| RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS | PROVIDER NO. : _____ | PERIOD : FROM _____ TO _____ | WORKSHEET C |
|---|---|---|---|

| | Cost Center | TOTAL (From Wkst B, Pt. I, Col. 18) | Total Charges | Ratio (col. 1 divided by col. 2) | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 21 | Radiology | | | | 21 |
| 22 | Laboratory | | | | 22 |
| 23 | Intravenous Therapy | | | | 23 |
| 24 | Oxygen ( Inhalation ) Therapy | | | | 24 |
| 25 | Physical Therapy | | | | 25 |
| 26 | Occupational Therapy | | | | 26 |
| 27 | Speech Pathology | | | | 27 |
| 28 | Electrocardiology | | | | 28 |
| 29 | Medical Supplies Charged | | | | 29 |
| 30 | Drugs Charged to Patients | | | | 30 |
| 31 | Dental Care - Title XIX only | | | | 31 |
| 32 | Support Surfaces | | | | 32 |
| 33 | Other Ancillary Service Cost | | | | 33 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 34 | Clinic | | | | 34 |
| 35 | R H C | | | | 35 |
| 36 | Other Outpatient Service Cost | | | | 36 |
| 48 | Ambulance | | | | 48 |
| 75 | Total | | | | 75 |

| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST AND REDUCTION OF THERAPY COST | PROVIDER NO. : _____ | PERIOD : FROM _____ TO _____ | WORKSHEET D PART I |
|---|---|---|---|

**PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST**

Check One: [ ] Title V (1) [ ] Title XVIII [ ] Title XIX (1)

Check One: [ ] SNF [ ] NF [ ] ICF/MR [ ] Other _____
[ ] PPS (For cost reporting periods beginning before 07/01/98)
**>PPS FISCAL YEARS BEGINNING 07/01/98 MUST ALSO COMPLETE PART III <**

| | Cost Center | RATIO OF COST TO CHARGES ( Fr. Wkst. C Column 3 ) | HEALTH CARE PROGRAM CHARGES Part A | HEALTH CARE PROGRAM CHARGES Part B | HEALTH CARE PROGRAM COST Part A (Col. 1 X Col. 2) | HEALTH CARE PROGRAM COST Part B (Col. 1 X Col. 3) | TITLE XVIII CHARGES ON AND AFTER 1/1/1998 | PART B THERAPY COSTS ON AND AFTER 1/1/1998 Col. 1 X 6) | 10% REDUCTION OF THERAPY (Col. 7 X 10%) | NET ALLOWABLE PART B COSTS Col. 5 less Col. 8) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| **ANCILLARY SERVICE COST CENTERS** | | | | | | | | | | | |
| 21 | Radiology | | | | | | | | | | 21 |
| 22 | Laboratory | | | | | | | | | | 22 |
| 23 | Intravenous Therapy | | | | | | | | | | 23 |
| 24 | Oxygen ( Inhalation ) Therapy | | | | | | | | | | 24 |
| 25 | Physical Therapy | | | | | | | | | | 25 |
| 26 | Occupational Therapy | | | | | | | | | | 26 |
| 27 | Speech Pathology | | | | | | | | | | 27 |
| 28 | Electrocardiology | | | | | | | | | | 28 |
| 29 | Medical Supplies Charged To Patients | | | | | | | | | | 29 |
| 30 | Drugs Charged to Patients | | | | | | | | | | 30 |
| 31 | Dental Care - Title XIX | | | | | | | | | | 31 |
| 32 | Support Surfaces | | | | | | | | | | 32 |
| 33 | Other Ancillary Services | | | | | | | | | | 33 |
| **OUTPATIENT COST CENTERS** | | | | | | | | | | | |
| 34 | Clinic | | | | | | | | | | 34 |
| 35 | R H C | | | | | | | | | | 35 |
| 36 | Other Outpatient Services | | | | | | | | | | 36 |
| 48 | Ambulance (2) | | | | | | | | | | 48 |
| 75 | Total (Sum of lines 21 - 48) | | | | | | | | | | 75 |

**( 1 ) For titles V and XIX use columns 1, 2 and 4 only.**

**( 2 ) Line 48 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.**

| APPORTIONMENT OF ANCILLARY AND OUTPATIENT COST AND REDUCTION OF THERAPY COST FOR TITLE XVIII | PROVIDER NO. : | PERIOD : FROM _____ TO _____ | WORKSHEET D PARTS II & III |
|---|---|---|---|

**Check One:** [ ] SNF [ ] NF [ ] ICF/MR

**PART II - APPORTIONMENT OF VACCINE COST**

| | | | |
|---|---|---|---|
| 1 | Drugs charged to patients - ratio of cost to charges ( From Worksheet C, column 3, line 30) | | 1 |
| 2 | Program vaccine charges ( From your records, or the P S & R.) | | 2 |
| 3 | Program costs ( Line 1 X line 2) ( Title XVIII, PPS providers, transfer this amount to Worksheet E, Part III, line 20) | | 3 |

