4090) (Cont.)	FOR	M CMS-2	552-10						0	3-14
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVID	ER CCN:		PERIOD:		WORKSHEET	Г J-1,	
COM	MUNITY MENTAL HEALTH CENTERS						FROM		PART I		
				COMPO	NENT CCN:		то				
PART	I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY ME	NTAL HEALTH CE	NTER COST	CENTER	S						
		NET									
		EXPENSES	CAPIT	ΓAL							
	COMPONENT COST CENTER	FOR COST	RELATED	COSTS	EMPLOYEE		ADMINIS-	MAIN-		LAUNDRY	
	(omit cents)	ALLOCATION	BLDGS. &	MOVABLI	BENEFITS	SUBTOTAL	TRATIVE &	TENANCE	OPERATION	& LINEN	
		(see instru.)	FIXTURES	QUIPMEN	DEPARTMENT	(cols. 0-4)	GENERAL	& REPAIRS	OF PLANT	SERVICE	
		0	1	2	4	4A	5	6	7	8	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

10-12			FOF	RM CMS-2	552-10						4090 (C	ont.)
ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS					PROVIDER C	CCN:		PERIOD: FROM		WORKSHEE PART I (CON	,	
					COMPONEN	T CCN:		ТО				
PART I - ALLOCATION OF GENERAL SERVICE	COSTS TO CO	MMUNITY M	IENTAL HEAI	TH CENTER	COST CENTE	RS	T	1		T	T	
				MAIN-		CENTRAL		MEDICAL			NON-	
COMPONENT COST CENTER				TENANCE	NURSING	SERVICES		RECORDS		OTHER	PHYSICIAN	
(omit cents)	HOUSE-			OF	ADMINIS-	&		&	SOCIAL	GENERAL	ANES-	
	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	SERVICE	THETISTS	
	9	10	11	12	13	14	15	16	17	18	19	
1 Administrative and General												1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological Services												8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Therapies												11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)(1)												22
23 Unit Cost Multiplier (see instructions)												23

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

4090) (Cont.)	FO	RM CMS-25	52-10						1	0-12
ALLC	CATION OF GENERAL SERVICE COSTS TO			PROVIDER CO	CN:		PERIOD:		WORKSHEET	J-1,	
COM	MUNITY MENTAL HEALTH CENTERS						FROM		PART I (CONT	.)	
				COMPONENT	CCN:		то				
PART	TI-ALLOCATION OF GENERAL SERVICE COSTS TO COMMUN	NITY MENTAL	HEALTH CEN	FER COST CEN	NTERS						
							INTERN &				
					PARA-		RESIDENT		ALLOCATED		
	COMPONENT COST CENTER		INTERNS &	RESIDENTS	MEDICAL	SUBTOTAL	COST & POST	SUBTOTAL	COMPONENT	TOTAL	
	(omit cents)	NURSING	SALARY &	PROGRAM	EDUCATION	(sum of	STEPDOWN	(sum of cols.	A&G (see	(sum of cols.	
		SCHOOL	FRINGES	COSTS	(SPECIFY)	cols. 4A-23)	ADJ.	$24\pm25)$	Part II) (2)	26 ± 27)	
		20	21	22	23	24	25	26	27	28	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

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

					DEDIOD		WORKSHEE	、 、	
		PROVIDER C	.CN:					l J-1,	
		COMPONENT	T CON				PARTI		
					10				
MUNITY MENTAL HEA	1		.K5 - 51A1151	ICAL BASIS	I	I			Т
			EMDI OVEE		ADMINIS	MAIN			
		1					OPERATION		
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	MUNITY MENTAL HEA	MUNITY MENTAL HEALTH CENTER CAF RELAT BLDGS & FIXTURES (SQUARE FEET)	PROVIDER C COMPONENT MUNITY MENTAL HEALTH CENTER COST CENTE CAPITAL RELATED COST BLDGS & MOVABLE FIXTURES EQUIPMENT (SQUARE FEET) FEET)	MUNITY MENTAL HEALTH CENTER COST CENTERS - STATIST CAPITAL CAPITAL CAPITAL CAPITAL RELATE COST BLDGS & MOVABLE BLDGS & MOVABLE BLDGS & MOVABLE BLDGS & MOVABLE BLDGS & GRUIPMENT (SQUARE (SQUARE (SQUARE FEET) FEET) SALARIES)	PROVIDER CCN:	PROVIDER CCN: PERIOD: FROM COMPONENT CCN: TO MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS CAPITAL RELATED COST BLDGS & MOVABLE BLDGS & MOVABLE FIXTURES EQUIPMENT DEPARTMENT (SQUARE (SQUARE (SQUARE (GROSS RECONCIL- (ACCUM. FEET) FEET) SALARIES) IATION COST)	PROVIDER CCN: PERIOD: FROM TO COMPONENT CCN: TO MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS MUNITY MENTAL HEALTH CENTER COST CENTERS - TRATIVE & TENANCE & FIXTURES EQUIPMENT DEPARTMENT GENERAL REPAIRS (SQUARE (SQUARE (GROSS RECONCIL- (ACCUM. (SQUARE FEET) FEET) SALARIES) IATION COST) FEET)	PROVIDER CCN: PERIOD: FROM PART II COMPONENT CCN: TO MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS	PROVIDER CCN: PERIOD: WORKSHEET J-1, FROM PART II COMPONENT CCN: TO MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS MUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS MAIN- RELATED COST BLDGS & MOVABLE BENEFITS FIXTURES EQUIPMENT DEPARTMENT (SQUARE

