ANAL	YSIS OF	SNF-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
			SALARIES	OTHER 2	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	
GENE	AI SEE	RVICE COST CENTERS	1	2	3	4	3	0	/	
OENE 1		Cap Rel Costs-Bldg & Fixt*								1
2	0200	Cap Rel Costs-Bidg & Fixt Cap Rel Costs-Myble Equip*			+					2
3	0300	Employee Benefits Department*			+					3
4	0400	Administrative & General *								4
- 5	0500	Plant Operation & Maintenance*								5
- 6	0600	Laundry & Linen Service*								6
7	0700	Housekeeping*								7
- 8	0800	Dietary*								8
9	0900	Nursing Administration*								9
10	1000	Routine Medical Supplies*								10
11	1100	Medical Records*								11
12	1200	Staff Transportation*								12
13	1300	Volunteer Service Coordination*								13
14	1400	Pharmacy*								14
15	1500	Physician Administrative Services*								15
16	1600	Other General Service*								16
17	1700	Patient/Residential Care Services								17
DIREC	T PATIE	ENT CARE SERVICE COST CENTERS								
25	2500	Inpatient Care-Contracted**								25
26	2600	Physician Services**								26
27	2700	Nurse Practitioner**								27
28	2800	Registered Nurse**								28
29	2900	LPN/LVN**								29
30	3000	Physical Therapy**								30
31	3100	Occupational Therapy**								31
32	3200	Speech/ Language Pathology**								32
33		Medical Social Services**								33
34		Spiritual Counseling**								34
35		Dietary Counseling**								35
36		Counseling - Other**								36
37		Hospice Aide and Homemaker Services**								37
38		Durable Medical Equipment/Oxygen**								38
39	3900	Patient Transportation**			1		1			39

^{*} Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164)

41-396 Rev. 9

ANALYSIS OF SNF-BASED HOSPICE COSTS					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O	
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS 6	TOTAL (col. 5 ± col. 6)	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)	1	2	3	7	,	0	,	-
40 4000 Imaging Services**								40
41 4100 Labs and Diagnostics**								41
42 4200 Medical Supplies-Non-routine**								42
43 4300 Outpatient Services**								43
44 4400 Palliative Radiation Therapy**								44
45 4500 Palliative Chemotherapy**								45
46 Other Patient Care Services **								46
NONREIMBURSABLE COST CENTERS								
60 6000 Bereavement Program *								60
61 6100 Volunteer Program *								61
62 6200 Fundraising*								62
63 6300 Hospice/Palliative Medicine Fellows*								63
64 6400 Palliative Care Program*								64
65 6500 Other Physician Services*								65
66 6600 Residential Care *								66
67 6700 Advertising*								67
68 6800 Telehealth/Telemonitoring*								68
69 6900 Thrift Store*								69
70 7000 Nursing Facility Room & Board*								70
71 7100 Other Nonreimbursable*					ļ			71
100 Total								100

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164)

Rev. 8 41-397

^{*} Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate. ** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

11-19		FORM CMS-254		4190 (Cont.
	d by law (42 USC 1395g; 42 CFR 413.20(b)). Fail the beginning of the cost reporting period being de			FORM APPROVEI OMB NO. 0938-046 <i>Expires: 12/31/202</i> .
FACILITY HEALT	G FACILITY AND SKILLED NURSING TH CARE COMPLEX COST REPORT AND SETTLEMENT SUMMARY	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S
PART I - COST I	REPORT STATUS			
Provider use only	[] Electronic filed cost report [] Manually submitted cost report [] If this is an amended report enter [] [] No Medicare Utilization. Enter []			
Contractor use only:	4. [] Cost Report Status [1] As Submitted: [2] Settled without audit [3] Settled with audit [4] Reopened [5] Amended 5. Date Received	6. Contrac 7. [] Fir. 8. [] La: 9. NPR Da 10. If line 4, 11. Contrac	tor No	-
DADE W. CEDE	EVG LEWOY.			
ADMINISTRATIVE THROUGH THE PA	TION OR FALSIFICATION OF ANY INFORMA E ACTION, FINE AND/OR IMPRISONMENT UN AYMENT DIRECTLY OR INDIRECTLY OF A K INMENT MAY RESULT.	NDER FEDERAL LAW. FURTH IICKBACK OR WERE OTHERV	IERMORE, IF SERVICES IDENTIFI VISE ILLEGAL, CRIMINAL, CIVIL,	ED IN THIS REPORT WERE PROVIDED
and the Balan period beginn prepared fron	CERTIFICATION BY CHIEF FINANCIAL OFF CERTIFY that I have read the above certification states and Statement of Revenue and Expenses pring and ending the books and records of the provider in accordant provision of health care services, and that the services.	atement and that I have examined or prepared by and that to the best of my known ce with applicable instructions, ex	the accompanying electronically filed of the accompanying electronical	ider CCN(s)} for the cost reporting ment are true, correct, complete and m familiar with the laws and regulations
	I have read and agree with the above certification be the legally binding equivalent of my original si		ny electronic signature on this certifica	tion statement to