**PART III - CALCULATION OF PASS THROUGH COSTS FOR INTERNS & RESIDENTS**

>> ***FOR COST REPORTING PERIODS BEGINNING ON AND AFTER 07/01/98*** <<

| | Cost Centers | Total Cost (From Worksheet B, Part I, Col 18) | Intern and Residents Costs (From Wkst. B, Part I, Column 14) | Ratio of Intern & Residents Costs To Total Costs - Part A (Col. 2 / Col.. 1) | Program Part A Cost (From Wkst. D. Part 1, Col. 4) | Program Intern & Residents Costs for Pass Through (Col. 3 X Col. 4) | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| **ANCILLARY SERVICE COST CENTERS** | | | | | | | |
| 21 | Radiology | | | | | | 21 |
| 22 | Laboratory | | | | | | 22 |
| 23 | Intravenous Therapy | | | | | | 23 |
| 24 | Oxygen ( Inhalation ) Therapy | | | | | | 24 |
| 25 | Physical Therapy | | | | | | 25 |
| 26 | Occupational Therapy | | | | | | 26 |
| 27 | Speech Pathology | | | | | | 27 |
| 28 | Electrocardiology | | | | | | 28 |
| 29 | Medical Supplies | | | | | | 29 |
| 30 | Drugs Charged to Patients | | | | | | 30 |
| 31 | Dental Care - Title XIX only | | | | | | 31 |
| 32 | Support Surfaces | | | | | | 32 |
| 33 | Other Ancillary Service Costs | | | | | | 33 |
| 75 | Total ( Sum of lines 21 - 33) | | | | | | 75 |

| COMPUTATION OF INPATIENT ROUTINE COSTS | PROVIDER NO. _____ | PERIOD : FROM _____ TO _____ | WORKSHEET D-1 PARTS I & II |
|---|---|---|---|

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

Check One: [ ] SNF [ ] NF [ ] ICF/MR

**PART I CALCULATION OF INPATIENT ROUTINE COSTS**

| | | | |
|---|---|---|---|
| | INPATIENT DAYS | | |
| 1 | Inpatient days including private room days | | 1 |
| 2 | Private room days | | 2 |
| 3 | Inpatient days including private room days applicable to the Program | | 3 |
| 4 | Medically necessary private room days applicable to the Program | | 4 |
| 5 | Total general inpatient routine service cost | | 5 |
| | PRIVATE ROOM DIFFERENTAL ADJUSTMENT | | |
| 6 | General inpatient routine service charges | | 6 |
| 7 | General inpatient routine service cost/charge ratio (Line 5 divided by line 6) | | 7 |
| 8 | Enter private room charges from your records | | 8 |
| 9 | Average private room per diem charge (Private room charges line 8 divided by private room days, line 2) | | 9 |
| 10 | Enter semi-private room charges from your records | | 10 |
| 11 | Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days) | | 11 |
| 12 | Average per diem private room charge differental ( Line 9 minus line 11 ) | | 12 |
| 13 | Average per diem private room cost differental ( Line 7 times line 12 ) | | 13 |
| 14 | Private room cost differental adjustment ( Line 2 times line 13 ) | | 14 |
| 15 | General inpatient routine service cost net of private room cost differential ( Line 5 minus line 14 ) | | 15 |
| | PROGRAM INPATIENT ROUTINE SERVICE COSTS | | |
| 16 | Adjusted general inpatient service cost per diem ( Line 15 divided by line 1 ) | | 16 |
| 17 | Program routine service cost ( Line 3 times line 16 ) | | 17 |
| 18 | Medically necessary private room cost applicable to program ( line 4 times line 13 ) | | 18 |
| 19 | Total program general inpatient routine service cost ( Line 17 plus line 18 ) | | 19 |
| 20 | Capital related cost allocated to inpatient routine service costs ( From Wkst. B, Part II column 18, - line 16 for SNF; line 18 for NF. | | 20 |
| 21 | Per diem capital related costs ( Line 20 divided by line 1 ) | | 21 |
| 22 | Program capital related cost ( Line 3 times line 21 ) | | 22 |
| 23 | Inpatient routine service cost ( Line 19 minus line 22 ) | | 23 |
| 24 | Aggregate charges to beneficiaries for excess costs ( From provider records ) | | 24 |
| 25 | Total program routine service costs for comparison to the cost limitation ( Line 23 minus line 24 ) | | 25 |
| 26 | Enter the per diem limitation *SEE NOTE BELOW* | | 26 |
| 27 | Inpatient routine service cost limitation ( Line 3 times the per diem limitation line 26) *SEE NOTE BELOW* | | 27 |
| 28 | Reimbursable inpatient routine service costs ( Line 22 plus the lesser of line 25 or line 27 ) ( Transfer to Worksheet E, Part I, line 4)( See instructions ) | | 28 |

