#### FORM CMS-2552-10

4090 (Cont.)

	RTIONMENT OF INPATIENT ROUTINE ICE CAPITAL COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET D, PART I	
Check applica boxes:		[ ] PPS [ ] TEFRA				10			
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	-
	INPATIENT ROUTNE SERVICE COST CENTERS Adults & Pediatrics								┼──
30	(General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)								200

	0 (Cont.) DRTIONMENT OF INPATIENT ANC	LLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D,		
	VICE CAPITAL COSTS		The viblic cert.			FROM		,	
DER	iel chimie cosis		COMPONENT CC	'N:	то		PART II		
Check	(	[] Title V		[] Hospital	[] Subprovider (0		[] PPS		
applic		[] Title XVIII, I	Part A	[] IPF		,	[] TEFRA		
boxes		[] Title XIX		[] IRF					
			Capital						
			Related Cost		Ratio of Cost		Capital		
			(from Wkst.	Total Charges	to Charges	Inpatient	Costs		
			B, Part II,	(from Wkst. C,	(col .1 ÷	Program	(column 3 x		
			col. 26)	Part I, col. 8)	col. 2)	Charges	column 4)		
(A)	Cost Center Description		1	2	3	4	5		
	ANCILLARY SERVICE COST CEN	TERS							
50	Operating Room							50	
51	Recovery Room							51	
52	Labor Room and Delivery Room							52	
53	Anesthesiology							53	
54	Radiology-Diagnostic							54	
55	Radiology-Therapeutic							55	
56								56	
57	Computed Tomography (CT) Scan							57	
58	Magnetic Resonance Imaging (MRI)							58	
59	Cardiac Catheterization							60	
60	Laboratory							60	
61	PBP Clinical Laboratory Services-Pre	gm. Only						61	
62	Whole Blood & Packed Red Blood C	Cells						62	
63	Blood Storing, Processing, & Transfu	ising						63	
64	Intravenous Therapy							64	
65	Respiratory Therapy							65	
66	Physical Therapy							66	
67	Occupational Therapy							67	
68	Speech Pathology							68	
69	Electrocardiology							69	
70	Electroencephalography							70	
71	Medical Supplies Charged to Patients							71	
72	Implantable Devices Charged to Patie	ents						72	
73	Drugs Charged to Patients						_	73	
74	Renal Dialysis			ļ	<u> </u>			74	
75	ASC (Non-Distinct Part)			ļ				75	
76	5 (1 5)							76	
88	Rural Health Clinic (RHC)						_	88	
89	Federally Qualified Health Center (F	QHC)			<u> </u>			89	
90	Clinic				<u> </u>			90	
91	Emergency			ļ	<u> </u>			91	
92	Observation Beds		+	<b> </b>	┨────┤			92	
93	Other Outpatient Service (specify)							93	
	OTHER REIMBURSABLE COST C	ENTERS					-	_	
94	Home Program Dialysis							94	
95	Ambulance Services							95	
96	1 1			<b> </b>	┨────┤		-	96	
97	Durable Medical Equipment-Sold				┨			97	
98	Other Reimbursable (specify)			<b> </b>			-	98	
200	Total (sum of lines 50 through 199)							200	

09-1	13	52-10					4090 (Cont.)					
	ORTIONMENT OF INPATIENT ROUTINE VICE OTHER PASS THROUGH COSTS					PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET D, PART III		
Check applic boxes:	able	[] Title V [] Title XVIII, I [] Title XIX	Part A	[ ] PPS [ ] TEFRA								
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)			1	2	3	4	5	6	7	8	9	
30	INPATIENT ROUTINE SERVICE COST CENT Adults & Pediatrics (General Routine Care)	ERS										30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											35
40	Subprovider IPF											40
41	Subprovider IRF											41
42	Subprovider (Other)											42
43	Nursery											43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
200	Total (sum of lines 30-199)											200

