges	Program	Through Costs	Program	Through Costs	
	•	Cost	Cost	(col. 1 + col. 2)	Part I, col. 8)	(col. 3 ÷ col. 4)	Charges	(col. 5 x col. 6)	Charges	(col. 5 x col. 8)	
		-	2	3	4	5	9	7	8	6	
0	OUTPATIENT SERVICE COST CENTERS										
D 09	Clinic										09
61 B	Emergency										61
29	Observation Beds										62
63	63 Other Outpatient Service (specify)										63
0	OTHER REIMBURSABLE COST CENTERS										
64 H	64 Home Program Dialysis										25
65 A	65 Ambulance Services		-								65
99 D	66 Durable Medical Equipment-Rented										99
67 D	Durable Medical Equipment-Sold										67
0 89	Other Reimbursable (specify)										68
101 T	101 Total (sum of lines 37 through 68)										101

(A) Worksheet A line numbers

07	60-20			FORM	FORM CMS-2552-96	9				3690 (Cont.)	ont.)
API HE	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Ĭ.	PROVIDER NO.:		PERIOD: FROM	-	WORKSHEET D. PARTS V & VI	
						COMPONENT NO.:	:: ::	TO	,		
Check Applica Boxes	Check Applicable Boxes	[] Title V - O/P [] Title XVIII, Part B [] Title XIX - O/P	a 1		[] Hospital [] Subprovider [] SNF		[] NF [] Swing Bed SNF [] Swing Bed NF	F. H.	[]ICF/MR		
PA	PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	ER HEALTH SERV	ICES COSTS								
				1			PROGRA	PROGRAM CHARGES			
	Cost Center Description	Cost to Charge	Cost to Charge Ratio From Worksheet C.	orksheet C.	Outpatient Ambulatory Surrical	Outpatient	Other	All Other (1)	PPS services	All Other	
		Part II, col. 8	Part I, col. 9	Part II, col. 9	Center	Radiology	Diagnostic	(see instru.)	(see instru.)	(see instru.)	
3	ANION I ADV GEDVING COST CENTEDS		1.01	1.02	2	3	4	5	5.01	5.02	
3 5											7.5
38	Recovery Room										; «
39	Delivery & Labor Room										8 8
4	Anesthesiology										9
41											4
45											42
43	Radioisotope										43
4	Laboratory										4
45	PBP Clinic Laboratory Services-Prgm, Only										45
4	46 Whole Blood & Packed Red Blood Cells										46
4	47 Blood Storing, Processing, & Transfusing						-				47
84	Intravenous Therapy										48
9	Respiratory Therapy										46
S	Physical Therapy										50
51	Occupational Therapy										51
52	Speech Pathology										52
53	Electrocardiology										53
54	Electroencephalography										22
55	Medical Supplies Charged To Patients										55
;; -	15.30 Implantable Devices Charged to Patients										55.30
36	Drugs Charged To Patients										26
57	Renal Dialysis										57
28	ASC (Non-Distinct Part)										88
55	59 Other Ancillary (specify)										SS.

FORM CMS 2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3621.5 & 3621.6)

07-09	6(FORM	FORM CMS-2552-96	9(3690 (Cont.)	t.)
APPC	APPORTIONMENT OF MEDICAL, OTHER HEAT TH SERVICES AND VACCINE COST			PROVIDER NO.:		PERIOD: FROM		WORKSHEET D, PARTS V (Cont.) & VI	l I
				COMPONENT NO.	ı	TO			
Check		[] Title V - O/P	[]Hospital		[]WF		[]ICF/MR		l
Applicable	cable	[] Title XVIII, Part B	[] Subprovider		[] Swing Bed Sh	臣			
Boxes	M.	[] Title XIX - O/P	[]SNF		Swing Bed NF	fr.			ı
PAR	PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	ER HEALTH SERVICES COSTS							١
					PROGRA	PROGRAM CHARGES			
			Outpatient						.
			Ambulatory		Other				
	Cost Center Description	to Charge Ratio From Worl	Surgical	Outpatient	Outpatient	All Other (1)	PPS services	All Other	
		Part II, col. 8 Part I, col. 9 Part II, col. 9	Center	Radiology	Diagnostic	(see instru.)	(see instru.)	(see instru.)	ļ
		1 1.01 1.02	2	3	4	5	5.01	5.02	
	OUTPATIENT SERVICE COST CENTERS								
99	60 Clinic								8
61	Emergency	THE PROPERTY OF THE PROPERTY O							61
62	Observation Bed								22
63	Other Outpatient Service (specify)								છ
	OTHER REIMBURSABLE COST CENTERS								١
8	64 Home Program Dialysis								হ
65	65 Ambulance								န္ဓါ
99	66 Durable Medical Equipment-Rented					٠			ध
67	67 Durable Medical Equipment-Sold								67
89	Other Reimbursable Cost Center								8
101	101 Subtotal (see instructions)							ī	101
102	CRNA Charges (see instructions)							1	102
103	103 Less PBP Clinic Lab, Services-Program Only Charges								03
104	104 Net Charges (line 101 ± lines 102 and 103)				,			1	104 104

(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

3690 (Cont.)	WORKSHEET D, PART V (Cont.)				٠		Hospital	indepite.	I/P Part B	(columns	1.02 × 10)	11		37	38	39	40	41	42	. 43	44	45	46	47	48	49	- 50	51	52	53	54	55	55.30	56	57	58
						Homester -		: : T	Hospital	Charges	(see instru.)	10								-																
	PERIOD: FROM	TO	C ATOT 7	I JICE/INEK					T V	All Outer	1.01 x 5.02)	9.02																						•		
		NO.:		1	SNE				200	(columns	1.01 x 5.01)	9.01																								
	PROVIDER NO.:	COMPONENT NO.:	E.C.)		[] Swing Bed SNF [] Swing Red NF	1	Say Contraction	CAMI COSTS		AllOther	(cols. 1 x 5)	6																								
S-2552-96			T. D. T. T.	i j nospital	[] Subprovider		I COOL	LINOR	Other	Diagnostic	(cols. 1 x 4)	8																								
FORM CMS-2552-96					Part B vP	TE COSTS	E COSTO			Culpanent	(cols. 1 x 3)	7																						-		
			0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		J Title XVIII, Part B	THE SERVICES COSTS	CHALLI SENVIC		Outpatient	Surgical Center	(cols 1 x 2)	9																								
6	APPORTIONMENT OF MEDICAL, OTHER HEAT THE SED VICES AND VACCINE CORT				able	V APPODITIONATION OF MEDICAL AND OTHE	V - AFFOREIOIVMENT OF MEDICAL AND OTHER TO						ANCILLARY SERVICE COST CENTERS	Operating Room	Recovery Room	Delivery & Labor Rom	Anesthesiology	Radiology-Diagnostic	Radiolow-Theraneutic	Radioisotope	Laboratory	PBP Clinic Laboratory Services-Prem. Only	Whole Blood & Packed Red Blood Cells	Blood Storing, Processing, & Transfusing	Intravenous Therapy	Respiratory Therapy	Physical Therapy	Occupational Therapy	Speech Pathology	Electrocardiology	Electroencephalography	Medical Supplies Charged To Patients	Implantable Devices Charged to Patients	Drugs Charged To Patients	Renal Dialysis	ASC (Non-Distinct Part)
07-09	APPO	7		Check	Applicable	DOXOS							3	L.	æ	30		4		_	_		4	47	7	6	20	51		53	22	55	15.30	35	57	58

FORM CMS 2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3621.5 & 3621.6)