4090 (Cont.)				FORM CM	AS-2552-10						0	9-13
ALLOCATION OF GENERAL SERVICE COSTS TO					PROVIDER C	CN:		PERIOD:		WORKSHEE	Г J-1,	
COMMUNITY MENTAL HEALTH CENTERS								FROM		PART II (CON	JT.)	
					COMPONEN	T CCN:		то				
PART II - ALLOCATION OF GENERAL SERVIC	E COSTS TO CO	MMUNITY M	IENTAL HEAI	TH CENTER	COST CENTE	RS - STATIST	ICAL BASIS					
				MAIN-							NON-	
				TENANCE	NURSING	CENTRAL		MEDICAL			PHYSICIAN	
	HOUSE-			OF	ADMINIS-	SERVICES &		RECORDS &	SOCIAL	OTHER	ANES-	
CORF COST CENTER	KEEPING	DIETARY	CAFETERIA	PERSONNEL	TRATION	SUPPLY	PHARMACY	LIBRARY	SERVICE	GENERAL	THETISTS	
(omit cents)	(HOURS OF	(MEALS	(MEALS	(NUMBER	(DIRECT	(COSTED	(COSTED	(TIME	(TIME	SERVICE	(ASSIGNED	
	SERVICE)	SERVED)	SERVED)	HOUSED)	NURS. HRS)*	REQUIS.)	REQUIS.)	SPENT)	SPENT)	(SPECIFY)	TIME)	
	9	10	11	12	13	14	15	16	17	18	19	
1 Administrative and General												1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological Services												8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Therapies												11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)												22
23 Total Cost to be Allocated												23
24 Unit Cost Multiplier (see instructions)												24

LLOCATION OF GENERAL SERVICE COSTS TO			PROVIDER CC	N:	_	PERIOD:		WORKSHEET	J-1,	
OMMUNITY MENTAL HEALTH CENTERS						FROM		PART II (CON	Г.)	
			COMPONENT O	CCN:	_	то				
ART II - ALLOCATION OF GENERAL SERVICE CO	OSTS TO COMMUNIT	Y MENTAL HEA	LTH CENTER O	COST CENTERS -	STATISTICA	L BASIS				
				PARA-						
		INTERNS &	RESIDENTS	MEDICAL						
	NURSING	SALARY &	PROGRAM	EDUCATION						
CORF COST CENTER	SCHOOL	FRINGES	COSTS	(SPECIFY)						
(omit cents)	(ASSIGNED	(ASSIGNED	(ASSIGNED	(ASSIGNED						
	TIME)	TIME)	TIME)	TIME)						
	20	21	22	23	24	25	26	27	28	
1 Administrative and General										
2 Skilled Nursing Care										
3 Physical Therapy										
4 Occupational Therapy										
5 Speech Pathology										
6 Medical Social Services										
7 Respiratory Therapy										
8 Psychiatric/Psychological Services										
9 Individual Therapy										
10 Group Therapy										1
11 Individualized Activity Therapies										1
12 Family Counseling										1
13 Diagnostic Services										1
14 Approved Patient Training & Education										1
15 Prosthetic and Orthotic Devices										1
16 Drugs and Biologicals										1
17 Medical Supplies										1
18 Medical Appliances										1
19 Durable Medical Equipment-Rented										1
20 Durable Medical Equipment-Sold										2
21 All Others										2
22 Totals (sum of lines 1-21)										2
23 Total Cost to be Allocated										2
24 Unit Cost Multiplier (see instructions)										2

409	0 (Cont.)		FOI	RM CMS-255	2-10					1	10-12
COM	PUTATION OF COMMUNITY MENTAL HEALTH CENT	ER PROVIDER CO	STS		PROVIDER CCI	N:	-	PERIOD: FROM TO		WORKSHEET J PART I	-2,
PART	I - APPORTIONMENT OF CMHC COST CENTERS										
		(From Wkst. J-1, Part I, col. 28)	Total Component Charges	Ratio of Costs to Charges (col. 1 ÷ col. 2) 3	Title V Component Charges 4	Title V Component Costs (col. 3 x col. 4)	Title XVIII Component Charges	Title XVIII Component Costs (col. 3 x col. 6) 7	Title XIX Component Charges	Title XIX Component Costs (col. 3 x col. 8) 9	
1	Administrative and General	1	2	3	4	5	6	/	8	9	
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
	Approved Patient Training & Education	_									14
	Prosthetic and Orthotic Devices	_									15
	Drugs and Biologicals										16
	Medical Supplies		ļ	1		 		-			17
	Medical Appliances										18
	All Others (1)										19
20	Totals (sum of lines 1-19)										20