4090	4090 (Cont.)		FORM CM	IS-2552-10				09-13		
APPO	RTIONMENT OF INPATII	ENT/OUTPATIENT ANCILLA	RY	PROVIDER CC	N:	PERIOD:		WORKSHEET D,		
SERV	ICE OTHER PASS THROU	JGH COSTS				FROM		PART IV		
				COMPONENT O	CCN:	TO	T			
Check		[] Title V	[] Hospital	[] Subprov	vider (Other)	[] ICF/MR	[] PPS			
applica	able	[] Title XVIII, Part A	[ ] IPF	[ ] SNF			[] TEFRA			
boxes:		[] Title XIX	[] IRF	[ ] NF					<del></del>	
								<b>T</b> . 1		
			Nee			All		Total		
			Non Physician			Other Medical	Total cost	Outpatient Cost		
			Anesthetist	Nursing	Allied	Education	(sum of col 1	(sum of col. 2,		
			Cost	School	Health	Cost	(sum of col 1 through col. 4)	(sull of coll 2, 3 and 4)		
(A)	Cost Center Descript	ion	1	2	3	4	5	6		
	ANCILLARY SERVICE C	COST CENTERS								
50	Operating Room								50	
51	Recovery Room								51	
52	Labor room and Delivery	Room							52	
53	Anesthesiology								53	
54	Radiology-Diagnostic								54	
55	Radiology-Therapeutic								55	
56 57	Radioisotope Computed Tomography (C	T) Scan							56 57	
58	Magnetic Resonance Imag								58	
59	Cardiac Catheterization								59	
60	Laboratory								60	
61	PBP Clinical Laboratory S	ervPrgm. Only							61	
62	Whole Blood & Packed Ro	ed Blood Cells							62	
63	Blood Storing, Processing,	, & Transfusing							63	
64	Intravenous Therapy								64	
65	Respiratory Therapy								65	
66	Physical Therapy								66	
67	Occupational Therapy								67	
68	Speech Pathology								68	
69 70	Electrocardiology								69 70	
70	Electroencephalography Medical Supplies Charged	To Patients							70	
72	Implantable Devices Charge								72	
73	Drugs Charged to Patients								73	
	Renal Dialysis								74	
75	ASC (Non-Distinct Part)								75	
76									76	
	OUTPATIENT SERVICE	COST CENTERS							$\square$	
88	Rural Health Clinic (RHC)								88	
89	Federally Qualified Health	Center (FQHC)							89	
90	Clinic								90	
91 92	Emergency Observation Bads								91 92	
92	Observation Beds Other Outpatient Service (s	specify)		1				L	92 93	
73	OTHER REIMBURSABL								- 23	
94	Home Program Dialysis	_ COST CLATERO							94	
95	Ambulance Services								95	
96	Durable Medical Equipme	nt-Rented							96	
97	Durable Medical Equipme								97	
98	Other Reimbursable (speci	ify)							98	
200	Total (sum of lines 50 thro	ough 199)							200	

10-1	2			FORM CM	S-2552-10				4090 (Cont.)	
APPO	RTIONMENT OF INPATI	ENT/OUTPATIEN	T ANCILLARY		PROVIDER CCN	I:	PERIOD:		WORKSHEET D,	
SERV	ICE OTHER PASS THRO	UGH COSTS					FROM		PART IV (Cont.)	
					COMPONENT CCN:		ТО			
Check		[] Title V		[] Hospital	[] Subprov	ider (Other)	[] ICF/MR	[] PPS		
applica	able	[] Title XVIII, Pa	art A	[] IPF	[ ] SNF			[] TEFRA		
boxes:		[] Title XIX		[] IRF	[] NF		-			
							Inpatient		Outpatient	
					Outpatient		Program		Program	
			Total	Ratio	Ratio		Pass-		Pass-	
			Charges	of Cost	of Cost	Inpatient	Through	Outpatient	Through	
			(from Wkst. C,	to Charges	to Charges	Program	Costs	Program	Costs	
			Part I, col. 8)	$(col. 5 \div col. 7)$	(col. 6 ÷ col. 7)	Charges	(col. 8 x col. 10)	Charges	(col. 9 x col. 12)	<u> </u>
(A)	Cost Center Descript		7	8	9	10	11	12	13	
50	ANCILLARY SERVICE	COST CENTERS							1	50
50	Operating Room								<b> </b>	50
51 52	Recovery Room Delivery Room and Labor	r Doom							łł	51 52
53	-	Koom								53
54	Anesthesiology Radiology-Diagnostic								ł	54
55	Radiology-Therapeutic								<u>├</u>	55
56	Radioisotope								<b> </b>	56
57	Computed Tomography (	CT) Scan								57
58	Magnetic Resonance Imag						1			58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory	ServPrgm. Only								61
62	Whole Blood & Packed R	Red Blood Cells								62
63	Blood Storing, Processing	g, & Transfusing								63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy								ļ!	67
68	Speech Pathology								<b> </b>	68
69	Electrocardiology								<b></b>	69
70	Electroencephalography								<b> </b>	70
71	Medical Supplies Charged									71
72	Implantable Devices Char									72 73
73	Drugs Charged to Patients Renal Dialysis	,							ł – – †	73
74	ASC (Non-Distinct Part)						1			75
76	Other Ancillary (specify)					<b></b>	1		<b> </b>	76
	OUTPATIENT SERVICE	COST CENTERS								
88	Rural Health Clinic (RHC									88
89	Federally Qualified Health									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service	(specify)								93
	OTHER REIMBURSABL	E COST CENTER	S							<u> </u>
94	Home Program Dialysis									94
95	Ambulance Services	_								95
96	Durable Medical Equipme								<b> </b>	96
97	Durable Medical Equipme								<b> </b>	97
98 200	Other Reimbursable (spec	-							<u> </u>	98 200
200	Total (sum of lines 50 three	ougii 199)					I		<u> </u>	200