	08-02	02		FORM CMS-2552-96	3-2552-96					3690 (Cont.)	nt.)
The services and vaccine continues and vac	ı⊼. ˈ	ORTIONMENT OF MEDICAL, OTHER				PROVIDER NO.:		PERIOD:		WORKSHEET D.	
1 Title V. O.P	< −	LTH SERVICES AND VACCINE COST				COMPONENT NO	1	FROM	1 .	PAKT V (Cont.)	
Trite VOP Trite VOP Trite VOP Hospital JNF JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR JCFAIR											
1 Trite XVIII. Per B [1 Subprovider [1 Swing Bed SNF 1	ΓŖ	К	[] Title V - O/P	,	[] Hospital	JNE		[] ICF/MR			
VAPPORTIONALENT OF MEDICAL AND OTHERR HEALTH SERVICES COSTS PROGRAM COSTS PROGRAM COSTS VAPPORTIONALENT OF MEDICAL AND OTHERR HEALTH SERVICES COSTS PROGRAM COSTS All Other PPS services And Disputed the Application of Comparison of Comparison of Comparison of Comparison of Cools In x 2) (cols In x 2) (cols In x 3) (cols	ᇹ	icable	Title XVIII, P	artB	[] Subprovider	[] Swing Bed SN	된				
National Part Control Comparison Com	. 9	S	Title XIX - O	ſΡ	[]SNF	[] Swing Bed NF	_				
Compatient	IΜ	V - APPORTIONMENT OF MEDICAL AND OTHER	EALTH SERVICE	ES COSTS							
Outpatient	i				PROGR	AM COSTS				Hospital	1
Ambulatory Outpatient	ì		Outpatient		Other				Hospital	I/P Part B	
Surgical Center Radiology Diagnostic All Other (columns) (columns) Charges 6 cols. 1 x 2) (cols. 1 x 3) (cols. 1 x 4) (cols. 1 x 5) 1.01 x 5.02) (see instru.) RS 7 8 9 9.01 9.02 10 RS 9 9.01 9.02 10 10 ERS 8 9 9.01 9.02 10 ERS 9 9.01 9.02 10 10 ERS 9 9.01 9.02 10 10 ERS 9 9.01 9.02 10 10 10			Ambulatory	Outpatient	Outpatient		PPS services	All Other	I/P Part B	Cost	
RS (cols 1x 2) (cols 1x 3) (cols 1x 4) (cols 1x 5) 1.01 x 5.02) (see instru.) RS 6 7 8 901 902 10 RS 9 901 902 10 10 10 ERS 8 9 10 x 5 x 5 10			Surgical Center	Radiology	Diagnostic	All Other	(columns	(columns	Charges	(columns	
RS 6 7 8 901 902 10 10 RS 9 901 902 10 </td <td></td> <td></td> <td>(cols. 1 x 2)</td> <td>(cols. 1 x 3)</td> <td>(cols. 1 x 4)</td> <td>(cols. 1 x 5)</td> <td>1.01×5.01)</td> <td>1.01×5.02)</td> <td>(see instru.)</td> <td>1.02 x 10)</td> <td></td>			(cols. 1 x 2)	(cols. 1 x 3)	(cols. 1 x 4)	(cols. 1 x 5)	1.01×5.01)	1.01×5.02)	(see instru.)	1.02 x 10)	
ERS	ı		9	7	8	6	9.01	9.02	10	11	
Emergency Clinic Emergency Charter Description Each Other Outpatient Service (specify) Other Plant ReIMal Urs. Ability Hour Plant ReIMal Urs. Ability Hour Plant Reimbursable Cost Center Durable Medical Equipment-Rented Durable Medical Equipment-Rented Durable Medical Equipment-Sold Other Reimbursable Cost Center Subtotal (see instructions) Subtotal (see instructions) Subtotal (see instructions) CRNA Charges (see instructions) Less PBP Clinic Lab. Services-Program Only Charges (see instructions) Charter Reimbursable Cost Center Subtotal (see instructions) CRNA Charges (see instructions)	ı	OUTPATIENT SERVICE COST CENTERS									
Emergency Cheervation Bed Cost Centre Cost Centre Cost Centre Comparison Centre Cost Centre Control Edutation Centre Control Edutation Centre Cost Cen		Clinic									09
Observation Bed Observation Bed Observation Bed Observation Bed Other Outpatient Service (specify) Other Outpatient Service (specify) Other Outpatient Service (specify) Other ReinAbursable Cost Center Other ReinAbursable Cost Center Other ReinAbursable Cost Center Other ReinAbursable Cost Center Subtotal (see instructions) Other ReinAbursable Cost Center Subtotal (see instructions) Other ReinAbursable Cost Center		Emergency									61
Other Outpatient Service (specify)	~	Observation Bed									62
OTHER REIMBURSABLE COST CENTERS	m	Other Outpatient Service (specify)									63
Home Program Dialysis Home Program Dialysis Home Program Dialysis Home Program Dialysis Homelean Equipment-Rented Durable Medical Equipment-Sold Homelean Equi		OTHER REIMBURSABLE COST CENTERS									
Ambulance Durable Medical Equipment-Rented Durable Medical Equipment-Rented Durable Medical Equipment-Sold Durable Medical Equipment-Sold Other Reimbursable Cost Center Subtoral (see instructions) Subtoral (see instructions) Subtoral (see instructions) Only Charges (see instructions) O	l च±	Home Program Dialysis				2220					49
Durable Medical Equipment-Rented	S	Ambulance									65
Durable Medical Equipment-Sold Cher Reimbursable Cost Center Subtotal (see instructions) CRNA Charges (see instructions) Toward Charges (see instructions) CRNA Charges (see instructions)	lω	Durable Medical Equipment-Rented									99
Other Reimbursable Cost Center Subtotal (see instructions) Subtotal (see instructions) CENA Charges (see instructions) Less PBP Clinic Lab. Services-Program Only Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges And Ander Charges Ander Charges And An	[~]	Durable Medical Equipment-Sold									67
Subtotal (see instructions) CRNA Charges (see instructions) Less PBP Clinic Lab. Services-Program Chirt Charges (and 1702)	00	Other Reimbursable Cost Center									89
CRNA Charges (see instructions)	ا ــــا	Subtotal (see instructions)									101
3 Less PBP Clinic Lab. Services-Program Only Charges A Mate Putter and A Material And A Material	2	CRNA Charges (see instructions)									102
1 Note (Many 10) 11 11 11 11 11 11 11 11 11 11 11 11 11		Less PBP Clinic Lab. Services-Program Only Charges									103
+ Inet Charges (line 101 ± ines 102 and 105) }	Ι ↔	104 Net Charges (line 101 ± lines 102 and 103)									104

(A) Worksheet A line numbers

369	90 (Cont.)		FORM C	MS-2552-96				08-02
	APUTATION OF I	NPATIENT	PROVIDER NO.:	COMPONENT NO.:	PERIOD:		WORKSHEET D	-l,
OPE	RATING COST				FROM		PART I	
					TO			
Che	:k	[] Title V - I/P	[] Hospital	[] NF		[]PPS		
appi	icable	[] Title XVIII, Part A	[] Subprovider	[] ICF/MR		[]TEFRA	1	
boxe		[] Title XIX - I/P	[]SNF			[] Other		
PAI	RT I - ALL PROV	IDER COMPONENTS		L	****			
			INPATIENT DAYS					
1		luding private room days and		-				1
2		luding private room days, exc		ewborn days)				2
		(excluding swing-bed private						3
4		days (excluding swing-bed p						4
5		NF type inpatient days (includ						5
6		NF type inpatient days (includ	ling private room days)	after December 31 of the	cost reporting pend	od (11		6
_	calendar year, enter							
· 7	Total swing-bed NI	F type inpatient days (includi	ng private room days) ti	arough December 31 of the	he cost reporting per	nod		8
8		F type inpatient days (includi	ng private room days) a	tter December 31 of the	cost reporting period	1 (П		l °
	calendar year, enter						<u></u>	
9		s including private room days				.1	<u> </u>	9 10
10		pe inpatient days applicable to	title XVIII (including	private room days) throu	gh December 31 of	tne		10
		od (see instructions).		1 \ 0	D 21 -Cal		1	11
11		pe inpatient days applicable to		private room days) after	December 31 of the	3	ł	11
		od (if calendar year, enter 0 c		1 34		-6	-	12
12		e inpatient days applicable to	titles V or XIX (includi	ing private room days) th	rougn December 31	01		12
	the cost reporting		TEXTE (: 1 1:	1		41		13
13		inpatient days applicable to		ing private room days) an	er December 31 of	ine		13
		od (if calendar year, enter 0 o						14
		y private room days applicab	e to the Program (exci	uoing swing-bed days)				15
		(title V or XIX only)						16
16	Nursery days (title	v or AtA only)	SWING BED ADJU	SLIVENII,			1	1.0
17	Madiagra sata for a	wing-bed SNF services appli		*****	st reporting period			17
18	Medicare rate for s	wing-bed SNF services appli	cable to services after F	December 31 of the cost r	enorting period	4.177	-	18
19	Medicaid rate for s	wing-bed NF services applications	ble to services through	December 31 of the cost	reporting period			19
20		wing-bed NF services applications				****		20
21		ient routine service cost (see		oblinder by or alle converg	<u>S</u> F			21
22	Swing-hed cost and	olicable to SNF type services	through December 31	of the cost reporting perio	od (line 5 x line 17)		****	22
23	Swing-bed cost apr	olicable to SNF type services	after December 31 of t	he cost reporting period (line 6 x line 18)			23
24		olicable to NF type services t						24
25		olicable to NF type services a						25
26		st (see instructions)		. 5,		•		26
27		outine service cost net of swi	ng-bed cost (line 21 mi	nus line 26)				27
				IFFERENTIAL ADJUS	TMENT			
28	General inpatient r	outine service charges (exclu	ding swing-bed charges)				28
29		es (excluding swing-bed char						29
30	Semi-private room	charges (excluding swing-be	d charges)					30
31	*	outine service cost/charge rat						31
32		om per diem charge (line 29						32
33		ate room per diem charge (lir				-		33
34		private room charge different		3)				34
35	Average per diem j	private room cost differential	(line 34 x line 31)				1	35
36		lifferential adjustment (line 3						36
37	General inpatient re	outine service cost net of swi	ng-bed cost and private	room cost differential (li	ne 27 minus line 36)	<u> </u>	37