**NOTE: Lines 26 and 27 will not be used for cost reporting periods beginning on and after 7/1/98.**

**PART II CALCULATION OF INPATIENT INTERN AND RESIDENTS COST FOR PPS PASSTHROUGH**

**>> FOR COST REPORTING PERIODS BEGINNING ON AND AFTER 07/01/98 <<**

| | | | |
|---|---|---|---|
| 1 | Total inpatient days. ( From Worksheet S-3, Part I, column 7, line 9, less line 8) | | 1 |
| 2 | Program inpatient days. ( From Worksheet S-3, Part I, cols. 3, 4, or 5, lines 1 or 2 , as applicable) | | 2 |
| 3 | Total intern and residence cost. ( From Worksheet B, Part I, column 14, line 14) | | 3 |
| 4 | Intern and residents retio. ( Line 2 divided by line 1) | | 4 |
| 5 | Program Intern and resident cost for passthrough. (Line 3 times line 4) | | 5 |

**APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS**

**PROVIDER NO.:** _____

**PERIOD FROM**_____ **TO** _____

**WORKSHEET D-2 PARTS I & II**

PART I - NOT IN APPROVED TEACHING PROGRAM

| | Cost Centers | Percent of Assigned Time | Expense | Total Inpatient Days All Patients | Average Cost Per Day (Col. 2 ÷ 3) | Health Care Program Inpatient Days Title V | Title XVIII Part B | Title XIX | Health Care program inpatient cost Title V | Title XVIII Part B | Title XIX | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 1 | Total cost of services rendered | 100.00 | | | | | | | | | | 1 |
| | **SNF Inpatient Routine Services:** | | | | | | | | | | | |
| 2 | SNF | | | | | | | | | | | 2 |
| 3 | | | | | | | | | | | | 3 |
| 4 | Nursing Facility | | | | | | | | | | | 4 |
| 4.1 | ICF/MR | | | | | | | | | | | 4.1 |
| 5 | Other Long Term Care | | | | | | | | | | | 5 |
| 6 | Home Health Agency | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | | 7 |
| 8 | Outpatient Rehabilitation Provider | | | | | | | | | | | 8 |
| 9 | Ambulatory Surgical Center | | | | | | | | | | | 9 |
| 10 | Hospice | | | | | | | | | | | 10 |
| 11 | Other Inpatient Routine Service Costs | | | | | | | | | | | 11 |
| 12 | Subtotal (Sum of lines 2 through 11) | | | | | | | | | | | 12 |

| | **SNF Outpatient Services:** | | | Total Charges (From Wkst. C. Col. 2, lines 34 & 35) | Ratio of Cost to Charges (Col. 2 ÷ by Col. 3) | Titles V and XIX Outpatient and Title XVIII, Part B Charges Title V | Title XVIII Part B | Title XIX | Titles V and XIX Outpatient and Title XVIII, Part B Costs Title V | Title XVIII Part B | Title XIX | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| 13 | Clinic | | | | | | | | | | | 13 |
| 14 | R H C | | | | | | | | | | | 14 |
| 15 | Subtotal (Sum of lines 13 and 14) | | | | | | | | | | | 15 |
| 16 | Total (Sum of lines 12 and 15) | 100.00 | | | | | | | | | | 16 |

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

| | | Exp. allocated to cost centers on Wkst. B, Part I Col. 14 | Total Inpatient Days All Patients | Average Cost Per Day (Col. 1 ÷ Col. 2) | Title XVIII Part B Inpatient Days | Expenses Applicable To Title XVIII (Col. 4 X Col. 3) | Enter the amounts from Part I, Column 9, lines as indicated | | Total title XVIII Costs (Sum of Cols 5 + 7 ) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | |
| 17 | SNF | | | | | | 2 | | | | 17 |
| 18 | | | | | | | | | | | 18 |
| 19 | | | | | | | | | | | 19 |
| 20 | Total (Sum of lines 17 through 19) | | | | | | | | | | 20 |

**FORM CMS 2540-96 (12/99 ) ( INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 3532 )**

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E PART I |
|---|---|---|---|