4090	) (Cont.)			FORM CM	IS-2552-10				1	0-12
	RTIONMENT OF M TH SERVICES COS	EDICAL AND OTHER			PROVIDER CCI	N:	PERIOD: FROM		WORKSHEET D, PART V	
					COMPONENT O	CCN:	то			
Check applica		[] Title V - O/P [] Title XVIII, Part B		[] Hospital [] IPF	[] Subprov [] SNF	ider (Other)	[] Swing Be [] Swing Be			
boxes:		[] Title XIX - O/P MENT OF MEDICAL A	ND OTHED I	[] IRF	[]NF		[] ICF/MR			<b>—</b>
PARI	v - AFFORTION	MENT OF MEDICAL P	IND UTHER I	IEAL I II SEK	Program Charges		1	Program Cos		-
						1				-
			Cost		Cost	Cost		Cost	Cost	
			to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
			Charge	PPS	Services	Services Not	PPS	Services	Services Not	
			Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
			Worksheet C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
			Part I, col. 9	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	(see inst.)	
(A)	Cost Cen	ter Description	1	2	3	4	5	6	7	
	ANCILLARY SERV	/ICE COST CENTERS								
50	Operating Room									50
51	Recovery Room									51
52	Labor & Delivery R	loom								52
53	Anesthesiology									53
54	Radiology-Diagnost	tic								54
55	Radiology-Theraper	atic								55
56	Radioisotope									56
57	Computed Tomogra	phy (CT) Scan								57
58	Magnetic Resonanc	e Imaging (MRI)								58
59	Cardiac Catheteriza	tion								59
60	Laboratory									60
61	PBP Clinical Labora	atory ServPrgm. Only								61
62	Whole Blood & Pac	ked Red Blood Cells								62
63	Blood Storing, Proc	essing, & Transfusing								63
64	Intravenous Therap	у								64
65	Respiratory Therapy	у								65
66	Physical Therapy									66
67	Occupational Thera	ру								67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalogra									70
71	Medical Supplies C									71
72		s Charged to Patients								72
73	Drugs Charged to P	atients								73
74	Renal Dialysis	D()								74 75
75	ASC (Non-Distinct	/								75
76	Other Ancillary (spe	VICE COST CENTERS								/0
88	Rural Health Clinic								-	88
89		Health Center (FQHC)			1	<del> </del>		<del> </del>	<del> </del>	89
90	Clinic	ricului Center (FQHC)				1		1	<del> </del>	90
90	Emergency								<u> </u>	90
92	Observation Bed								<u> </u>	92
93	Other Outpatient Se	rvice (specify)							<u> </u>	92
73		SABLE COST CENTER:	s							95
94	Home Program Dial									94
95	Ambulance	y . "								95
96	Durable Medical Ec	uipment-Rented				1				96
97	Durable Medical Ec								1	97
98	Other Reimbursable				1	1		1	1	98
200	Subtotal (see instru					1		1		200
200	Less PBP Clinic La	,			1	1			1	200
	Only Charges									
202	Net Charges (line 2	00 - line 201 )				İ		İ		202
	. <u>.</u>	,								

10-12 COMPUTATION OF I	NPATIENT	FORM CMS-2552-10  PROVIDER CCN.:	PERIOD:	4090 (Co worksheet d-1,
	NPATIENT	PROVIDER CCN.:		PART I
OPERATING COST		COMPONENT CCN.:	FROM TO	PART I
Check	[] Title V - I/P	[] Hospital [] Subprovide		[] PPS
pplicable	[] Title XVIII, Part A	[] IPF [] SNF	(	[] TEFRA
ooxes:	[] Title XIX - I/P	[] IRF		[] Other
	VIDER COMPONENTS	[]		
		INPATIENT DAYS		
1 Inpatient days (	including private room days and swir			
	including private room days, excludin			
3 Private room da	ys (excluding swing-bed and observa	tion bed days). If you have only private room of	days, do not complete this line.	
4 Semi-private ro	om days (excluding swing-bed and o	bservation bed days)		
5 Total swing-bec	I SNF type inpatient days (including	private room days) through December 31 of the	e cost reporting period	
6 Total swing-bec	I SNF type inpatient days (including	private room days) after December 31 of the co	ost reporting period (if	
calendar year, e	nter 0 on this line)			
7 Total swing-bec	I NF type inpatient days (including pa	ivate room days) through December 31 of the	cost reporting period	
8 Total swing-bed	I NF type inpatient days (including p	ivate room days) after December 31 of the cos	t reporting period (if	
calendar year, e	nter 0 on this line)			
9 Total inpatient of	days including private room days app	licable to the Program (excluding swing-bed ar	nd newborn days)	
10 Swing-bed SNF	type inpatient days applicable to title	e XVIII only (including private room days) thro	ough December 31 of the	
cost reporting p	period (see instructions).		-	
11 Swing-bed SNF	type inpatient days applicable to title	e XVIII only (including private room days) afte	er December 31 of the	
cost reporting I	period (if calendar year, enter 0 on thi	s line)		
12 Swing-bed NF t	ype inpatient days applicable to titles	V or XIX only (including private room days)	through December 31 of	
the cost reporti	ng period.		-	
13 Swing-bed NF t	ype inpatient days applicable to titles	V or XIX only (including private room days)	after December 31 of the	
cost reporting p	eriod (if calendar year, enter 0 on this	s line)		
14 Medically neces	ssary private room days applicable to	the Program (excluding swing-bed days)		
15 Total nursery da	ays (title V or XIX only)			
16 Nursery days (ti	itle V or XIX only)			
		SWING BED ADJUSTMENT		
17 Medicare rate for	or swing-bed SNF services applicable	to services through December 31 of the cost re	eporting period	
18 Medicare rate for	or swing-bed SNF services applicable	to services after December 31 of the cost repo	orting period	
19 Medicaid rate for	or swing-bed NF services applicable	to services through December 31 of the cost rep	porting period	
20 Medicaid rate for	or swing-bed NF services applicable	to services after December 31 of the cost report	ting period	
21 Total general in	patient routine service cost (see instru	actions)		
22 Swing-bed cost	applicable to SNF type services through	ugh December 31 of the cost reporting period	(line 5 x line 17)	
23 Swing-bed cost	applicable to SNF type services after	December 31 of the cost reporting period (lin	e 6 x line 18)	
24 Swing-bed cost	applicable to NF type services throug	gh December 31 of the cost reporting period (l	ine 7 x line 19)	
25 Swing-bed cost	applicable to NF type services after l	December 31 of the cost reporting period (line	8 x line 20)	
26 Total swing-bed	l cost (see instructions)			
27 General inpatien	nt routine service cost net of swing-be	ed cost (line 21 minus line 26)		
		PRIVATE ROOM DIFFERENTIAL AD	JUSTMENT	
28 General inpatier	nt routine service charges (excluding	swing-bed and observation bed charges)		
29 Private room ch	arges (excluding swing-bed charges)			
30 Semi-private ro	om charges (excluding swing-bed cha	arges)		
31 General inpatien	nt routine service cost/charge ratio (li	ne 27 ÷ line 28)		
32 Average private	room per diem charge (line 29 ÷ line	23)		
1	rivate room per diem charge (line 30	÷ line 4)		
33 Average semi-p				
	m private room charge differential (1	ine 32 minus line 33) (see instructions)		
34 Average per die	m private room charge differential (1 m private room cost differential (line			