Rev. 9

05-04	1 ·	FORM	м CMS-2552	-96		3690 (C	Cont.)
	UTATION OF INPATIENT	PROVIDER NO.:		NENT NO.:	PERIOD:	WORKSHEET D-	l,
	TING COST				FROM	PART II	
					TO		
Check	[] Title V - I/P		[] Hospital		[] PPS		
applicat			[] Subprovider		[] TEFRA		
boxes	[] Title XIX - I/P II - HOSPITAL AND SUBPROVIDERS ON		<u> </u>		1 Council	,,,,	
PARI	PROGRAM INPA		NG COST BEFO	RE	*		
		H COST ADJUST				1	
38	Adjusted general inpatient routine service cost p	er diem (see instruc	tions)				38
39	Program general inpatient routine service cost (l	ine 9 x line 38)					39
40	Medically necessary private room cost applicable	e to the Program (lir	ne 14 x line 35)	···	****		40 41
41	Total Program general inpatient routine service	cost (line 39 + line 4	10) I	Average	1	***	
		Total	Total	Per Diem	Program	Program Cost	
		Inpatient Cost	Inpatient Days	(col. 1 ÷ col. 2)	Days	(col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)		448				42
	Intensive Care Type Inpatient						
	Hospital Units						
43	Intensive Care Unit				<u> </u>		43
44	Coronary Care Unit		<u> </u>	<u> </u>	 		44 45
45	Burn Intensive Care Unit		 	 	 	-	46
46	Surgical Intensive Care Unit			 	+		47
47	Other Special Care Unit (specify)		<u> </u>	<u></u>		1	<u> </u>
48	Program inpatient ancillary service cost (Wkst. I	D-4. col. 3. line 101)	*****			48
49	Total Program inpatient costs (sum of lines 41 to	hrough 48) (see inst	ructions)				49
	<u> </u>						
	PASS THROUGH						
50	Pass through costs applicable to Program inpatie	nt routine services (from Wkst. D, sum	of Parts I and III)			50
51	Pass through costs applicable to Program inpatie		s (from Wkst. D, su	m of Parts II and IV)		51 52
52	Total Program excludable cost (sum of lines 50 Total Program inpatient operating cost excluding	and 51)	inion on outbati	ist and medical edi	cetion costs		53
53	(line 49 minus line 52)	g capital related, nor	apnysician aitesineu	isi, and intedicated	ication costs		
	(time 49 minus time 32)						
	TARGET AMOU	NT AND LIMIT C	OMPUTATION				
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted impatient operating	cost and target amo	ount (line 56 minus	line 53)			58
58	Bonus payment (see instructions)		106dated and agr	anounded by the m	orket backet	 	58.01
58.01	Lesser of lines 53/54 or 55 from the cost reporti Lesser of lines 53/54 or 55 from prior year cost	ng period ending 19 report, undated by th	he market hasket	inpotentied by the in	aret odsket.		58.02
58.02 58.03	If line 53/54 is less than the lower of lines 55, 5	8 01 or 58 02 enter	the lesser of 50% of	f the amount by whi	ch operating costs		58.03
20.03	(line 53) are less than expected costs (lines 54)	(58.02), or 1 % of the	he target amount (li	ne 56), otherwise en	nter zero.		
	(see instructions)	<i>y</i>	`	·			<u> </u>
58.04	Relief payment (see instructions)			· ·			58.04
59	Allowable inpatient cost plus incentive paymen	t (see instructions)				_	59
	Allowable inpatient cost per discharge (line 59 d	livided by line 54) (LTCH only)			 	59.01 59.02
	Program discharges prior to July 1	- · · · ·		***		 	59.02
59.03	<u> </u>						59.04
59.04 59.05		ges prior to July 1 (s	see instructions) (T.)	rch only)			59.05
	Reduced inpatient cost per discharge for discharge	ges after July 1 (see	instructions) (LTC	H only)			59.06
59.07	<u> </u>						59.07
59.08							59.08
-	PROGRAM INPA		E SWING BED CO	OST			
60	Medicare swing-bed SNF inpatient routine cost	s through December	r 31 of the cost repo	orting period (See in	structions)		60
61	1 -	s after December 31	of the cost reporting	ng period (See instr	uctions)		61
	(title XVIII only)		lima 613 (4:41- 3717	III anhi) Ear CAII	(see instructions)		62
62		e costs (line 60 plu	mber 31 of the cost	reporting period (6)	ne 12 x line 19)		63
63 64		costs after Decemb	er 31 of the cost rer	orting period (line	13 x line 20)		64
65		utine costs (line 63	+ line 64)	- 5,			65

369	90 (Cont.)		CMS FORM-2	552-96		05-	-04
COV	PUTATION OF INPATH RATING COST	ENT	PROVIDER NO.:	COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET D-1, PARTS III & IV	
boxe	cable [] Tit	le V - I/P le XVIII, Part A le XIX - I/P	[] Subprovider [] SNF] NF] ICF/MR	[] PPS [] TEFRA [] Other		
PAR	**		R NURSING FACILITY, A	ND ICENNIK ONLI	.		Г.,
66	Skilled nursing facility/oth	er nursing facility/ICF/MR	routine service cost (line 37)		<u> </u>	<u>.</u>	66
67	Adjusted general inpatient	routine service cost per die	m (line 66 ÷ line 2)		1847/107		67
68	Program routine service co	est (line 9 x line 67)					68
69	Medically necessary privat	te room cost applicable to Pr	rogram (line 14 x line 35)				69
70		atient routine service costs (70
71	Capital-related cost allocat	ed to inpatient routine servi	ce costs				71
	(from Worksheet B, sum o	of Parts II and III, column 2	/)	***			
72	Per diem capital-related co	osts (line 71 ÷ line 2)					72
73	Program capital-related co	sts (line 9 x line 72)	***				73
74	Inpatient routine service c	ost (line 70 minus line 73)					74
75	Aggregate charges to bene	ficiaries for excess costs (fro	om provider records)				75
76			the cost limitation (line 74 mi	nus line 75)			76
	***			***			77
77	Inpatient routine service c						78
78	Inpatient routine service c	ost limitation (line 9 x line	//)	***			
79	Reasonable inpatient routi	ne service costs (see instruc	tions)	Ma ^a			79
80	Program inpatient ancillar	y services (see instructions)					80
81	Utilization review - physic	cian compensation		wit-			81
82	Total Program inpatient o	perating costs (sum of lines	79 through 81)				82
PAI	RT IV - COMPUTATIO	N OF OBSERVATION B	ED PASS THROUGH COS	T			
83	Total observation bed day						83
			27 ± line 2)		···		84
		t routine cost per diem (line			***	 	Т
85		83 x line 84) (see instructi				<u></u>	85
_	COMP	UTATION OF OBSERV	VATION BED PASS THRO	OUGH COST	Total	Observation Bed	Т
		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Observation Bed Cost (from line 85)	Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	\vdash
86	Old capital-related cost						86
87	New capital-related cost						87
88	Non Physician Anesthetis	t					88
	Medical Education						89

41

42 44

col. 9, line 24

col. 9, line 10

col. 9, line 12

40

41

Outpatient

44 Skilled Nursing Facility

42 Subprovider

Total Hospital (sum of lines 39 and 40)

APPOR	TIONMENT OF COS	ì	PROVIDER NO.:	101411 01110 .	PERIOD:		WORKSHEET D-2,	
	CES RENDERED BY				FROM		PARTS I-III (Cont.)	
	NS AND RESIDENTS I - NOT IN APPRO		IDOCD A M		ТО			
PARI	1 - NO1 IN APPRO	VED TEACHING P	Care Program Inpatie	ent Dave	Title V	Title XVIII	Title XIX	T
	Average Cost	Title	Title XVIII	Title	(col. 4 x	(col. 4 x	(col. 4 x	
	Per Day	V	Part B	XIX	col. 5)	col. 6)	col. 7)	
	4	5	. 6	7	8	9	10	
1								1
2								2
3						*****		3
4						· · · · · · · · · · · · · · · · · · ·	<u> </u>	4
5	****					_		5
6						 	 	7
7								8
8 9								9
10						- }		10
12					<u> </u>		1	11
13	***				<u> </u>			12
14								14
15								15
16								16
17								17
18								18
19					m'i	W 1377/0 / //		19
	Ratio of Cost		V and XIX Outpatier		111	les V and XIX Outpation Title XVIII Part B Co		
	to Charges	Title	le XVIII Part B Char Title XVIII	ges Title	Title	Title XVIII	Title	1
	(col. 2 ÷ col. 3)	V	Part B	XIX	V	Part B	XIX	
20	COI. 3)	····	Tares	21111				20
21					-	****	-	21
22				***				22
23	<u> </u>							23
24								24
25								25
PART	II - IN AN APPROV	ED TEACHING PI	ROGRAM (TITLE	XVIII, PART B IN	PATIENT ROUTIN	E COSTS ONLY)		
				Expenses				
	Total	Average Cost Per Day	Title XVIII Part B	Applicable to Title XVIII				
	Inpatient Days -	(col. 3 ÷ col. 4)	Inpatient Days	(col. 5 x col. 6)				
	All Patients 4	(cor. 3 ÷ cor. 4)	6	7				1
26	· · · · · · · · · · · · · · · · · · ·							26
27			***	~ .				27
28								28
29	4/3939/							29
30								30
31								31
32								32
33								33
34							1000	35
35			******					37
37								38
38 PART	III - SUMMARY FO	OP TITLE VVIII (I	O BE COMPLETE	D ONLV IF BOTH	I PARTS LAND II .	ARE USED)		
raki'.		aching Program		XVIII Costs	TAKISTANDII A	00ED)		
	from Part II, col. 7, -	Amount	to Wkst. E, Part B -	(col. 2 + col. 4)				
	3	4	5	6				
39	line 34	•					0.00	39
40								40
41			line 2					41
42	line 35		line 2			1000		42
44	line 37		line 2					44