**PART I - PART A INPATIENT SERVICES**

Check one: [ ] Title XVIII [ ] Title V [ ] Title XIX

Check one: [ ] SNF [ ] NF [ ] ICF/MR

| | | | |
|---|---|---|---|
| | COMPUTATION OF NET COST OF COVERED SERVICES | | |
| 1 | Inpatient ancillary services (See Instructions) | | 1 |
| 2 | Intern and Resident Cost (From Supplemental Worksheet D-2) | | 2 |
| 3 | Outpatient services | | 3 |
| 4 | Inpatient routine services (See instructions) | | 4 |
| 5 | Utilization review--physicians' compensation (From provider records) | | 5 |
| 6 | Cost of covered services (Sum of lines 1 - 5) | | 6 |
| 7 | Differential in charges between semiprivate accomodations and less than semiprivate accomodations | | 7 |
| 8 | SUBTOTAL (Line 6 minus line 7) | | 8 |
| 9 | Primary payor amounts | | 9 |
| 10 | Total Reasonable Cost (Line 8 minus line 9) | | 10 |
| | REASONABLE CHARGES | | |
| 11 | Inpatient ancillary service charges | | 11 |
| 12 | Intern and Resident Charges (From Provider Records) | | 12 |
| 13 | Outpatient service charges | | 13 |
| 14 | Inpatient routine service charges | | 14 |
| 15 | Differential in charges between semiprivate accomodations and less than semiprivate accomodations | | 15 |
| 16 | Total reasonable charges | | 16 |
| | CUSTOMARY CHARGES | | |
| 17 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 17 |
| 18 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | | 18 |
| 19 | Ratio of line 17 to line 18 (not to exceed 1.000000) | | 19 |
| 20 | Total customary charges (See instructions) | | 20 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | |
| 21 | Cost of covered services (See Instructions) | | 21 |
| 22 | Deductibles ( Titles V and XIX only ) | | 22 |
| 23 | Subtotal (Line 21 minus line 22) | | 23 |
| 24 | Coinsurance | | 24 |
| 25 | Subtotal (Line 23 minus line 24) | | 25 |
| 26 | Reimbursable bad debts ( From your records) | | 26 |
| 27 | Subtotal (Sum of lines 25 and 26) | | 27 |
| 28 | Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit | | 28 |
| 29 | Recovery of excess depreciation resulting from provider termination or a decrease in program utilization | | 29 |
| 30 | Other Adjustments (See instructions) Specify | | 30 |
| 31 | Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( If minus, enter amount in brackets) | | 31 |
| 32 | Subtotal (Line 27 plus or minus lines 30, and 31, minus lines 28 and 29) | | 32 |
| 33 | Sequestration amount | | 33 |
| 34 | Sub total (Line 32 minus line 33) | | 34 |
| 35 | Interim payments | | 35 |
| 36 | Balance due provider/program (Line 34 minus line 35) (Indicate overpayments in brackets) (See Instructions) | | 36 |
| 37 | Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2) | | 37 |

**FORM CMS 2540-96 ( 07/99 ) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3534 - 3534.1 )**

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

**PART II - PART B - MEDICAL AND OTHER HEALTH SERVICES**

| | | | |
|---|---|---|---|
| COMPUTATION OF NET COST OF COVERED SERVICES | | | |
| 1 | Inpatient ancillary services (See Instructions) | | 1 |
| 2 | Outpatient services | | 2 |
| 3 | Vaccine cost (From Wkst D., Part II, line 3) | | 3 |
| 4 | Interns and Residents (From Supp. Wkst. D-2) | | 4 |
| 5 | Subtotal (Sum of lines 1, 2, 3 and 4) | | 5 |
| 6 | Primary payor amounts | | 6 |
| 7 | Total Reasonable Cost ( Line 5 minus line 6) | | 7 |
| REASONABLE CHARGES | | | |
| 8 | Inpatient ancillary service charges | | 8 |
| 9 | Outpatient service charges | | 9 |
| 10 | Intern & Resident Charges (From Provider Records) | | 10 |
| 11 | Total reasonable charges (See Instructions) | | 11 |
| CUSTOMARY CHARGES | | | |
| 12 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | | 12 |
| 13 | Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) | | 13 |
| 14 | Ratio of line 12 to line 13 (not to exceed 1.000000) | | 14 |
| 15 | Total customary charges (See instructions) | | 15 |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 16 | Cost of covered services (Lesser of Cost or Charges) (Lesser of ln 5 or ln 15 minus ln 6) | | 16 |
| 17 | Deductibles and coinsurance | | 17 |
| 18 | Subtotal (Line 16 minus line 17) | | 18 |
| 19 | Reimbursable bad debts ( From your records ) | | 19 |
| 20 | Subtotal (Sum of lines 18, and 19) | | 20 |
| 21 | Recovery of excess depreciation resulting from provider termination or a decrease in program utilization | | 21 |
| 22 | Other Adjustments (See instructions) Specify | | 22 |
| 23 | Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets ( If minus, enter amount in brackets) | | 23 |
| 24 | Subtotal (Line 20 minus line 21 plus or minus lines 22 and 23) | | 24 |
| 25 | Sequestration amount | | 25 |
| 26 | Subtotal (Line 24 minus line 25) | | 26 |
| 27 | Interim payments | | 27 |
| 28 | Balance due provider/program (Line 26 minus line 27) (Indicate overpayments in brackets) (See Instructions) | | 28 |
| 29 | Protested amounts (Nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2) | | 29 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E PART III |
|---|---|---|---|