4090 (Cont.)		FORM	A CMS-2552-10	1	10-12		
COMPUTATION OF INPA	ATIENT		PROVIDER CCN:		PERIOD:	WORKSHEET D-1,	,
OPERATING COST					FROM	PART II	
			COMPONENT CCN:		то		
Check	[] Title V - I/F	,	[] Hospital	[]Subprovider (othe	r)	[] PPS	
applicable	[] Title XVIII,	Part A	[] IPF			[] TEFRA	
boxes:	[] Title XIX -	I/P	[] IRF			[] Other	
PART II - HOSPITAL AN	ND SUBPROVIDERS ON	LY					
	PROGRAM INPA	TIENT OPERATIN	G COST BEFORE				
	PASS-THR	OUGH COST ADJU	STMENTS			1	
38 Adjusted general inp	patient routine service cost p	er diem (see instructio	ns)				38
39 Program general inp	atient routine service cost (l	ine 9 x line 38)					39
40 Medically necessary	private room cost applicabl	e to the Program (line	14 x line 35)				40
41 Total Program gener	ral inpatient routine service	cost (line 39 + line 40)					41
-				Average			
		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	1
42 Nursery (title V & X	(IX only)						42
Intensive Care Type	e Inpatient						
Hospital Units							
43 Intensive Care Unit							43
44 Coronary Care Unit							44
45 Burn Intensive Care	Unit						45
46 Surgical Intensive C	are Unit						46
47 Other Special Care	Unit (specify)						47
						1	
48 Program inpatient a	ncillary service cost (Worksl	neet D-3, column 3, lii	ne 200)				48
49 Total Program inpat	ient costs (sum of lines 41 th	nrough 48) (see instruc	tions)				49

#### PASS-THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet 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	53
	(line 49 minus line 52)	

#### 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
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket	59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket	60
61	If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs	61
	(line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero.	
	(see instructions)	
62	Relief payment (see instructions)	62
63	Allowable Inpatient cost plus incentive payment (see instructions)	63

#### PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions)	64
	(title XVIII only)	
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions)	65
	(title XVIII only)	
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	69

10-1	2		FORM CMS-2552-	DRM CMS-2552-10				
COM	PUTATION OF	INPATIENT	PROVIDER CCN:		PERIOD:	WORKSHEET D-1,		
OPER	ATING COST				FROM	PARTS III & IV		
		•	COMPONENT CC	N:	то			
Check	-	[] Title V - I/P	[] Hospital	[] Subprovider (othe	er) [] ICF/MR	[] PPS		
applic	able	[] Title XVIII, Part A	[] IPF	[] SNF		[] TEFRA		
boxes:		[] Title XIX - I/P	[] IRF	[] NF		[] Other		
PART	T III - SKILLEI	O NURSING FACILITY, OTHER NU	RSING FACILITY, AND IC	F/MR ONLY			T	
70	Skilled nursing	facility/other nursing facility/ICF/MR ro	utine service cost (line 37)				70	
71	A J:		(line 70 : line 2)				71	
71	Adjusted gener	al inpatient routine service cost per diem	(Inte 70 - Inte 2)				71	
72	Program routin	e service cost (line 9 x line 71)					72	
12	i iogiani ioaan	is service cost (line ) x line (1)						
73	Medically nece	essary private room cost applicable to Pro	gram (line 14 x line 35)				73	
74	Total Program	general inpatient routine service costs (lin	e 72 + line 73)				74	
75	Capital-related	cost allocated to inpatient routine service	costs (from Worksheet B, Par	ts II, column 26, line 45)			75	
76	Per diem capita	al-related costs (line 75 ÷ line 2)					76	
77	Program capita	ll-related costs (line 9 x line 76)					77	
78	Inpatient routin	ne service cost (line 74 minus line 77)					78	
79	Aggragata abar	reas to hanafiaiarias for avaass aasts (fron	n providor records)				70	
/9	Aggregate char	rges to beneficiaries for excess costs (fron	provider records)				79	
80	Total Program	routine service costs for comparison to th	e cost limitation (line 78 minu	s line 79)			80	
00	Total Tiogram	Tourne service costs for comparison to in	e cost minitation (inic 78 minit	(3 mic 77)			00	
81	Inpatient routin	ne service cost per diem limitation					81	
	1	······						
82	Inpatient routin	ne service cost limitation (line 9 x line 81)					82	
83	Reasonable inp	patient routine service costs (see instructio	ns)				83	
84	Program inpation	ent ancillary services (see instructions)					84	
85	Utilization revi	ew - physician compensation (see instruct	tions)				85	
							Ι.	
86	Total Program	inpatient operating costs (sum of lines 83	through 85)			<u> </u>	86	
<b>D</b> 4 <b>D</b> 7	W COMPT	LATION OF OBSERVATION PER P	ASS THEOLOGY COST					
PAR		TATION OF OBSERVATION BED PA	ASS-THROUGH COST				T	
87	Total observation	on bed days (see instructions)					87	
01							<u> </u>	