(A) Worksheet A line numbers

D = Worksheet D-1 line numbers

35

TOTAL (sum of lines 8-34)

C = Worksheet C line numbers

05-07		FOR	LM CMS-2552-96	<u></u>	3690 (C	ont.)
COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES		PROV	IDER NO.:	PERIOD: FROM	WORKSHEET D-6, PART II	
C0313	AND CHIROLD	OPO I	NO.:	то		
Check	[] HEART	[]L	IVER	[] PANCREAS	[] ISLET	
Applicable	e Box [] KIDNEY		UNG	[] INTESTINE	[] OTHER (specify)	
PART I	I - COMPUTATION OF ORGAN ACQUISITI	ON COSTS	(OTHER THAN INPA	TIENT ROUTINE AND		
	ANCILLARY SERVICES COSTS)					
			Average Cost		Organ	
	Computation of the Cost of Inpatient		Per Day	•	Acquisition	
	Services of Interns and Residents Not		(from Wkst. D-2,	Organ	Costs	1
	In Approved Teaching Program	ļ	Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)	_
		D	1	2	3 -	<u> </u>
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)		Ratio of Cost To Charges from Wkst. D-2, Part I, col. 4)	Organ Acquisition Costs (col. 1 x col. 2)	
		1	D	2	3	<u>↓</u> _
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

3690	(Cont.)		FORM CM	· · · · · · · · · · · · · · · · · · ·			-07
	PUTATION OF ORGAN S AND CHARGES	ACQUISITION		PROVIDER NO.: OPO NO.:	PERIOD: FROM TO	WORKSHEET D-6, PARTS III & IV	
Check Applie	eable Box	[] HEART	[]LIVER	[]PANCREAS []INTESTINE	[]ISLET []OTHER (speci	fy)	
		COSTS AND CHARGES					
		***	Cost		Charg		
			Part A	Part B	Part A	Part B	
			1	2	3	4	
48	Routine and Ancillary fro	m Part I					48
	Interns and Residents (in					_	49
50	Interns and Residents (ou	tpatient)					50
51	Direct Organ Acquisition	(see instructions)					51_
52	Cost of Services of Teach	ning Physicians (Wkst. D-9)					52
53	Total (sum of lines 48 thr	ru 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					56
	Organs (line 55 ÷ line 54))					Ь—
57	Medicare Cost/Charges (see instructions)					57
58	Revenue for Organs Sold						58
59	Subtotal (line 57 minus li	ine 58)					59
60	Organs Furnished Part B				<u> </u>		60
61	Net Organ Acquisition C	ost and Charges (see instructions)					61
PAR'	Γ IV - STATISTICS						
				Living Related	Cadaveric	Revenue	
				1	2	3	
62	Organs Excised in Provide	ler (1)					62
		Other Transplant Hospitals (2)		1			63
	Organs Purchased from N						64
	Organs Purchased from C		****				65
	Total (sum of lines 62 th			1"	1		66

68

69 70 71

72

73

74

75

76

66 Total (sum of lines 62 thru 65)

68 Organs Sold to Other Hospitals

72 Organs Sold Outside the U.S.

74 Organs Used for Research

75 Unusable/Discarded Organs

70 Organs Sold to Transplant Hospitals 71 Organs Sold to Military or VA Hospitals

73 Organs Sent Outside the U.S. (no revenue received)

76 Total (sum of lines 67 thru 75 should equal line 66)

67 Organs Transplanted

69 Organs Sold to OPOs

⁽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.

Professional Position Prof	05-07	-07	FORM CMS-2552-96	96				3690 (Cont.)	(;
Total Processing Processi	APP.	ORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICL	ANS	PROVIDER NO.:		PERIOD:		WORKSHEET D-9,	
Unidential Staff (1 Medical Staff Total Professional RCE Professional RCE Limin RCE Limi	REA	ASONABLE COMPENSATION EQUIVALENT COMPUTATION				FROM TO		raki i	
Professional Professional RCE Professional RCE	Chec	[] Hospital Staff	al Staff		The state of the s				1
Speciality Total Prefessional Professional		i de contra de c				Physician/		5 Percent	
Operating Pacition Descriptions Plysteian Infamilier Reminentation Component Amount Component Present Programment Plones RCE Limit	Line		Total	Professional	RCE	Professional	Unadjusted	of Unadjusted	
General Princitioner Plannity Practice 3 4 5 6 7 8 Suggesty Suggesty Problemice Problemice Problemice Problemice Problemice Redictory Problemice	Š		Remuneration	Component	Amount	Component Hours	RCE Limit	RCE Limit	١
Control Proteition Control Proteition Control Control Adjust Control District Synthesion Cost of Description Cost of Description Cost of Description Adjust Cost of Thysician State of Cost of Description Adjust Cost of Thysician State of Cost of Description Adjust Cost of Thysician State of Cost of Description Adjust Cost of Thysician Description Adjust Cost of Thysician State of Cost of Thysician State of Cost of Description Adjust Cost of Thysician Description Adjust Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Cost of Thysician State of Thysician State of Cost of Thysician State	-	2	3	4	ž	9	7	8	′
Internal Medicine Cost of Description Cost of Description Cost of Description Adjust Cost of Description Adjust Cost of Description Adjust Cost of Description Adjust Cost of Description Provision Identifier Adjust Cost of Identifier Adjust Cost of Description Provision Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Identifier Adjust Cost of Ide	-	General Practitioner Family Practice							-
Surgecy Surgecy Pediatrics Pediatrics <td>2</td> <td>_</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>7</td>	2	_							7
Pediatrics Pediatrics Obstelites-Gymecology Cost of Equation According According According Acquist According Acquist According According According According Acquist According According According According According According Acquist According	3	_							Э
Relations Connected Symbol Relations Connected Symbol Relations Connected Symbol Adjust Cost of Education Adjust Cost of Instituted Symbol Cost of Instituted Symbol Adjust	4	-							4
Radiology Psychiatry Adjust Cost	5								~
Psychiatry Austlesciology Part Object	9								ه
Authology Cost of Education Cost of Education Cost of Education Adjust Cost Adjust Cost Cost Cost Cost Cost Cost Cost Co	7	—							7
Pathology All Other All Other All Other All Other Cost of All Other Cost of Cost of Cost of Component Alize of Physician Specialty Cost of Component Alize of Component Alize of Coll of Physician Share of col. 11 Adjust Cost of Alize to Cost of Component Alize of Coll of Component Alize of Col. 11 Adjust Cost of Alize to Cost of Component Alize of Col. 12 Adjust Cost of Alize to Cost of Component Alize of Col. 13 Adjust Cost of Cost of Cost of Cost of Cost of Cost of Cost of Component Alize of Col. 13 Adjust Cost of Cost	8	_							8
Total Total Const of Equations Equation Equations Eq	^	-							6
Total Tota	≏	-							2
Cost of Description Professional Education Cost of Description Professional Description Professional Education Professional Professional Education Cost of Component Physician Identifier Adjust Cost of Physician Identifier Adjust Cost of Physician Identifier Adjust Cost of Physician Identifier Adjust Cost of III Professional Adjusted Direct Medical & Direct Medical & Share of col. II Insurance Share of col. II Insurance Share of col. II Insurance Insurance <td>=</td> <td>_</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>= </td>	=	_							=
Cost of Public Internal Procession Adjust Cost of Description Procession Adjust Cost of Description Physician Identifier Cost of Description Physician Identifier Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Physician Identifier Adjust Medicial Solution Physician Identifier Adjust Cost of Description Physician Identifier Adjust Cost of Description Iden									
Specialty Membership Professional Physician Professional of Physician's Physician's Professional Description/Physician Identifier Education Share of col. 11 Insurance Share of col. 13 RCEI_Limit Surgical Services Internal Description/Physician Identifier 10 11 12 13 14 15 16 General Practitioner Family Practice 11 12 13 14 15 16 Shurgery 11 12 13 14 15 16 Shurgery 12 13 14 15 16 Obstetices-Optocology 13 14 15 16 Packidistry 14 15 15 16 Psychiatry 15 15 16 17 17 Pathology 15 16 16 17 17 17 17 17 17 17 17 17 17 17 17 17 17 17 17 17			Cost of		Cost of			Adjust Cost	
Specially & Continuing Component Malpractice Component Adjusted Divect Medical & Share of col. 13 RCE Limit Suggest General Practitioner Family Practice 11 12 13 14 15 16 Internal Medicine Share of col. 11 Insurance Share of col. 13 RCE Limit Surgical Services Internal Medicine Share of col. 11 12 13 14 15 16 Bediancies Share of col. 12 RCE Limit Surgical Services 16 16 16 Posterier Chrecology Radiology Radiology Radiology 1 <td></td> <td></td> <td>Membership</td> <td>Professional</td> <td>Physician</td> <td>Professional</td> <td></td> <td>of Physician's</td> <td></td>			Membership	Professional	Physician	Professional		of Physician's	
Note Share of col. 13 RCE Limit Surgical Services 14 15 16 16	Line		& Continuing	Component	Malpractice	Component	Adjusted	Direct Medical &	
14 15 16	No.		Education	Share of col. 11	Insurance	Share of col. 13	RCE Limit	Surgical Services	
	6		11	12	13	14	15	16	
	'''	General Practitioner Family Practice							-
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	,								7
	∞	-							8
	۳ م	-							6
	=	╌							2
Part II, line 1, column 1 or 2, as appropriate)	=					·*·			11
		Part II, line 1, colunn 1 or 2, as appropriate)							