**PART III - SNF REIMBURSEMENT UNDER PPS**

**Check one: [ ] Title V [ ] Title XVIII [ ] Title XIX**

| | | | |
|---|---|---|---|
| PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES | | | |
| 1 | Inpatient ancillary services - Part A - ( See Instructions ) | | 1 |
| 2 | Interns & Residents and Medical Education cost for Title XVIII ( See Instructions ) | | 2 |
| 3 | Total cost ( Sum of lines 1 and 2) | | 3 |
| 4 | Medicare inpatient ancillary charges (see instructions) | | 4 |
| 5 | Intern and Resident Charges ( From Provider Records) | | 5 |
| 6 | Cost of covered services (lesser of line 3, or the sum of lines 4 and 5) | | 6 |
| 7 | Inpatient PPS amount (see instructions) | | 7 |
| 8 | Primary payor amounts | | 8 |
| 9 | Coinsurance | | 9 |
| 10 | Reimbursable bad debts (From your records) | | 10 |
| 10.01 | Adjusted reimbursable bad debts for periods before 10/01/2005 (See instructions) | | *10.01* |
| 10.02 | Reimbursable bad debts for dual eligible beneficiaries (See instructions) | | *10.02* |
| 10.03 | Adjusted reimbursable bad debts for periods ending on & after 10/01/2005 (See instructions) | | *10.03* |
| 10.04 | *Recovery of reimbursable bad debts for dual eligible beneficiaries* | | *10.04* |
| 11 | Utilization review | | 11 |
| 12 | Recovery of excess depreciation resulting from provider termination or a decrease in Program utilization. | | 12 |
| 13 | Amounts applicable to prior cost reporting periods resulting from disposition of assets. (If minus, enter amount in brackets) | | 13 |
| 14 | Subtotal (See instructions) | | 14 |
| 15 | Sequestration adjustment | | 15 |
| 16 | Interim payments (See instructions) | | 16 |
| 16.01 | Tenative adjustment | | 16.01 |
| 16.20 | OTHER adjustment (See instructions) | | 16.20 |
| 17 | Balance due provider/program (Line 14 minus the sum of lines 15 and 16) (Indicate overpayments in brackets) (See Instructions | | 17 |
| 18 | Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2) | | 18 |
| PART B - ANCILLARY SERVICES COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY | | | |
| 19 | Ancillary services Part B | | 19 |
| 20 | Vaccine cost (From Wkst D, Part II, line 3) | | 20 |
| 21 | Intern and Resident Cost ( From Worksheet D-2) | | 21 |
| 22 | Total reasonable costs (Sum of lines 19 to 21) | | 22 |
| 23 | Medicare Part B ancillary charges (See instructions) | | 23 |
| 24 | Intern and Resident Charges ( From Provider Records ) | | 24 |
| 25 | Cost of covered services (Lesser of line 22, or sum of lines 23 and 24) | | 25 |
| 26 | Primary payor amounts | | 26 |
| 27 | Coinsurance and deductibles | | 27 |
| 28 | Reimbursable bad debts (From your records) | | 28 |
| 29 | Recovery of unreimbursed cost under the lesser of reasonable cost or customary charges | | 29 |
| 30 | 80% of recovery of unreimbursed cost under the lesser of reasonable cost or customary charges (Line 29 times 0.80) | | 30 |
| 31 | Recovery of excess depreciation resulting from provider termination or a decrease in Program utilization. | | 31 |
| 32 | Other Adjustments (See instructions) Specify | | 32 |
| 33 | Amounts applicable to prior cost reporting periods resulting from disposition of assets. (If minus, enter amount in brackets) | | 33 |
| 34 | Subtotal (Sum of lines 25, 28, & 30, minus lines 26, 27, and 31,plus or minus lines 32 and 33. | | 34 |
| 35 | Sequestration adjustment | | 35 |
| 36 | Interim payments (See instructions) | | 36 |
| 36.01 | Tenative adjustment | | 36.01 |
| *36.20* | *OTHER adjustments (See instructions)* | | 36.20 |
| 37 | Balance due provider/program (Line 34 minus the sum of lines 35 and 36) (Indicate overpayments in brackets) (See Instructions) | | 37 |
| 38 | Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-II, section 115.2 | | 38 |

| CALCULATION OF PPS REIMBURSEMENT SETTLEMENT | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET E, PART V |
|---|---|---|---|