87	Total observation bed days (see instructions)	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	88
89	Observation bed cost (line 87 x line 88) (see instructions)	89

#### COMPUTATION OF OBSERVATION BED PASS THROUGH COST

					Total	Observation Bed	
			Routine		Observation	Pass-Through Cost	
			Cost	column 1 $\div$	Bed Cost	(col. 3 x col. 4)	
		Cost	(from line 27)	column 2	(from line 89)	(see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90

91	Nursing School cost			91
92	Allied Health cost			92
93	All other Medical Education			93

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RVI	RTIONMENT OF COST OF CES RENDERED BY NS AND RESIDENTS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-2, PARTS I-III	
	I - NOT IN APPROVED TEACHING PROGRAM				
	Cost Centers	Percent of Assigned Time	Expense Allocation	Total Inpatient Days All Patients	
		1	2	3	L
	Total cost of services rendered	100.00			L
_	Hospital Inpatient Routine Services:				Ļ
2	Adults & pediatrics (general routine care)				╞
3	Intensive care unit				┝
4	Coronary care unit				┝
5	Burn Intensive Care Unit				╉
6	Surgical Intensive Care Unit				╋
7	Other Special Care (specify)				╋
8	Nursery				┢
	Subtotal (sum of lines 2 through 8)				ł
-	IPF - Inpatient routine service IRF - Inpatient routine service				t
	Subprovider (Other) - Inpatient routine service				t
	Subprovider (Other) - inpatient routine service Skilled Nursing Facility			1	t
_	Nursing Facility		1	1	t
-	Other Long Term Care				t
-	Home Health Agency		1		t
	Outpatient Rehabilitation Providers				t
-	Ambulatory Surgical Center				t
	Hospice				ſ
0	Subtotal (sum of lines 9 through 19)				Γ
1	Hospital Outpatient Services: Rural Health Clinic (RHC)			Part I, column 8, lines 88 through 93)	╞
2	Federally Qualified Health Center (FQHC)				t
3	Clinic				T
4	Emergency				Γ
5	Observation beds				
6	Other Outpatient Service (specify)				
7	Subtotal (sum of lines 21 through 26)				
8	Total (sum of lines 20 and 27)	100.00			
RT	II - IN AN APPROVED TEACHING PROGRAM (TITLE XVII		STS ONLY)	Т	т
		Expenses Allocated			1
		to cost centers		Net Cost	
		on Worksheet B, Part	ũ	(column 1 plus	I
	Hospital Inpatiant Pouting Sometics	columns 21 and 22	Amount 2	column 2) 3	1
9	Hospital Inpatient Routine Services: Adults & Pediatrics (general routine care)	1	2	3	t
9 0	Swing Bed - SNF			1	t
1	Swing Bed - NF				t
2	Intensive care unit				t
3	Coronary care unit				t
4	Burn Intensive Care Unit				t
5	Surgical Intensive Care Unit				Γ
6	Other Special Care (specify)				Γ
7	Subtotal (sum of lines 28, and 29 through 36)				Γ
	IPF - Inpatient routine service				ſ
9	IRF - Inpatient routine service				Γ
0	Subprovider (Other)- Inpatient routine service				ſ
1	Skilled Nursing Facility				Ĺ
т					1Ĩ

Not In Approved Teaching Program

		(from Part I)	Amount	
	Hospital	1	2	
3	Inpatient	column 9, line 9		
4	Outpatient	column 9, line 27		
5	Total Hospital (sum of lines 43 and 44)			
6	IPF - Inpatient routine service	column 9, line 10		
7	IRF - Inpatient routine service	column 9, line 11		
8	Subprovider (Other)- Inpatient routine service	column 9, line 12		
.9	Skilled Nursing Facility	column 9, line 13		

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4026)