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

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	

23.03 Inpatient and Outpatient Islet Acquisition (line 3 x line 13.03)

Rev. 17

23.03

4.04

Disproportionate share adjustment (see instructions)

3690	(Cont.)		CMS FORM-2552-	-96		12-08
	LATION OF REIMBURS	EMENT	PROVIDER NO.:	PERIOD:	WORKSHEET E,	
SETTLE				FROM	PART A (Cont.)	
			COMPONENT NO.:	то		
Check	.	[] Hospital				
Applical	ole Box	[] Subprovider				
PART A	A - INPATIENT HOSPITA	AL SERVICES UNDE	R PPS		_	
	Additional payment for his	gh percentage of ESRD	beneficiary discharges			<u> </u>
5	Total Medicare discharges	on Worksheet S-3, Par	t I excluding discharges for DRGs 30	2, 316, 317 or M S-DRG 652,		5
	682 - 685. (see instructio	ns)				<u> </u>
5.01	Total ESRD Medicare di	ischarges excluding DR	Gs 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 in	patient days excluding	DRGs 302, 316, 317, or MS-DRGs 6	552, 682 - 685 (see instructions)		5.03
5.04	Ratio of average length of	of stay to one week (line	5.03 divided by line 5.01 divided by	7)		5.04
5.05	Average weekly cost for					5.05
5.06	Total additional payment	t (line 5.04 times line 5	05 times line 5.01)			5.06
6	Subtotal (see instructions))				6_
7	Hospital specific payment	s (to be completed by S	CH and MDH, small rural hospitals o	only.(see instructions)		7
7.01	Hospital specific payment	s (to be completed by S	CH and MDH, small rural hospitals of	only.		7.01
	See instructions FY beg.					 _
8	Total payment for inpatien	nt operating costs SCH	and MDH only (see instructions)			8
9	Payment for inpatient prop	gram capital (from Wor	ksheet L, Parts I, II, or III, as applical	ole)		9
10	Exception payment for in	patient program capital	(Worksheet L, Part IV, see instruction	ns)		10
			n Worksheet E-3, Part IV, see instruct	ions).		11 01
11.01	Nursing and Allied Health	n Managed Care payme	nt			11.01
11.02	Special add-on payments:	for new technologies				11.02
12	Net organ acquisition cost	t				12
	Cost of teaching physician					14
	Routine service other pas			-W-		15
	Ancillary service other pa					16
16	Total (sum of amounts on	lines 8 through 15)	.			17
	Primary payer payments					18
	Total amount payable for		line 16 minus line 17)			19
	Deductibles billed to pros		······································			20
20	Coinsurance billed to pro					21
21	Reimbursable bad debts (*	2			21.01
	Adjusted reimbursable ba					21.02
						22
22	Subtotal (line 18 plus line	e 21.01 minus lines 19 a	rovider termination or a decrease in p	rogram utilization		23
			govider termination of a decrease in p			24
24	Other adjustments (see in	ior cost reporting perior	ds resulting from disposition of depre	niable assets		25
25	Amounts applicable to pr Amount due provider (lir	tor cost reporting perior	s 24 and 25 minus line 23)			26
	Amount due provider (III Sequestration adjustment		s ar and as minim into as j			27
		, (see monucions)	··· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ··			28
	Interim payments Tentative settlement (for	fiscal intermediany use	e only)			28.01
20.01	Ralance due provider (Pr	noram) (line 26 minus 1	the sum of lines 27, 28, and 28.01)	**		29
20	Protested amounts (nona	llowable cost report iter	ns) in accordance with CMS Pub. 15-	II, section 115.2		30
30	11 consiste amounts (none					

51

52

53

54

55

TO BE COMPLETED BY INTERMEDIARY

50 Operating outlier amount from Worksheet E, Part A line 2.01

51 Capital outlier amount from Worksheet L, Part I line 3.01

52 Operating outlier reconciliation amount (see instructions)

53 Capital outlier reconciliation amount (see instructions)

54 The rate used to calculate the Time Value of Money

Operating Time Value of Money (see instructions)Capital Time Value of Money (see instructions)

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

3690 (Cont.)	FORM CMS-2552-	96	07-09
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET E, PART B
PART B - MEDICAL AND OTHER HEAL			
TO BE COMPLETED BY CONTR			50
50 Original outlier amount (see instructi	ons)		
51 Outlier reconciliation amount (see in	structions)		51
52 The rate used to calculate the Time V	alue of Money		52
53 Time Value of Money (see instruction			53
54 Total (sum of lines 51 and 53)			54

05-99	CMS FORM-2552-96		3690 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET E, PART C
Check Applicable	[] Title V [] Title XVIII [] Title XIX	[] Hospital	
PART C - OUTPATIENT AMBULATORY SURG			
1 Standard overhead amounts (ASC fees)			1

1	Standard overhead amounts (ASC fees)		1_
2	Deductibles		
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		
	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	i i	9
	basis had such payment been made in accordance with 42 CFR 413.13 (e)		
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
		1	16

18

19

20

17 Hospital specific portion of blend (42% of line 16)

21 ASC payment amount (column 1 amount from line 19, column 1.01, line 19 minus line 20)

18 ASC blended amount (line 5 plus line 17)

20 Part B deductibles and coinsurance

19 Lesser of lines 16 or 18

369	0 (Cont.)	CMS FORM-2552-9)6	05	-99
	CULATION OF REIMBURSEMENT	PROVIDER NO.:	PERIOD:	WORKSHEET E,	
	LEMENT		FROM	PART D	
DELL		COMPONENT NO.:	то		
Check		[] Title V	[] Hospital		
Appli	_	[] Title XVIII	[] Subprovider		
Box		[] Title XIX			
PAR'	T D - OUTPATIENT RADIOLOGY SERVICES	S			
1	Prevailing charges (from PS&R or your records)				1
2	62 percent of line 1				2
3				_	3
$\overline{4}$	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, I	Part V (see instructions))			6
	COMPUTATION OF LESSER OF REASONABLE	LE COST OR CHARGES			⊢_
7	Total charges			***************************************	7
	CUSTOMARY CHARGES		<u> </u>		
-8		liable for payment for services on a charge	basis		8
9	Amounts that would have been realized from patie	ents liable for payment for services on a cha	иде		9
	basis had such payment been made in accordance	with 42 CFR 413.13 (e)			L.
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		(complete only if line 6 exceeds line 11) (see instru.)		13
	Lesser of cost or charges (see instructions)				14
	COMPUTATION OF REIMBURSEMENT SET	TLEMENT			
15	Deductibles and coinsurance (exclude professions				15

20

21

16 Total (see instructions)

19 Lesser of lines 16 or 18

20 Part B deductibles and coinsurance

17 Cost proportion (column 1 enter 42% of line 16 and column 1.01 enter 42% of line 14)
18 Outpatient radiology blended amount (sum of line 5 plus line 17)

21 Radiology payment amount (column 1 amount from line 19, column 1.01, line 19 minus line 20)

05-99	CMS FORM-2552-	96	3690 (Cont.)
CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET E, PART E
Check Applicable	[] Title V [] Title XVIII [] Title XIX	[] Hospital [] Subprovider	

