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

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

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

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line number

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

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

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

(A) Worksheet A line numbers

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

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

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

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

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

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

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

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

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

(A) Worksheet A line numbers

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

PART VI - VACCINE COST APPORTIONMENT

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

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

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

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

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

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

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

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

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

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

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

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

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						38
39	Program general inpatient routine service cost (line 9 x line 38)						39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)						48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)						49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket.						58.02
58.03	If line 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 58.02), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						58.03
58.04	Relief payment (see instructions)						58.04
59	Allowable inpatient cost plus incentive payment (see instructions)						59
59.01	Allowable inpatient cost per discharge (line 59 divided by line 54) (LTCH only)						59.01
59.02	Program discharges prior to July 1						59.02
59.03	Program discharges after July 1						59.03
59.04	Program discharges (see instructions)						59.04
59.05	Reduced inpatient cost per discharge for discharges prior to July 1 (see instructions) (LTCH only)						59.05
59.06	Reduced inpatient cost per discharge for discharges after July 1 (see instructions) (LTCH only)						59.06
59.07	Reduced inpatient cost per discharge (see instructions) (LTCH only)						59.07
59.08	Reduced inpatient cost plus incentive payment (see instructions)						59.08
	PROGRAM INPATIENT ROUTINE SWING BED COST						
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						61
62	Total Medicare swing-bed SNF inpatient routine costs (line 60 plus line 61) (title XVIII only). For CAH (see instructions)						62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						63
64	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)						65

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER NO.: _____	COMPONENT NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PARTS III & IV
Check applicable boxes	[ ] Title V - I/P [ ] Title XVIII, Part A [ ] Title XIX - I/P	[ ] Hospital [ ] NF [ ] Subprovider [ ] ICF/MR [ ] SNF		[ ] PPS [ ] TEFRA [ ] Other	

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

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

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

PART I - NOT IN APPROVED TEACHING PROGRAM

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

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

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

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

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

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

PART I - NOT IN APPROVED TEACHING PROGRAM

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

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

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

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

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

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET D-4
Check Applicable Boxes	[ ] Title V [ ] Title XVIII, Part A [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] Swing-Bed SNF [ ] Swing-Bed NF	[ ] ICF/MR	[ ] PPS [ ] TEFRA [ ] Other

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

(A) Worksheet A line numbers

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

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

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

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

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

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

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

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

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

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

	Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program	Organ Charges (see instructions)	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	
43	Clinic		20			43
44	Emergency		21			44
45	Observation Beds		22			45
46	Other Outpatient Service (specify)		23			46
47	TOTAL (sum of lines 43 through 46)					47

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

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

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

PART III - SUMMARY OF COSTS AND CHARGES

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

PART IV - STATISTICS

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

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

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