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10-1	2			FORM CMS-2	2552-10		4090 ( <b>C</b>	Cont.)
APPOI	RTIONMENT OF CO	ST OF			PROVIDER CCN:	PERIOD:	WORKSHEET D-2,	
	CES RENDERED BY					FROM	PARTS I-III (Cont.)	
INTER	NS AND RESIDENT	S				то		
		VED TEACHING PH	ROGRAM		-			
	Average Cost	Health	n Care Program Inpatier	nt Days	Title V	Title XVIII	Title XIX	T
	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
11								11
12								12
13					1			13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
	Ratio of Cost	Title	s V and XIX Outpatien	and	Ti	tles V and XIX Outpatien	t and	
	to Charges	Т	itle XVIII Part B Charg	ges		Title XVIII Part B Cos	t	
	(column 2 $\div$	Title	Title XVIII	Title	Title	Title XVIII	Title	
	column 3)	V	Part B	XIX	V	Part B	XIX	
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
PART	II - IN AN APPROV	ED TEACHING PR	OGRAM (TITLE XV	III, PART B INPAT	IENT ROUTINE COS	TS ONLY)		_
		Average Cost		Expenses				
	Total	Per Day	Title XVIII	Applicable				
	Inpatient Days -	(column 3 ÷	Part B	to Title XVIII				
	All Patients	column 4)	Inpatient Days	(col. 5 x col. 6)				_
	4	5	6	7				—
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42				l				42
PART					RTS I AND II ARE US	ED)		<b>—</b>
I	In Approved Te	eaching Program	Total Title	XVIII Costs				

	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)		
	3	4	5	6		
43	line 37					43
44						44
45			line 2			45
46	line 38		line 2			46
47	line 39		line 2			47
48	line 40		line 2			48
49	line 41		line 2			49

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4026)

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40-577

4090	(Cont.)		FORM CM	S-2552-10			10-12
INPAT	IENT ANCILLAI	RY SERVICE		PROVIDER CCN:	PERIOD:	WORKSHEET D-3	
COST A	APPORTIONME	NT			FROM		
				COMPONENT CCN:	то		
		1	1				
Check		[] Title V	[] Hospital	[] Subprovider (other)	[] Swing-Bed SNF	[] PPS	
applical	ble	[] Title XVIII, Part A	[] IPF	[] SNF	[] Swing-Bed NF	[] TEFRA	
boxes:		[] Title XIX	[] IRF	[] NF	[] ICF/MR	[] Other	
				Ratio of Cost	Inpatient	Inpatient Program Costs	
	COST CENTER	DESCRIPTION		to Charges	Program Charges	(col. 1 x col. 2)	-
(A)				1	2	3	
		JTINE SERVICE COST CENT	IEKS				20
		trics (General Routine Care)					30
	Intensive Care Un Coronary Care U						31 32
	Burn Intensive Ca						33
	Surgical Intensive						34
	Other Special Ca						35
	Subprovider IPF	(speen)					40
	Subprovider IRF						40
	Subprovider (Spe	cify)					42
	Nursery	(inf)					43
		RVICE COST CENTERS					
	Operating Room						50
-	Recovery Room						51
	Labor Room and	Delivery Room					52
	Anesthesiology						53
54	Radiology-Diagn	ostic					54
55	Radiology-Thera	peutic					55
56	Radioisotope						56
57	Computed Tomo	graphy (CT) Scan					57
58	Magnetic Resona	nce Imaging (MRI)					58
59	Cardiac Catheteri	zation					59
60	Laboratory						60
61	PBP Clinical Lab	oratory Services-Prgm. Only					61
62	Whole Blood & I	Packed Red Blood Cells					62
63	Blood Storing, Pr	rocessing, & Trans.					63
64	Intravenous Thera	ару					64
	Respiratory Thera						65
	Physical Therapy						66
-	Occupational The						67
	Speech Pathology						68
	Electrocardiology						69
	Electroencephalo				+	1	70
	**	Charged to Patients					71
		ces Charged to Patients					72
	Drugs Charged to Repair Dialysis	r auents					73 74
	Renal Dialysis ASC (Non-Distin	oct Part)					74
	Other Ancillary (s						75
		ERVICE COST CENTERS					70
	Rural Health Clin						88
		ed Health Center (FQHC)					89
	Clinic	time tomor (r grie)					90
	Emergency				1	1	90
		s (see instructions)					92
	Other Outpatient						93
		JRSABLE COST CENTERS					
	Home Program D						94
	Ambulance Servi						95

96	Durable Medical Equipment-Rented		96
97	Durable Medical Equipment-Sold		97
98	Other Reimbursable (specify)		98
200	Total (sum of lines 50-94 and 96-98)		200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)		201
202	Net Charges (line 200 minus line 201)		202

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4027)

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### FORM CMS-2552-10

4090 (Cont.)