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

		1 ···	
1_	Prevailing charges (from PS&R or your records)		
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		9
-	basis had such payment been made in accordance with 42 CFR 413.13 (e)		
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		Щ
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
21	Diagnosis physicae annount (warness a see a see a see a see a see a see a see a see a see a see a see a see a		

05-99		FORM CMS-2552-96	-2552-96			3690 (Cont.)	ont.)
ANAL YSIS OF 1	ANALYSIS OF PAYMENTS TO PROVIDERS	PROVIDER NO.:		PERIOD:		WORKSHEET E-1	
FOR SERVICES RENDERED	S KENDEKEL)	COMPONENT NO.:		TO			
Check	[] Hospital [] Swing-Bed SNF		inps Par	Inpatient Part A	Рап	Part B	
Box	ENS []		mm/dd/yyyy	Amount	mm/dd/yyyy.	Amount	
Description	7			2	3	4	
1 Total interin	Total interim payments paid to provider						1,00
2 Interim payr	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	the intermediary					2.00
3 List separate	List senarately each retroactive		.01				3.01
	lump sum adjustment amount based		02				3.02
on sapsedne	on subsequent revision of the	Program to	.03				3.03
interim rate	interin rate for the cost reporting period.		.04				3.04
Also show d	Also show date of each payment,		05				3.05
If none, writ	If none, write "NONE" or enter a zero. (1)		.50				3.50
			.51				3.51
		Provider to	52				3 52
		Program	53				3.53
			54				3.54
Subtotal (su	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		66				3,99
4 Total interin (transfer to	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line						00.4
and column	and column as appropriate)						-
5 List separate	5 List separately each tentative settlement	Program to	.01				5.01
payment aft	payment after desk review. Also show	·	707				2.02
date of each payment.) psyment.		.03				5.03
If none, wri	If none, write "NONE" or enter a zero. (1)		50				5.50
			.51				5.51
•		Program	52				5.52
Subtotal (su	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		66				5.99
6 Determined	Determined net settlement amount (balance	\neg	.01				6,01
due) based	due) based on the cost report. (1)	Provider to program	.02				6.02
7 Total Media	Total Medicare program liability (see instructions)						2.00
Name of Intermediary	ediary	Intermediary Number		Signature of Authorized Person	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.

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

22

section 115.2

3690	(Cont.)	FORM (CMS-2552-96		01-10)
CALCU	JLATION OF MEDICA	RE REIMBURSEMENT	PROVIDER NO.:	PERIOD:	WORKSHEET E-3, PART I	
SETTL	EMENT UNDER TEF	RA, IRF PPS, LTCH PPS AND IPF PPS	GOV BOOKENED NO.	FROM	- PARII	
			COMPONENT NO.	TO	- [
Check		[] Hospital		<u> </u>		_
Applical	ble	[] Subprovider				
Арриса Вох	oic	[] Buotroviaca				
DUA			***	****		_
PART I	I - MEDICARE PART	A SERVICES - TEFRA AND IRF PPS, LT	CH PPS AND IPF PPS			
1	Inpatient hospital service	ces (see instructions)			1	
	Hospital specific amou				1.01	
	Net Federal PPS Payme				1.02	<u>;</u>
		F PPS only) (see instructions)		**	1.03	
1.04	Inpatient Rehabilitation	LIP Payments (see instructions)	***		1.04	_
	Outlier Payments				1.05	
		um of lines 1.01, (1.02, 1.04, <i>1.42</i> for columns	1 and 1.01), and 1.05}	*****	1.06	
1.07	Nursing and Allied Hea	aith Managed Care payment (see instruction)			1.07	_
	er af en ar ar e	The CINE				
1.00	Inpatient Psychiatric Fa	aculity (IPF) ayments (excluding outlier, ECT, stop-loss, and	madical education parment	e)	1.08	-
			inedicar education payment	5)	1.09	
	Net IPF PPS Outlier Pa Net IPF PPS ECT Pays			****	1.10	_
1.11	I Invesichted intern and	resident FTE count for latest cost report filed p	rior to November 15, 2004.	see instructions)	1.13	
		adjustment. (see instructions)		,	1.12	<u>-</u>
1.13	Current year's unweight	ted FTE count of I&R other than FTEs in the fi	rst 3 years of a "new teaching	g program". (see inst.)	1.13	3
1.14	Current year's unweigh	ted I&R FTE count for residents within the first	t 3 years of a "new teaching r	orogram". (see inst.)	1.14	Į.
		nt for IPF PPS medical education adjustment (s			1.15	<u>; </u>
	Average Daily Census				1.16	ŝ
1.17	Medical Education Adj	ustment Factor {((1 + (line 1.15/line 1.16)) rais	sed to the power of .5150 -1}		1.17	7
		ustment (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 Flo	or (line 1 x 70%).			1.2	
1.21	Adjusted Net Payment	Floor (line 1.20 x the appropriate Federal blend	l percentage)		1.21	_
1.22	Stop Loss Adjustment	(If line 1.21 is greater than line 1.19 enter the ar	mount on line 1.21 less line	1.19	1.22	2
	otherwise enter -0-)			****	12	_
1.23	Total IPF PPS Paymen	ts (sum of lines 1.01, 1.19 and 1.22)		····	1.2	<u>-</u>
	T	. F IDE (TRE)				
1.35	Inpatient Rehabilitation	resident FTE count for cost report periods endi	ng on/or prior to November	15, 2004, (see inst.)	1.35	<u>-</u>
		adjustment. (see instructions)	ing our or prior to 110 temper	200 11 (000 1 - 2)	1.36	_
1.30	Current year's unweigh	ted FTE count of I&R other than FTEs in the fi	rst 3 years of a "new teachin	g program". (see inst.)	1.37	7
1.38	Current year's unweigh	ted I&R FTE count for residents within the firs	t 3 years of a "new teaching p	orogram". (see inst.)	1.38	<u> </u>
		nt for IRF PPS medical education adjustment (s			1.39	<u>}</u>
	Average Daily Census				1.4	_
		justment Factor (see instructions).			1.4	
1.42	Medical Education Ad	justment (line 1.02 multiplied by line 1.41).		WII-	1.42	2
		www.				_
	Organ acquisition				-	2
3	Cost of teaching physic	cians (from Worksheet D-9, Part II, column 3, li	ne 16) (see instructions)		.]	3
4	Subtotal (see instruction	ons)	***			4
5	Primary payer payment	s ·				5
	Subtotal (line 4 less lin	ne 5).		****		6
	Deductibles					7
	Subtotal (line 6 minus	line 7)				8
	Coinsurance					9
	Subtotal (line 8 minus				10	
		ts (exclude bad debts for professional services)	(see instructions)		110	_
		bad debts (see instructions)			11.0	_
11.02	Reimbursable bad deb	ts for dual eligible beneficiaries (see instruction	s)		11.00	_

12 Subtotal (sum of lines 10 and 11.01)

36-594 Rev. 21

36-594.1

53 Operating Time Value of Money (see instructions)

05-04	FORM CMS	S-2552-96		3690 (0	Cont.)
CALCUL SETTLE	ATION OF REIMBURSEMENT MENT	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET E-3, PART II	
Check Applicabl Box	[] Hospital [] Subprovider [] SNF				
	- MEDICARE PART A SERVICES - COST REIMBURSEMEN	T			1
	Inpatient services			-	1.01
	Nursing and Allied Health Managed Care payment (see instruction)				2
2	Organ acquisition				3
	Cost of teaching physicians (from Worksheet D-9, Part II, column 3,	line 16) (see instructions)			4
	Subtotal (sum of lines 1 through 3)			-	5
	Primary payer payments				6
6	Total cost (line 4 less line 5). For CAH (see instructions)	·····			
	COMPUTATION OF LESSER OF COST OR CHARGES			-	
	Reasonable charges	****			7
	Routine service charges				- 8
	Ancillary service charges				<u></u> 9
	Organ acquisition charges, net of revenue			 	10
	Teaching physicians		·	_	11
11	Total reasonable charges				11

12 Aggregate amount actually collected from patients liable for payment for services on a charge basis

16 Excess of customary charges over reasonable cost (complete only if line 15 exceeds line 6) (see instructions)

17 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 15) (see instructions)

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)