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

09-13	FORM CMS-2552-10			
COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS	PROVIDER CCN:	PERIOD:	WORKSHEET J-2,	
		FROM	PART II	
	COMPONENT CCN:	то		

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

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

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

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

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

4090) (Cont.)		FORM CMS-25	52-10			09-13
CALC	ULATION OF REIMBURSEMENT SET	TLEMENT COMM	IUNITY	PROVIDER CCN:	PERIOD:	WORKSHEET J-3	
MEN	TAL HEALTH CENTER PROVIDER SE	RVICES			FROM		
				COMPONENT CCN:	то		
Check							
applic	able	[] Title V	[] Title XVIII	[] Title XIX			
boxes							
						PROGRAM	
						COST	
1	Cost of component services (from Work	sheet J-2, Part II, lir	ne 29)				1
2	PPS payments received excluding outlie	ers					2
3	Outlier payments						3
4	Primary payer payments						4
5	Total reasonable cost (see instructions)						5
6	Total charges for program services						6
	CUSTOMARY CHARGES						_
7	Aggregate amount actually collected from	m patients liable for	services on a charge basi	S			7
8	Amount that would have been realized f	from patients liable f	or payment for services of	n a charge			8
	basis had such payment been made in a	ccordance with 42 C	FR 413.13(e)				8
9	Ratio of line 7 to line 8 (not to exceed 1	.000000) (see instru	actions)				9
10	Total customary charges (see instruction	ns)					10
11	Excess of customary charges over reaso	nable cost (see instr	ructions)				11
12	Excess of reasonable cost over customa	ry charges (see instr	ructions)				12
	COMPUTATION OF REIMBURSEME	ENT SETTLEMENT					_
13	Total reasonable cost (from line 5)						13
14	1 0 1	ents					14
15	Net cost (line 13 minus line 14)						15
16		ry charges (from line	e 12)				16
17	Subtotal (line 15 minus line 16)						17
18	80 percent of costs (80% of line 17) (se						18
19	Actual coinsurance billed to program pa						19
20	Net cost less actual billed coinsurance (20
21	Allowable bad debts (from provider rec		ns)				21
22	Adjusted reimbursable bad debts (see in						22
23	Allowable bad debts for dual eligible be		ructions)				23
24	Net reimbursable amount (see instruction						24
25	Other adjustments (see instructions) (sp						25
26	Total cost (line 24 plus or minus line 25						26
26.01	Sequestration adjustment (see instruction	ms)					26.01
27	Interim payments (see instructions)						27
28 29	Tentative settlement (for contractor use Balance due component/program line 20	•	27 and 28				28 29
30	Protested amounts (nonallowable cost re-			section 115.2)			30
50	1 rolested amounts (nonanowable cost ro	eport nems in accord	iance with Civis Fub. 13-	2, SCOUDII 113.2)			- 50

03-14

FORM CMS-2552-10

4090 (Cont.)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH	PROVIDER CCN:	PERIOD:	WORKSHEET J-4
CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		FROM	
	COMPONENT CCN:	то	

Check applicable boxes:

[] Title XVIII

				Pa	rt B	
	DESCRIPTION			1	2	
				mm/dd/yyyy	Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either					2
	submitted or to be submitted to the intermediary, for					
	services rendered in the cost reporting periods. If					
	none, write "NONE", or enter zero.					
3	List separately each retroactive		.01			3.01
	lump sum adjustment amount	Program	.02			3.02
	based on subsequent revision of	to	.03			3.03
	the interim rate for the	Provider	.04			3.04
	cost reporting period. Also show		.05			3.05
	date of each payment.		.50			3.50
	If none, write "NONE",	Provider	.51			3.51
	or enter zero (1).	to	.52			3.52
		Program	.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49					
	minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99)					4
	(transfer to Worksheet J-3, line 27)					

5	List separately each tentative		Program	.01		5.01
	settlement payment after des	sk review.	to	.02		5.02
	Also show date of each payment.		Provider	.03		5.03
	If none, write "NONE,"		Provider	.50		5.50
	or enter zero (1).		to	.51		5.51
			Program	.52		5.52
	Subtotal (sum of lines 5.01-5.49 minus					
	sum of lines 5.50-5.98)			.99		5.99
6	Determine net settlement amount		Program			
	(balance due) based on the c	ost	to			
	report (see instructions). (1)		Provider	.01		6.01
			to			
			Program	.02		6.02
7	Total Medicare liability (see	tal Medicare liability (see instructions)				7
8	Name of Contractor Contractor Number			NPR Date (Month, Day, Year)		8

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