COMPUTATION OF ORGAN ACQ				PROVIDER CCN:	PERIOD:	WORKSHEET D-4,
FOR HOSPITALS WHICH ARE CE	RTIFIED TRANSPLANT	CENTERS		FROM	PART I	
	OPO CCN:	то				
Check	[] HEART	[] LIVER	[] PANCREAS		[] ISLET	
applicable box:	applicable box: [] KIDNEY [] LUNG [] INTE		ESTINE	[] OTHER (specify)		

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

	Inpatient			Organ		
mputation of Inpatient	Routine Organ	e Organ Per Diem Costs		Acquisition	Cost	
utine Service Costs	Charges		(from Wkst. D-1, Part II)	Days	(col. 2 x col. 3)	
plicable to Organ Acquisition	1	D	2	3	4	
Adults and Pediatrics		38				1
Intensive Care		43				2
Coronary Care		44				3
Burn Intensive Care Unit		45				4
Surgical Intensive Care Unit		46				5
Other Special Care (specify)		47				6
TOTAL (sum of lines 1-6)						7
	Intensive Care Coronary Care Burn Intensive Care Unit Surgical Intensive Care Unit Other Special Care (specify)	mputation of Inpatient     Routine Organ       utine Service Costs     Charges       plicable to Organ Acquisition     1       Adults and Pediatrics     1       Intensive Care     Coronary Care       Burn Intensive Care Unit     1       Surgical Intensive Care Unit     1       Other Special Care (specify)     1	mputation of Inpatient utine Service CostsRoutine Organ Chargesplicable to Organ Acquisition1DAdults and Pediatrics38Intensive Care43Coronary Care44Burn Intensive Care Unit45Surgical Intensive Care Unit46Other Special Care (specify)47	mutation of Inpatient utine Service CostsRoutine Organ (from Wkst. D-1, Part II) DDeltable to Organ Acquisition1D2Adults and Pediatrics38Intensive Care43Coronary Care44Burn Intensive Care Unit45Surgical Intensive Care (specify)47	Per Diem Costs     Acquisition       uine Service Costs     Charges     (from Wkst. D-1, Part II)     Days       plcable to Organ Acquisition     1     D     2     3       Adults and Pediatrics     38         Intensive Care     43         Coronary Care     44         Burn Intensive Care Unit     45         Surgical Intensive Care (specify)     47	mputation of Inpatient utine Service CostsRoutine Organ ChargesPer Diem Costs (from Wkst. D-1, Part II)AcquisitionCost (col. 2 x col. 3)picable to Organ Acquisition1D234Adults and Pediatrics1D234Intensive Care043000Coronary Care044000Burn Intensive Care Unit045000Surgical Intensive Care Unit046000Other Special Care (specify)470000

			Ratio of Cost	Organ	Organ	
			to Charges	Acquisition	Acquisition	
Cor	nputation of Ancillary		(from	Ancillary	Ancillary	
Ser	vice Costs Applicable		Wkst. C)	Charges	Costs	
to C	Organ Acquisition	С	1	2	3	
8	Operating Room	50				8
9	Recovery Room	51				9
10	Labor Room & Delivery Room	52				10
11	Anesthesiology	53				11
12	Radiology-Diagnostic	54				12
13	Radiology-Therapeutic	55				13
14	Radioisotope	56				14
15	Computed Tomography (CT) Scan	57				15
16	Magnetic Resonance Imaging (MRI)	58				16
17	Cardiac Catheterization	59				17
18	Laboratory	60				18
19	PBP Clinical Laboratory Services-Program Only	61				19
20	Whole Blood & Packed Red Blood Cells	62				20
21	Blood Storage, Processing, & Transfusing	63				21
22	IV Therapy	64				22
23	Respiratory Therapy	65				23
24	Physical Therapy	66				24
25	Occupational Therapy	67				25
26	Speech Pathology	68				26
27	Electrocardiology	69				27
28	Electroencephalography	70				28
29	Medical Supplies Charged to Patients	71				29
30	Implantable Devices Charged to Patients	72				30
31	Drugs Charged to Patients	73				31
32	Renal Dialysis	74				32
33	ASC (non-distinct part)	75				33
34	Other Ancillary (specify)	76				34
35	Rural Health Clinic (RHC)	88				35
36	Federally Qualified Health Center (FQHC)	89				36
37	Clinic	90				37
38	Emergency Room	91				38
39	Observation Beds	92				39
40	Other Outpatient Service (specify)	93				40
41	TOTAL (sum of lines 8-40)					41

### 4090 (Cont.)

#### FORM CMS-2552-10

COMPUTATION OF ORGAN ACQUISITI FOR HOSPITALS WHICH ARE CERTIFIE		PROVIDER CCN: OPO CCN:	PERIOD: FROM TO	WORKSHEET D-4, PART II
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)

# PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND ANCILLARY SERVICE 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	
	In Approved Teaching Program		Part I, col. 4)	Acquisition Days	(col. 1 x col. 2)	
		D	1	2	3	1
42	Adults & Pediatrics (General routine care)	2				42
43	Intensive Care Unit	3				43
44	Coronary Care Unit	4				44
45	Burn Intensive Care Unit	5				45
46	Surgical Intensive Care Unit	6				46
47	Other Special Care (specify)	7				47
48	TOTAL (sum of lines 42 through 47)					48

				Ratio of Cost	Organ	
	Computation of the Cost of Outpatient	Organ		to Charges	Acquisition	
	Services of Interns and Residents Not	Charges		from Wkst. D-2,	Costs	
	In Approved Teaching Program	(see instructions)		Part I, col. 4)	(col. 1 x col. 2)	
		1	D	2	3	
49	Rural Health Clinic (RHC)		21			49
50	Federally Qualified Health Center (FQHC)		22			50
51	Clinic		23			51
52	Emergency		24			52
53	Observation Beds		25			53
54	Other Outpatient Service (specify)		26			54
55	TOTAL (sum of lines 49 through 54)					55

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

10-12

### FORM CMS-2552-10

4090 (Cont.)