25 Reimbursable bad debts (exclude bad debts for professional services) (see instructions)

26 Subtotal (sum of lines 24 and 25 or 25.01(line 25.01 hospital and subprovider only))

33 Balance due provider/program (line 30 minus the sum of lines 31, 32, and 32.01)

27 Recovery of excess depreciation resulting from provider termination or a decrease in program utilization

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

29 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets

14 Ratio of line 12 to line 13 (not to exceed 1.000000)

19 Cost of covered services (sum of lines 6 and 18)

25.01 Adjusted reimbursable bad debts (see instructions)

28 Other adjustments (see instructions) (specify)

31 Sequestration adjustment (see instructions)

32.01 Tentative settlement (for fiscal intermediary use only)

Interim payments

20 Deductibles (exclude professional component)

21 Excess reasonable cost (from line 17)22 Subtotal (line 19 minus sum of lines 20 and 21)

24 Subtotal (line 22 minus line 23)

23 Coinsurance

COMPUTATION OF REIMBURSEMENT SETTLEMENT

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

30 Subtotal (line 26, plus or minus lines 28 and 29, minus line 27)

18 Direct graduate medical education payments (from Worksheet E-3, Part IV)

15 Total customary charges (see instructions)

12

13

14

15

16

17

18

19

20

21

23

24

25

25.01

25.02

26

27

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29 30

31

32

33

32.01

32

3690	(Cont.)		FORM CMS-2552-96			05-04
	LATION OF REIM	BURSEMENT	PROVIDER NO.:	PERIOD:	WORKSHEET E-3,	
	EMENT	JOINDINIDIVI		FROM	PART III	
DETTE	LAPIDI I		COMPONENT NO.:	TO		
Check		[] Title V	[]Hospital	[]NF	[]PPS	
Applical	ble	[] Title XVIII	[]Subprovider	[] ICF/MR	[]TEFRA	
Boxes		Title XIX	[]SNF		[]Other	
PART I	II - TITLE V OR T	ITLE XIX SERVICES OR	TITLE XVIII SNF PPS ONLY			
				Title V or	Title XVIII	
				Title XIX	SNF PPS	
				1	2	
		F NET COST OF COVERE	D SERVICES			
	Inpatient hospital/Si					1 2
	Medical and other se					3
	Interns and residents					4
		ertified transplant centers only	y)			5
		sicians (see instructions)				6
	Subtotal (sum of line			-		7
	Inpatient primary pa		*****	_		8
	Outpatient primary p					9
9		sum of lines 7 and 8)	HADADS			<u> </u>
		OF LESSER OF COST OR C	HARGES	_		
10	Reasonable Charges					10
10	Routine service char					11
	Ancillary service cha Interns and residents					12
		arges, net of revenue				13
	Teaching physicians		- AMIN'			14
		t amount computation				15
		rges (sum of lines 10 through	5.15)	**		16
10	CUSTOMARY CH					
17		lected from patients liable for	payment for			17
	services on a charge		• •			<u> </u>
18			ents liable for payment for services			18
			accordance with 42 CFR 413.13(e)			
19	Ratio of line 17 to li	ne 18 (not to exceed 1.00000	0)			19
		rges (see instructions)				20
21	Excess of customary	charges over reasonable cost	t (complete only if line 20		1	21
	exceeds line 9) (see					
22	Excess of reasonable	e cost over customary charges	(complete only if line 9			22
	exceeds line 20) (se	e instructions)				
23	Cost of covered serv					23
		YMENT AMOUNT (SEE I	NSTRUCTIONS)			
	Other than outlier pa	ryments				24 25
	Outlier payments					26
	Program capital pays			1		27
	<u> </u>	ryments (see instructions)				28
	Routine service other		140.			29
		ner pass through costs				30
	Subtotal (sum of lin					31
31	Customary charges (title XIX PPS covered services	nes only) n PPS and title XVIII enter amount from line 3	<u> </u>		32
		S, lesser of lines 30 or 31; not le professional component)	E FIN AND THE WALL SHEET SHOULD HOM THE S	~		33
33	Inconcubies (exclud	e broressionai component)				

FORM CMS-2552-96 (6/2003) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3633.3)

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

		Title V or	Title XVIII	T
		Title XIX	SNF PPS	_
c	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1	2	
	Excess of reasonable cost (from line 22)			34
	Subtotal (line 32 minus sum of lines 33 and 34)			35
	Coinsurance			36
37 S	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19			37
	Reimbursable bad debts (see instructions)			38
38.01 A	Adjusted reimbursable bad debts for periods ending before 10/01/05 (see instructions)			38.01
38.02 R	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			38.02
38.03 A	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)			38.03
	Julization review			39
40 S	Subtotal (see instructions)			40
41 I	npatient routine service cost (Wkst. D-1, Part III, line 70)			41
42 N	Medicare inpatient routine charges (from your records)			42
43 A	Amount actually collected from patients liable for payment for services on			43
la	charge basis (see instructions)		<u></u>	
44	Amounts that would have been realized from patients liable for payment of			44
l _E	Part A services (see instructions)			
45 F	Ratio of line 43 to line 44 (not to exceed 1.000000)			45
46	Fotal customary charges (see instructions)		<u></u>	46
47 I	Excess of customary charges over reasonable cost (see instructions)		<u></u>	47
48 I	Excess of reasonable cost over customary charges (see instructions)		<u> </u>	48
49 I	Recovery of excess depreciation resulting from provider termination or a			49
la	decrease in program utilization			+
50 0	Other adjustments (see instructions) (specify)			50
51	Amounts applicable to prior cost reporting periods resulting from disposition	1		51
l c	of depreciable assets			- 50
52 5	Subtotal (line 40 ± lines 50 and 51, minus line 49)			52
53	Indirect medical education adjustment (PPS only) (see instructions)		-	53 54
54 1	Direct graduate medical education payments (from Wkst. E-3, Part IV)			55
55	Total amount payable to the provider (sum of lines 52, 53, and 54)			56
56	Sequestration adjustment (see instructions)		×	57
	Interim payments		-	57.01
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)			59
	Protested amounts (nonallowable cost report items) in accordance with CMS	1		1 39
17	Pub. 15-II, section 115.2		L	Щ

3690	(Cont.) FORM CM	S-2552-96			5-08
DIREC:	GRADUATE MEDICAL EDUCATION (GME)	PROVIDER NO.:	PERIOD: FROM	WORKSHEET E-3, PART IV	
	OUTPATIENT DIRECT MEDICAL		TO	111111	
	TION COSTS	1	. 120		
Check	ble [] Title V				
Applical	i Title XiX				
Box	COMPUTATION OF TOTAL DIRECT GME AMOUNT	-			
	Number of FTE residents for OB/GYN and primary care (see instructions)	<u> </u>			1
	Number of FTE residents for OB/OTA and printer) services Number of FTE residents for all other (see instructions)				1.01
	Updated per resident amount for OB/GYN and primary care (see instruction	ons)			2
	Updated per resident amount for all other (see instructions)				2.01
	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	or cost reporting periods er	nding		3.01
3.01	on or before December 31, 1996.				
3.02	Unweighted resident FTE count for allopathic and osteopathic programs w	hich meet the criteria for	an add on to		3.02
5.02	the cap for new programs in accordance with 42 CFR 413.86(g)(6).				
3.03	Unweighted resident FTE count for allopathic and osteopathic programs for	or affiliated programs in	 -		3.03
	accordance with 42 CFR 413.86(g)(4).				
3.04	FTE adjustment cap (sum of lines 3.01 through 3.03). For cost reporting p	eriods ending on or after 7	1/1/2005 see instructions		3.04
3.05	Unweighted resident FTE count for allopathic and osteopathic programs for	or the current year from yo	ur records (see instru.)		3.05
3.06	Lesser of line 3.04 or line 3.05			ļ	3.06
3.07	Weighted FTE count for primary care physicians in an allopathic and oster	opathic program for the cu	rrent year in		3.07
	column 1. If current year is zero and teaching program was in existence in	n prior year enter count her	e		2.00
3.08	Weighted FTE count for all other physicians in an allopathic and osteopat	hic program for the current	t year in		3.08
	column 1. If current year is zero and teaching program was in existence in	n prior year enter count her	re		2.00
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 o	column 1. If current year is	s zero and		3.11
	teaching program was in existence in prior year enter count here				3.12
3.12	See instructions		11		3.13
3.13	Total weighted resident FTE count for the prior cost reporting year (see in	nstructions) If none, enter	I here:		3.14
	Total weighted resident FTE count for the penultimate cost reporting year	(see instructions) If none	e, enter i here:		3.15
3.15	Rolling average FTE count (see instructions)	41 + +1	antion (see instructions)		3.16
3.16	Weighted number of FTE residents in the initial years of the primary care	program that meet the ex	(eac instructions)	'	3.17
3.17	 	n that meet the exception.	(see tist actions)		3.18
3.18	FTE resident count (see instructions)		<u>.</u>	<u> </u>	3.19
3.19				-	3.20
3.20			· · · · · · · · · · · · · · · · · · ·	-	3.21
3.21	Primary care unadjusted approved amount (see instructions).				3.22
3.22	the state of the s	to 10/01/2001 or on or afte	r 10/01/2001		3.23
3.23	Annual of the state of the stat	to 10/01/2001 or on or afte	r 10/01/2001		3.24
3.24	See instructions depending on the cost reporting periods beginning prior to See instructions depending on the cost reporting periods beginning prior to	to 10/01/2001 or on or afte	r 10/01/2001		3.25
3.25	See instructions depending on the cost reporting periods organisming prior of COMPUTATION OF PROGRAM PATIENT LOAD	10/01/2001 04 011 01 01		•	
	Program Part A inpatient days (see instructions)	**			4
4	Total inpatient days (from Worksheet S-3, Part I, column 6, sum of lines	1, 6 thru 10, and 14)			5
	Ratio of program inpatient days to total inpatient days (line 4 ÷ line 5)				6
601	Total GME payment for non-managed care days (line 6 x line 3.25).	·····			6.01
6.01	Program managed care days occurring on or after January 1 of this cost rep	oorting period (see instruct	ions)		6.02
6.03					6.03
6,03	Appropriate percentage for inclusion of the managed care days (see instru	uctions)			6.04
6.05		anuary 1 through the end o	f the cost		6.05
0.00	reporting period (line 6.02 divided by line 6.03 x line 6.04 x line 3.25) (\$	See instructions prior to O	ctober 1, 1997)		<u> </u>
	Program managed care days occurring before January 1 of this cost report	ing year (see instructions)			6.06
6.07	3 11 10 1 1 1 1 1 6 04 sharro (a	ee instructions)			6.07
6.08	and the second s	ary 1 of this cost reporting	3		6.08
0.00	origination included by time 6.03 v line 6.07 v line 3.25)				!