**PART V - REIMBURSEMENT UNDER NHCMQ DEMONSTRATION**

***DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER JULY 1, 1998.***

| | | | |
|---|---|---|---|
| | PART A - INPATIENT SERVICES: PROVIDER COMPUTATION OF REIMBURSEMENT | | |
| | INPATIENT DAYS | | |
| 1 | Total Title XVIII Days ( From Wkst. S-3, Part I, col 4, sum of lines 1 and 2) | | 1 |
| 2 | Program Days (From Wkst. S-7, Part I, line 46, sum of cols. 3.01 and 4.01) | | 2 |
| | INPATIENT ANCILLARY SERVICES - PART A | | |
| 3 | Total Part A Ancillary Program Costs (From Wks. D, Col. 4, line 75) | | 3 |
| 4 | Less Physical, Occupational and Speech Therapy (Complete this line for Phase 3 only) (From Wks. D, Col. 4, sum of lines 25 - 27) | | 4 |
| 5 | Net Non-NHCMQ Demonstration Ancillary Services (Line 3 less line 4) | | 5 |
| | NHCMQ DEMONSTRATION INPATIENT/ANCILLARY SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT | | |
| 6 | Inpatient routine/ancillary PPS amount paid (From Supp. Wkst. S-7, Part I, Col 5, line 46) | | 6 |
| | PROGRAM INPATIENT CAPITAL COSTS | | |
| 7 | Capital related cost allocated to inpatient routine service cost (From Worksheet B, Part II column 18, sum of lines 16, 17 and 18) | | 7 |
| 8 | Per diem capital related costs (See instructions) | | 8 |
| 9 | Program capital related cost (Line 8 times line 1) | | 9 |
| | NHCMQ DEMONSTRATION ANCILLARY SERVICES: INDIRECT COST COMPONENT | | |
| | Total general service cost allocation - (Lines 10 through 24 are completed only for Phase 3) | | |
| 10 | Physical Therapy (Wkst. B, Part I, Col 18, line 25) | | 10 |
| 11 | Occupational Therapy (Wkst B, Part I, Col 18 line 26) | | 11 |
| 12 | Speech Therapy (Wkst B, Part I, Col 18 line 27) | | 12 |
| | Direct cost - | | |
| 13 | Physical Therapy (Wkst. B, Part I, Col 0, line 25) | | 13 |
| 14 | Occupational Therapy (Wkst B, Part I, Col 0 line 26) | | 14 |
| 15 | Speech Therapy (Wkst B, Part I, Col 0 line 27) | | 15 |
| | Indirect Cost - | | |
| 16 | Physical Therapy (Line 10 less line 13) | | 16 |
| 17 | Occupational Therapy (Line 11 less line 14) | | 17 |
| 18 | Speech Therapy (Line 12 less line 15) | | 18 |
| | Charge to Charge Ratio - | | |
| 19 | Physical Therapy (Wkst D, col 2, line 25 divided by Wkst C, Col 2, line 25) | | 19 |
| 20 | Occupational Therapy (Wkst D, Col 2, line 26 divided by Wkst C, Col 2, line 26) | | 20 |
| 21 | Speech Therapy (Wkst D, Col 2, line 27 divided by Wkst C, Col 2, line 27) | | 21 |
| | Demonstration Indirect Cost - | | |
| 22 | Physical Therapy (Line 16 times line 19) | | 22 |
| 23 | Occupational Therapy (Line 17 times line 20) | | 23 |
| 24 | Speech Therapy (Line 18 times line 21) | | 24 |
| | Total Reimbursed NHCMQ Demonstration | | |
| 25 | NHCMQ Demonstration Inpatient/Ancillary Services - Part A - PPS Provider Computation of Reimbursement (Phase II - enter sum of lines 5,6 and 9)(Phase III - enter the sum of lines 5, 6, 9, 22, 23 and 24.) Transfer this amount to Worksheet E, Part III, line 7 | | 25 |

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

| | Description | | | Inpatient Part A Mo / Day / Yr 1 | Inpatient Part A Amount 2 | Part B Mo / Day / Yr 3 | Part B Amount 4 | |
|---|---|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to provider | | | | | | | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, enter zero | | | | | | | 2 |
| 3 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero (1) | Program to Provider | .01 | | | | | 3.01 |
| | | | .02 | | | | | 3.02 |
| | | | .03 | | | | | 3.03 |
| | | | .04 | | | | | 3.04 |
| | | | .05 | | | | | 3.05 |
| | | Provider to Program | .50 | | | | | 3.50 |
| | | | .51 | | | | | 3.51 |
| | | | .52 | | | | | 3.52 |
| | | | .53 | | | | | 3.53 |
| | | | .54 | | | | | 3.54 |
| | SUBTOTAL (Sum of lines 3.01 - 3.05 minus sum of lines 3.50 - 3.54) | | .99 | | | | | 3.99 |
| 4 | TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 & 3.99) (Transfer to Wkst E, Part I line 35; Wkst E, Part II line 27; or Wkst E, Part III, line 16 for Part A, and line 36 for Part B ) | | | | | | | 4 |

**TO BE COMPLETED BY INTERMEDIARY**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 5 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter a zero.(1) | Program to Provider | .01 | | | | | 5.01 |
| | | | .02 | | | | | 5.02 |
| | | | .03 | | | | | 5.03 |
| | | Provider to Program | .50 | | | | | 5.50 |
| | | | .51 | | | | | 5.51 |
| | | | .52 | | | | | 5.52 |
| | SUBTOTAL (Sum of lines 5.01 - 5.03 minus sum of lines 5.50 - 5.52) | | .99 | | | | | 5.99 |
| 6 | Determined net settlement amount (balance due) based on the cost report. (1) | Program to provider | .01 | | | | | 6.01 |
| | | Provider to program | .50 | | | | | 6.50 |
| 7 | TOTAL MEDICARE PROGRAM LIABILITY (See Instructions) | | | | | | | 7 |