COMPUTATION OF ORGAN ACQUISITION	COSTS AND CHAR	GES	PROVIDER CCN:	PERIOD:	WORKSHEET D-4,
FOR HOSPITALS WHICH ARE CERTIFIED	FRANSPLANT CENT	ERS		FROM	PARTS III & IV
			OPO CCN:	то	
Check	[] HEART	[] LIVER	[] PANCREAS	[] ISLET	
applicable box:	[] KIDNEY	[] LUNG	[] INTESTINE	[] OTHER (specify)	

#### PART III - SUMMARY OF COSTS AND CHARGES

		C	ost	Cha	rges	
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and Ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct Organ Acquisition (see instructions)					59
60	Cost of Services of Teaching Physicians (Wkst. D-5, Part II)					60
61	Total (sum of lines 56 thru 60)					61
62	Total Usable Organs (see instructions)					62
63	Medicare Usable Organs (see instructions)					63
64	Ratio of Medicare Usable Organs to Total Usable					64
	Organs (line 63 ÷ line 62)					
65	Medicare Cost/Charges (see instructions)					65
66	Revenue for Organs Sold					66
67	Subtotal (line 65 minus line 66)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69

#### PART IV - STATISTICS

		Living Related	Cadaveric	Revenue	
		1	2	3	
70	Organs Excised in Provider (1)				70
71	Organs Purchased from Other Transplant Hospitals (2)				71
72	Organs Purchased from Non-Transplant Hospitals				72
73	Organs Purchased from OPOs				73
74	Total (sum of lines 70 thru 73)				74
75	Organs Transplanted				75
76	Organs Sold to Other Hospitals				76
77	Organs Sold to OPOs				77
78	Organs Sold to Transplant Hospitals				78
79	Organs Sold to Military or VA Hospitals				79
80	Organs Sold Outside the U.S.				80
81	Organs Sent Outside the U.S. (no revenue received)				81
82	Organs Used for Research				82
83	Unusable/Discarded Organs				83
84	Total (sum of lines 75 through 83 should equal line 74)				84

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

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

### 4090 (Cont.)

### FORM CMS-2552-10

09-13

APPORTIONMENT OF COST FOR THE SEL	T OF COST FOR THE SERVICES OF TEACHING PHYSICIANS	PROVIDER CCN:	PERIOD:	WORKSHEET D-5,	
				FROM	PART I
				то	
Check applicable box:	[] Hospital Staff	[] Medical Staff			

#### PART I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION

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

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

## FORM CMS-2552-10

4090 (Cont.)

	4	FORM CMS-2552	-10		4090 (C	ont
APPO	RTIONMENT OF COST FOR THE SER	VICES OF TEACHING PHYSICIANS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET D-5, _ PART II	
heck		[] Hospital	[] IPF		_	
plica	ble box:	[] IRF	[] Subprovider (other)	)		
ART	II - APPORTIONMENT OF COST FOR THE S	FRVICES OF TEACHING PHYSICIANS				
intr				Medical School	Total	
			Hospital Staff	Faculty	$(col \ 1 + col \ 2)$	
			1	2	3	
1	Adjusted Cost of Physician's Direct Med	č				_
2	Total Inpatient Days and Outpatient Vis	it Days				_
3	Average Per Diem (line 1 ÷ line 2)					
	HEALTH CARE PROGRAM REIMBU	RSABLE DAYS		-		
4	Title V - Inpatient					
5	Title V - Outpatient					
6	Title XVIII - Part A					
7	Title XVIII - Part B					
8	Title XIX - Inpatient					
9	Title XIX - Outpatient					
10	Inpatient and Outpatient Kidney Acquisi	tion				
11	Inpatient and Outpatient Liver Acquisition	n				
12	Inpatient and Outpatient Heart Acquisition	on				
13	Inpatient and Outpatient Lung Acquisition	on				
14	Inpatient and Outpatient Pancreas Acqui	sition				
15	Inpatient and Outpatient Intestine Acqui	sition				
16	Inpatient and Outpatient Islet Acquisition	n				
17	Other Organ Acquisition					
	HEALTH CARE PROGRAM REIMBU	RSABLE COST				
18	Title V - Inpatient (line 3 x line 4)					
19	Title V - Outpatient (line 3 x line 4) Title V - Outpatient (line 3 x line 5)					
20	Title XVIII - Part A (line 3 x line 6)					
21	Title XVIII - Part B (line 3 x line 7)					
22	Title XIX - Inpatient (line 3 x line 8)					
23	Title XIX - Mpatient (line 3 x line 3)			1		
24	Inpatient and Outpatient Kidney Acquisi	tion (line 3 x line 10)				
25	Inpatient and Outpatient Liver Acquisition					
26	Inpatient and Outpatient Heart Acquisition	· · · · · · · · · · · · · · · · · · ·				
27	Inpatient and Outpatient Lung Acquisition					
28	Inpatient and Outpatient Pancreas Acqui					
29	Inpatient and Outpatient Intestine Acqui					
30	Inpatient and Outpatient Islet Acquisition					
31	Inpatient and Outpatient Other Organ Ad					3

Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to IV as appropriate

Line 21 to Worksheet E, Part B

Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate

Sum of lines 24 through 31 to Worksheet D-4, Part III, line 60