period (line 6.06 divided by line 6.03 x line 6.07 x line 3.25)

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

36-599

3690	(Cont.)	CMS FORM-2552	2-96		07-09
CALCU	ILATION OF GME AND IME PAYMENTS FOR TRIBUTION OF UNUSED RESIDENCY SLOTS	PROVIDER NO.: COMPONENT NO.:	PERIOD: FROM TO	WORKSHEET E-3 PART VI	
Check Applica Box	[] Title V [] Title XVIII [] Title XIX		·		
PART	A - INPATIENT HOSPITAL				
Calcula	ation of Reduced Direct GME Cap Under Section 42	2 of MMA			
1	Ratio of days occurring on or after 7/1/2005 to total day	ys in the cost reporting period	(see instructions)		1
	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 instruction	ons)			4
Calcul	ation of Additional Direct GME Payment Attributab	le to Section 422 of MMA			
5	Additional unweighted allopathic and osteopathic direc	t GME FTE resident cap slots	received under 42 Sec. 413.79 (c	:)(4)	5
5.01	Prorated additional unweighted direct GME FTE reside	nt cap slots (cost reporting per	riods overlapping 7/1/2005 only)		5.01
	Direct GME FTE Resident count over Cap (see instruc				6
7	Section 422 Allowable Direct GME FTE Resident Cou	nt (see instructions)			7
8	Enter the locality adjustment national average per resid	ent 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 (mult	riply line 9 times line 10)			11
12	Direct GME payment for managed care days (multiply	line 9 by Wkst E-3, Part IV[(l	ine 6.02 +6.06)/line 5]		12
	ation of Reduced IME Cap Under Section 422 of MM				
	Reduced IME FTE Cap (see instructions)				13
	Unadjusted IME FTE Cap (Wkst E, Part A, sum of line	es 3.04 and 3.05)			14
	Prorated Reduced allowable IME FTE Cap				15
Calcul	ation of Additional IME Payments Attributable to Se	ection 422 of MMA			_
16	Number of additional allopathic and osteopathic IME I	TE resident cap slots under 42	2 Sec. 412.105 (f)(1)(iv)(C).		16
	IME FTE Resident Count Over Cap (see instructions)				17
	If the amount on line 17 is greater than -0-, then enter t	he lower of line 16 or line 17 ((see instructions for		18
	cost reporting periods overlapping 7/1/2005)				
19	Resident to bed ratio (divide line 18 by line 3 of Wkst	E, Part A)			19
	IME Adjustment Factor (see instructions)				20
	DRG other than outlier payments for discharges on or	after July 1, 2005.			21
	Simulated Medicare managed care payments for discha-				22

23 Additional IME payments attributable to section 422 of MMA

3690	(Cont.)	FORM CMS	3-2552-96			06-03
	ICE SHEET		PROVIDER NO.:	PERIOD:	WORKSHEET G	
	ure nonproprietary and do not maintain fund-type			FROM		
	ng records, complete the General Fund column only)			TO		
docount	3,000		Specific			
	Assets	General	Purpose	Endowment	Plant	
	(Omit cents)	Fund	Fund	Fund	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					6
	accounts receivable					
7	Inventory				<u> </u>	7
	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		<u> </u>			12
13	Land improvements		<u> </u>		<u> </u>	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
$\overline{}$	Fixed equipment					16
16.01	Accumulated depreciation					16.01
17	Automobiles and trucks					17
17.01	Accumulated depreciation				<u> </u>	17.01
18	Major movable equipment					18
18.01	Accumulated depreciation					18.01
	Minor equipment depreciable					19
19.01	Accumulated depreciation					19.01
20	· · · · · · · · · · · · · · · · · · ·					20_
21						21
	OTHER ASSETS					<u> </u>
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

10-96		FORM CMS	1-2332 - 90		3690 (0	жи.
	CE SHEET		PROVIDER NO.:	PERIOD:	WORKSHEET G	
	re nonproprietary and do not maintain fund-type			FROM	(CONT.)	
(II you a	ng records, complete the General Fund column only)			то		
accounti	Liabilities and Fund		Specific			
	Balances	General	Purpose	Endowment	Plant	
	(Omit cents)	Fund	Fund	Fund	Fund	
	(Offit Cettis)	1	2	3	4	
	OURDENET LABILITIES	_				
	CURRENT LIABILITIES	***		-		28
28	Accounts payable		1			29
	Salaries, wages, and fees payable			<u> </u>		30
	Payroll taxes payable					31
31	Notes and loans payable (short term)			 	***	32
	Deferred income	-				33
	Accelerated payments					34
	Due to other funds		 	 	+	35
35			<u> </u>	 		36
36	Total current liabilities (sum of					"
	lines 28 thru 35)				+	1
•	LONG TERM LIABILITIES					37
37	Mortgage payable			 		38
38	Notes payable					39
39	Unsecured loans			ļ.———		40.01
40	Loans from owners .01 Prior to 7/1/66		<u> </u>		 	
	.02 On or after 7/1/66					40.02
41	Other long term liabilities					41
42	Total long term liabilities (sum of					42
	lines 37 thru 41)					
43	Total liabilities (sum of lines 36 and 42)					43
]				1
	CAPITAL ACCOUNTS					
44	General fund balance					44
	Specific purpose fund					45
46	Donor created - endowment fund					46
	balance - restricted					<u> </u>
47	Donor created - endowment fund					47
	balance - unrestricted			*		<u> </u>
48	Governing body created - endowment					48
	fund balance					₩
49	Plant fund balance - invested in plant					49
50						50
50	improvement, replacement, and expansion					_
51	Total fund balances (sum of lines 44 thru 50)					51
52						52
34	lines 43 and 51)	ı	1		1	1

STATEMENT OF CHANGES IN FUND BALANCES			CONTRACTOR OF THE PARTY OF THE					Control Control
				PROVIDER NO.:		PERIOD: FROM TO		WORKSHEET G-1
William I	GENERAL FUND	FUND	SPECIFIC PU	SPECIFIC PURPOSE FUND	ENDOWM	ENDOWMENT FUND	PLANT FUND	QNS
	1	2	3	4	5	9	7	80
Fund balances at beginning of period								
Net income (loss) (from Wkst. G-3, line 31)								
Total (sum of line 1 and line 2)								
4 Additions (credit adjustments) (specify)			*****		3	- 1		
				* 1				
								1
				_				
Total additions (sum of lines 4-9)								
11 Subtotal (line 3 plus line 10)	ţ							
12 Deductions (debit adjustments) (specify)				···T	***************************************		Lwan	
								· · ·
						_		
- Walter I							i i i i i i i i i i i i i i i i i i i	
18 Total deductions (sum of lines 12-17)								
19 Fund balance at end of period per balance								

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3640)

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	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
	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				15
	of lines 10-14)				
16	Total inpatient routine care services (sum of lines 9 and 15)				16
	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

	V. 2	1	2	
26	Operating expenses (per Wkst. A, column 3, line 101)			26
	Add (specify)			27
28	That (spoonly)			28
29]	29
30		1		30
				31
31		 	i	32
32				33
33	Total additions (sum of lines 27-32)			34
34	Deduct (specify)			35
35			{	36
36				-
37			i	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

369	0 (Cont.)	FORM CMS-255	2-96	10-90
STA	TEMENT OF REVENUES	PROVIDER NO.:	PERIOD:	WORKSHEET G-3
AND	EXPENSES		FROM	
			то	
	Description	M*		
	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	5)	A.A.T.	1
2	Less contractual allowances and discounts on patients' accounts	400	mit W	2
	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
	Income from investments	- Hill		7
	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	n patients		16
17	Revenue from sale of drugs to other than patients		-481	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)			
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