PART	III - SETTLEMENT SUMMARY					
			TITI	LE XVIII		
		TITLE V	A	В	TITLE XIX	
		1	2	3		
1	SKILLED NURSING FACILITY					1
2	NURSING FACILITY					2
3	I C F / IID					3
4	SNF - BASED HHA					4
5	SNF - BASED RHC					5
6	SNF - BASED FQHC					6
7	SNF - BASED CMHC					7
100	TOTAL					100

Title Date

Chief Financial Officer or Administrator of Provider(s)

(Signed)

The above amounts represent "due to" or "due from" the applicable Program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4103)

41-303 Rev. 9

4190	(Cont.)	FORM	M CMS-2540-10						11-19
FACIL	ED NURSING FACILITY AND SKILLED NURSING ITY HEALTH CARE COMPLEX		PROVIDER (CCN:	PERIOD : FROM		WORKSHEET S-2 PART I		
IDENT	IFICATION DATA		<u> </u>		ТО		_ l		
Skilled	Nursing Facility and Skilled Nursing Facility Complex Address:								
	Street:	P.O. Box:							1
	City:	State:	ZIP Code						2
3	· ·	CBSA Code:	Urban / Rural						3
	County	CDD11 COGC.	Oldan / Italia						
SNF a	nd SNF - Based Component Identification:								
							Payment System		
				Provider	Date		(P, O or N)		
	Component	Compor	nent Name	CCN	Certified	V	XVIII	XIX	
	0		1	2	3	4	5	6	_
4	SNF	1		_		-			4
	Nursing Facility	1							5
	I C F/IID								6
	SNF-Based HHA								7
	SNF-Based RHC								8
	SNF-Based FOHC								9
	SNF-Based CMHC								10
	SNF-Based OLTC								11
	SNF-Based HOSPICE								12
	OTHER (specify)								13
	Cost Reporting Period (mm/dd/yyyy) From:	To:							14
	Type of Control (see instructions)	10.							15
13	Type of Control (see histractions)								13
Type (of Freestanding Skilled Nursing Facility			Y/N					
	Is this a distinct part skilled nursing facility that meets the requirements set forth in	A2 CFR section 483 59		1 / 11					16
	Is this a composite distinct part skilled nursing facility that meets the requirements		83 59						17
	Are there any costs included in Worksheet A that resulted from transactions with r		03.3.						18
10	organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksho								10
	organizations as defined in Civis Fab. 15-1, enapter 10. If yes, complete worksik	20171 0 1.		<u> </u>					
Miscel	laneous Cost Reporting Information								
	Is this a low Medicare utilization cost report, enter "Y" for yes or "N" for no.								19
	If the response to line 19 is "Y", does this cost report meet your contractor's criteri	a for filing a low utilization c	ost report? (Y/N)						19.01
17.01	The response to line 17 is 11, does this cost report most your contractors effect	a for imag a fow admination of	05010port: (1/11)						17.01
Deprec	iation - Enter the amount of depreciation reported in this SNF for the method indica	ited on lines 20 - 22.							
	Straight Line								20
	Declining Balance								21
	Sum of the Year's Digits								22
	Sum of line 20 through 22								23
	If depreciation is funded, enter the balance as of the end of the period.								24
	Were there any disposal of capital assets during the cost reporting period? (Y/N)								25
	Was accelerated depreciation claimed on any assets in the current or any prior cos	t reporting period? (Y/N)							26
	Did you cease to participate in the Medicare program at end of the period to which		?N)						27
	Was there a substantial decrease in health insurance proportion of allowable cost f								28