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

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

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

**PROVIDER NO.:**

**PERIOD: FROM _____ TO _____**

**WORKSHEET G**

| | **Assets** (Omit cents) | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| | **CURRENT ASSETS** | | | | | |
| 1 | Cash on hand and in banks | | | | | 1 |
| 2 | Temporary investments | | | | | 2 |
| 3 | Notes receivable | | | | | 3 |
| 4 | Accounts receivable | | | | | 4 |
| 5 | Other receivables | | | | | 5 |
| 6 | Less: allowances for uncollectible notes and accounts receivable | ( ) | ( ) | ( ) | ( ) | 6 |
| 7 | Inventory | | | | | 7 |
| 8 | Prepaid expenses | | | | | 8 |
| 9 | Other current assets | | | | | 9 |
| 10 | Due from other funds | | | | | 10 |
| 11 | TOTAL CURRENT ASSETS (Sum of lines 1 - 10) | | | | | 11 |
| | **FIXED ASSETS** | | | | | |
| 12 | Land | | | | | 12 |
| 13 | Land improvements | | | | | 13 |
| 14 | Less: Accumulated depreciation | ( ) | ( ) | ( ) | ( ) | 14 |
| 15 | Buildings | | | | | 15 |
| 16 | Less Accumulated depreciation | ( ) | ( ) | ( ) | ( ) | 16 |
| 17 | Leasehold improvements | | | | | 17 |
| 18 | Less: Accumulated Amortization | ( ) | ( ) | ( ) | ( ) | 18 |
| 19 | Fixed equipment | | | | | 19 |
| 20 | Less: Accumulated depreciation | ( ) | ( ) | ( ) | ( ) | 20 |
| 21 | Automobiles and trucks | | | | | 21 |
| 22 | Less: Accumulated depreciation | ( ) | ( ) | ( ) | ( ) | 22 |
| 23 | Major movable equipment | | | | | 23 |
| 24 | Less: Accumulated depreciation | ( ) | ( ) | ( ) | ( ) | 24 |
| 25 | Minor equipment nondepreciable | | | | | 25 |
| 26 | Other fixed assets | | | | | 26 |
| 27 | TOTAL FIXED ASSETS (Sum of lines 12 - 26) | | | | | 27 |
| | **OTHER ASSETS** | | | | | |
| 28 | Investments | | | | | 28 |
| 29 | Deposits on leases | | | | | 29 |
| 30 | Due from owners/officers | | | | | 30 |
| 31 | Other assets | | | | | 31 |
| 32 | TOTAL OTHER ASSETS (Sum of lines 28 - 31) | | | | | 32 |
| 33 | TOTAL ASSETS (Sum of lines 11, 27 and 32) | | | | | 33 |

( ) = contra amount

**FORM CMS 2540 96 ( 07/96 ) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3536 )**

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

**PROVIDER NO.:**

**PERIOD: FROM _____ TO _____**

**WORKSHEET G (Cont.)**

| | Liabilities and Fund Balances (Omit cents) | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| | **CURRENT LIABILITIES** | | | | | |
| 34 | Accounts payable | | | | | 34 |
| 35 | Salaries, wages & fees payable | | | | | 35 |
| 36 | Payroll taxes payable | | | | | 36 |
| 37 | Notes & loans payable (Short term) | | | | | 37 |
| 38 | Deferred income | | | | | 38 |
| 39 | Accelerated payments | | | | | 39 |
| 40 | Due to other funds | | | | | 40 |
| 41 | Other current liabilities | | | | | 41 |
| 42 | TOTAL CURRENT LIABILITIES (Sum of lines 34 - 41) | | | | | 42 |
| | **LONG TERM LIABILITIES** | | | | | |
| 43 | Mortgage payable | | | | | 43 |
| 44 | Notes payable | | | | | 44 |
| 45 | Unsecured loans | | | | | 45 |
| 46 | Loans from owners: a. Prior to 7/1/66<br>b. On or after 7/1/66 | | | | | 46 |
| 47 | Other long term liabilities | | | | | 47 |
| 48 | | | | | | 48 |
| 49 | TOTAL LONG TERM LIABILITIES (Sum of lines 43 - 48) | | | | | 49 |
| 50 | TOTAL LIABILITIES (Sum of lines 42 and 49) | | | | | 50 |
| | **CAPITAL ACCOUNTS** | | | | | |
| 51 | General fund balance | | | | | 51 |
| 52 | Specific purpose fund | | | | | 52 |
| 53 | Donor created - endowment fund balance - restricted | | | | | 53 |
| 54 | Donor created - endowment fund balance - unrestricted | | | | | 54 |
| 55 | Governing body created - endowment fund balance | | | | | 55 |
| 56 | Plant fund balance - invested in plant | | | | | 56 |
| 57 | Plant fund balance - reserve for plant improvement, replacement and expansion | | | | | 57 |
| 58 | TOTAL FUND BALANCES (Sum of lines 51 thru 57) | | | | | 58 |
| 59 | TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 50 and 58) | | | | | 59 |