41-304 Rev. 9

SKILLED NURSING FACILIFY HEALTH CARE	ITY AND SKILLED NURSING COMPLEX		PROVIDER CCN:	PERIOD FROM		WORKSHEET S PART I	-2	
IDENTIFICATION DATA				TO				
If this facility contains a public	or non-public provider that qualifies for an exemption	on from the application of the lower of			Part	Part		
	each component and type of service that qualifies for	r the exemption.			A	В	Other	
29 Skilled Nursing Facilit	ty							29
30 Nursing Facility								30
31 I C F/IID								31
32 SNF-Based HHA								32
33 SNF-Based RHC								33
34 SNF-Based FQHC								34
35 SNF-Based CMHC								35
36 SNF-Based OLTC								36
					Y / N			
	facility located in a state that certifies the provider as	s a SNF regardless of the level of care given for	Titles V & XIX patients. (Y/N))				37
	ed to carry malpractice insurance? (Y/N)							38
39 Is the malpractice a "c	claims-made" or "occurrence" policy? If the policy i	s "claims-made," enter 1. If the policy is "occur	rence", enter 2.					39
					•			
			Premiums	Pai	d Losses	Self in	surance	
41 List malpractice premi	iums and paid losses:							41
			Y /	N				
42 Are malpractice premi	iums and paid losses reported in other than the Adm	inistrative and General cost center?						42
Enter Y or N. If "Y",	check box, and submit supporting schedule listing c	ost centers and amounts.						
43 Are there any home of	ffice costs as defined in CMS Pub. 15-1, chapter 10°	?						43
44 If line 43 = "Y", and the	here are costs for the home office, enter the applical	ble home office chain number in column 1.						44
	•							
If this facility is part of a chain	organization, enter the name and address of the hom	e office on the lines below.						
45 Name:			Contractor Name:		Contractor Nun	iber:		45
46 Street:	P.O. Box:							46
47 City	State	ZIP Code						47

If	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.											
	45	Name:			Contractor Name:	Contractor Number:	45					
	46	Street:	P.O. Box:				46					
	47	City	State	ZIP Code			47					

Rev. 7 41-305

4190 (Cont.)	FORM CMS-254	40-10				08-16
SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX	PROVIDER CCN:	PERIOD : FROM		WORKSHEET PART II		-
REIMBURSEMENT QUESTIONNAIRE		TO		1		
General Instruction: For all column 1 responses, enter in column 1, For all dates responses, use the format mm/dd/						
Completed by All Skilled Nursing Facilities						
Provides Operation and Operation				Y/N	Date	
Provider Organization and Operation 1 Has the provider changed ownership immediately prior to the If column 1 is "Y", enter the date of the change in column 2.		d?		1	2	1
			Y/N	Date	V/I	
2 Has the provider terminated participation in the Medicare Pro	gram? If column 1 is "Y"		1	2	3	2
enter in column 2 the date of termination and in column 3, "V"						
3 Is the provider involved in business transactions, including ma entities (e.g., chain home offices, drug or medical supply com its officers, medical staff, management personnel, or member ownership, control, or family and other similar relationships?	panies) that are related to the provide s of the board of directors through					3
			Y/N	Туре	Date	
Financial Data and Reports			1	2	3	
4 Column 1: Were the financial statements prepared by a Certif Column 2: If yes, enter "A" for Audited, "C" for Compiled, o or enter date available in column 3. (see instructions) If no, s	r "R" for Reviewed. Submit complete	te copy				4
5 Are the cost report total expenses and total revenues different statements? If column 1 is "Y", submit reconciliation.	from those on the filed financial					5
				Y/N	Y/N	\exists
Approved Educational Activities 6 Column 1: Were costs claimed for nursing school? (Y/N)				1	2	6
Column 2: Is the provider the legal operator of the program?						, and the second
7 Were costs claimed for allied health programs? (Y/N) (see in:						7 8
Were approvals and/or renewals obtained during the cost reportal allied health program? (Y/N) (see instructions)	rung period for nursing school and/c)1				°
					Y/N	
Bad Debts	· · · · ·				1	9
9 Is the provider seeking reimbursement for bad debts? (Y/N) 10 If line 9 is "Y", did the provider's bad debt collection policy of		od? If "Y", submit copy.			 	10
11 If line 9 is "Y", are patient deductibles and/or coinsurance wa		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				11
Bed Complement					_	
12 Have total beds available changed from prior cost reporting pe	eriod? If "Y", see instructions.					12
		Y/N	Date	Y/N	Date	
PS&R Report Data		Part A	Part A	Part B	Part B 4	-
13 Was the cost report prepared using the PS&R only?						13
If either col. 1 or 3 is "Y", enter the paid-through date of the F to prepare this cost report in cols. 2 and 4. (see Instructions)						
Was the cost report prepared using the PS&R for total and the for allocation? If either col. 1 or 3 is "Y", enter the paid-throu	provider's records					14
used to prepare this cost report in columns 2 and 4.						
15 If line 13 or 14 is "Y", were adjustments made to PS&R data have been billed but are not included on the PS&R used to file If "Y", see instructions.						15
16 If line 13 or 14 is "Y", were adjustments made to PS&R data PS&R Report information? If yes, see instructions.	for corrections of other					16
17 If line 13 or 14 is "Y", were adjustments made to PS&R data Describe the other adjustments:	for Other?					17
18 Was the cost report prepared only using the provider's records	? If "Y", see instructions.					18

41-306 Rev. 7

SKILLED NURSING FACILITY AND	PROVIDER CCN:	PERIOD :	WORKSHEET S-3
SKILLED NURSING FACILITY HEALTH CARE COMPLEX	1	FROM	PART I
STATISTICAL DATA		то	

	Number	Bed		In	patient Days / Vi	sits				Discharges			
	of	Days	Title	Title	Title			Title	Title	Title			1
Component	Beds	Available	V	XVIII	XIX	Other	Total	V	XVIII	XIX	Other	Total	
	1	2	3	4	5	6	7	8	9	10	11	12	1
1 Skilled Nursing Facility													1
2 Nursing Facility													2
3 ICF/IID													3
4 Home Health Agency													4
5 Other Long Term Care													5
6 SNF-Based CMHC													6
7 Hospice													7
8 Total (sum of lines 1-7)													8

		. ,	1 60								Time	
		Average Le	ength of Stay				Admissions			Equi	ivalent	
	Title	Title	Title		Title	Title	Title			Employees	Nonpaid	
Component	V	XVIII	XIX	Total	V	XVIII	XIX	Other	Total	on Payroll	Workers	
_	13	14	15	16	17	18	19	20	21	22	23	1
1 Skilled Nursing Facility												1
2 Nursing Facility												2
3 ICF/IID												3
4 Home Health Agency												4
5 Other Long Term Care												5
6 SNF-Based CMHC												6

Rev. 7 41-307

.150 (001111)	1 014.1 01.12 20 10 10		00 10
SNF WAGE INDEX INFORMATION	PROVIDER CCN:	PERIOD:	WORKSHEET S-3
		FROM	PARTS II & III
		TO	

PART II - DIRECT SALARIES						
		Reclass.	Adjusted	Paid Hours	Average	
		of Salaries	Salaries	Related	Hourly Wage	
	Amount	from Wkst.	(col. 1 \pm	to Salary	(col. 3 ÷	
	Reported	A-6	col. 2)	in col. 3	col. 4)	
	1	2	3	4	5	
SALARIES						
1 Total salary (see instructions)						1
2 Physician salaries-Part A						2
3 Physician salaries-Part B						3
4 Home office personnel						4
5 Sum of lines 2 through 4						5
6 Revised wages (line 1 minus li	ne 5)					6
7 Other Long Term Care						7
8 Home Health Agency						8
9 CMHC						9
10 Hospice						10
11 Other excluded areas						11
12 Subtotal excluded salary (sum	of lines 7 through 11)					12
13 Total adjusted salaries (line 6 r	minus line 12)					13
OTHER WAGES AND RELATED	COSTS					
14 Contract Labor: Patient Related	d & Mgmt.					14
15 Contract Labor: Physician serv	rices-Part A					15
16 Home office salaries & wage r	elated costs					16
WAGE RELATED COSTS						
17 Wage related costs core (see I	Pt. IV)					17
18 Wage related costs other (see	Pt. IV)					18
19 Wage related costs (excluded	units)					19
20 Physicians Part A - WRC						20
21 Physicians Part B - WRC						21
22 Total adjusted wage related co	st (see instructions)					22

PART III	- OVERHEAD	COST -	DIRECT	SALARIES

1711(1	III - OVERHEAD COST - DIRECT SALARIES		p. 1	A 11 1	D:111		
			Reclass.	Adjusted	Paid Hours	Average	
			of Salaries	Salaries	Related	Hourly Wage	
		Amount	from	(col. 1 ±	to Salary	(col. 3 ÷	
		Reported	Wkst. A-6	col. 2)	in col. 3	col. 4)	
		1	2	3	4	5	1
1	Employee Benefits						1
2	Administrative & General						2
3	Plant Operation, Maintenance & Repairs						3
4	Laundry & Linen Service						4
5	Housekeeping						5
6	Dietary						6
7	Nursing Administration						7
8	Central Services and Supply						8
9	Pharmacy						9
10	Medical Records & Medical Records Library						10
11	Social Service						11
12	Nursing and Allied Health Ed. Act.						12
13	Other General Service (specify)						13
14	Total (sum lines 1 through 13)						14