( ) = contra amount

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

| | | GENERAL FUND | | SPECIFIC PURPOSE FUND | | ENDOWMENT FUND | | PLANT FUND | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | | 2 | | 3 | | 4 | | |
| 1 | Fund balances at beginning of period | | | | | | | | | 1 |
| 2 | Net income (loss) (From Wkst. G-3, line 32) | | | | | | | | | 2 |
| 3 | Total (Sum of line 1 and line 2) | | | | | | | | | 3 |
| 4 | Additions (Credit adjustments) | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | Total additions (Sum of lines 4 - 9) | | | | | | | | | 10 |
| 11 | Subtotal (Line 3 plus line 10) | | | | | | | | | 11 |
| 12 | Deductions (Debit adjustments) | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | Total deductions (Sum of lines 12 - 17) | | | | | | | | | 18 |
| 19 | Fund balance at end of period per balance sheet (Line 11 - line 18) | | | | | | | | | 19 |

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

PART I - PATIENT REVENUES

| | Revenue Center | INPATIENT | OUTPATIENT | TOTAL | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | |
| | GENERAL INPATIENT ROUTINE CARE SERVICES | | | | |
| 1 | Skilled Nursing Facility | | | | 1 |
| 2 | | | | | 2 |
| 3 | Nursing facility | | | | 3 |
| 4 | Other long term care | | | | 4 |
| 5 | Total general inpatient care services (Sum of lines 1 - 4) | | | | 5 |
| | All Other Care Service | | | | |
| 6 | Ancillary services | | | | 6 |
| 7 | Clinic | | | | 7 |
| 8 | Home health agency | | | | 8 |
| 9 | | | | | 9 |
| 10 | Ambulance | | | | 10 |
| 11 | Hospice | | | | 11 |
| 12 | Outpatient Rehabilitation Provider | | | | 12 |
| 13 | | | | | 13 |
| 14 | Total Patient Revenues ( Sum of lines 5 - 13 ) ( Transfer column 3 to Worksheet G-3, Line 1 ) | | | | 14 |

PART II - OPERATING EXPENSES

| | | | | |
|---|---|---|---|---|
| 1 | Operating Expenses ( Per Worksheet A, Col. 3, Line 75 ) | | | 1 |
| 2 | Add ( Specify ) | | | 2 |
| 3 | | | | 3 |
| 4 | | | | 4 |
| 5 | | | | 5 |
| 6 | | | | 6 |
| 7 | | | | 7 |
| 8 | Total Additions ( Sum of lines 2 - 7 ) | | | 8 |
| 9 | Deduct ( Specify ) | | | 9 |
| 10 | | | | 10 |
| 11 | | | | 11 |
| 12 | | | | 12 |
| 13 | | | | 13 |
| 14 | Total Deductions ( Sum of lines 9 - 13 ) | | | 14 |
| 15 | Total Operating Expenses ( Sum of lines 1 and 8, minus line 14 ) ( Transfer to Worksheet G-3, Line 4 ) | | | 15 |

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

| | | | |
|---|---|---|---|
| 1 | Total patient revenues (From Wkst. G - 2, Part I, col. 3, line 14) | | 1 |
| 2 | Less: contractual allowances and discounts on patients accounts | | 2 |
| 3 | Net patient revenues (Line 1 minus line 2) | | 3 |
| 4 | Less: total operating expenses (From Worksheet G-2, Part II, line 15) | | 4 |
| 5 | Net income from service to patients (Line 3 minus 4) | | 5 |
| 6 | Other income: | | 6 |
| 7 | Contributions, donations, bequests, etc | | 7 |
| 8 | Income from investments | | 8 |
| 9 | Revenues from telephone and telegraph service | | 9 |
| 10 | Revenue from television and radio service | | 10 |
| 11 | Purchase discounts | | 11 |
| 12 | Rebates and refunds of expenses | | 12 |
| 13 | Parking lot receipts | | 13 |
| 14 | Revenue from laundry and linen service | | 14 |
| 15 | Revenue from meals sold to employees and guests | | 15 |
| 16 | Revenue from rental of living quarters | | 16 |
| 17 | Revenue from sale of medical and surgical supplies to other than patients | | 17 |
| 18 | Revenue from sale of drugs to other than patients | | 18 |
| 19 | Revenue from sale of medical records and abstracts | | 19 |
| 20 | Tuition (fees, sale of textbooks, uniforms, etc.) | | 20 |
| 21 | Revenue from gifts, flower, coffee shops, canteen | | 21 |
| 22 | Rental of vending machines | | 22 |
| 23 | Rental of skilled nursing space | | 23 |
| 24 | Governmental appropriations | | 24 |
| 25 | Other (specify) | | 25 |
| 26 | Total other income (Sum of lines 7 - 25) | | 26 |
| 27 | Total (Line 5 plus line 26) | | 27 |
| 28 | Other expenses (specify) | | 28 |
| 29 | | | 29 |
| 30 | | | 30 |
| 31 | Total other expenses (Sum of lines 28 - 30) | | 31 |
| 32 | Net income (or loss) for the period (Line 27 minus line 31) | | 32 |