41-308 Rev. 7

08-16	FORM CMS-2540-10	FORM CMS-2540-10				
SNF WAGE RELATED COSTS	PROVIDER CCN:	PERIOD : FROM TO	WORKSHEET S-3 PART IV			
Part A - Core List	<u>.</u>		Amount Reported			
RETIREMENT COST						
1 401k Employer Contributions				1		
2 Tax Sheltered Annuity (TSA) Employer Contribution				2		
3 Qualified and Non-Qualified Pension Plan Cost				3		
4 Prior Year Pension Service Cost				4		
PLAN ADMINISTRATIVE COSTS (Paid to External Or	ganizations)					
5 401K/TSA Plan Administration fees				5		
6 Legal/Accounting/Management Fees-Pension Plan				6		
7 Employee Managed Care Program Administration Fee	S			7		
HEALTH AND INSURANCE COST						
8 Health Insurance (Purchased or Self Funded)				8		
9 Prescription Drug Plan				9		
10 Dental, Hearing and Vision Plan				10		
11 Life Insurance (If employee is owner or beneficiary)				11		
12 Accidental Insurance (If employee is owner or benefic	iary)			12		
13 Disability Insurance (If employee is owner or beneficia	ary)			13		
14 Long-Term Care Insurance (If employee is owner or be	eneficiary)			14		
15 Workers' Compensation Insurance				15		
16 Retirement Health Care Cost (Only current year, not t				16		
accrual required by FASB 106 Non cumulative portion	n)					
TAXES						
17 FICA - Employers Portion Only				17		
18 Medicare Taxes - Employers Portion Only				18		
19 Unemployment Insurance				19		
20 State or Federal Unemployment Taxes				20		
OTHER						
21 Executive Deferred Compensation				21		
22 Day Care Cost and Allowances				22		
23 Tuition Reimbursement				23		
24 Total Wage Related cost (sum of lines 1 -23)				24		
Part B Other than Core Related Cost			Amount Reported			
25 Other Wage Related Costs (specify)			•	25		

Rev. 7 41-309

SNF REPORTING OF DIRECT CARE		PROVIDER CCN:		PERIOD :		WORKSHEET S-3	
EXPE	NDITURES			FROM TO		PART V	
		Amount	Fringe	Adjusted Salaries (col. 1 +	Paid Hours Related to Salary	Average Hourly Wage (col. 3 ÷	
		Reported	Benefits	col. 2)	in col. 3	col. 4)	
	OCCUPATIONAL CATEGORY	1	2	3	4	5	
Direct	Salaries						
	Nursing Occupations						
1	Registered Nurses (RNs)						1
2	Licensed Practical Nurses (LPNs)						2
3	Certified Nursing Assistants/Nursing Assistants/Aides						3
4	Total Nursing (sum of lines 1 through 3)						4
5	Physical Therapists						5
6	Physical Therapy Assistants						6
7	Physical Therapy Aides						7
8	Occupational Therapists						8
9	Occupational Therapy Assistants						9
10	Occupational Therapy Aides						10
11	Speech Therapists						11
12	Respiratory Therapists						12
13	Other Medical Staff						13
Contra	act Labor						
	Nursing Occupations						
14	Registered Nurses (RNs)						14
15	Licensed Practical Nurses (LPNs)						15
16	Certified Nursing Assistants/Nursing Assistants/Aides						16
17	Total Nursing (sum of lines 14 through 16)						17
18	Physical Therapists						18
19	Physical Therapy Assistants						19
20	Physical Therapy Aides						20
21	Occupational Therapists						21
22	Occupational Therapy Assistants						22
	Occupational Therapy Aides						23
24	Speech Therapists						24
25	Respiratory Therapists						25
26	Other Medical Staff						26

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4105.5)

41-309.1 Rev. 7



HOME	E HEALTH AGENCY STATISTICAL DATA						
1	County						1
		m: 1 X/	TD:-1 3/3/THY	TD: 4 XZXX	0.1	T + 1	_
DESC	PRIPTION	Title V	Title XVIII	Title XIX	Other 4	Total 5	-
2	Home Health Aide Hours	1	2	3	4	3	2
3	Unduplicated Census Count (see instructions)						3
	Olduplicated Census Count (see histractions)	ļ					3
				Staff	Contract	Total	Т
HOM	E HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT	Γ)		1	2	3	7
4	Enter the number of hours in your normal work week				4		
5	Administrator and Assistant Administrator(s)						5
6	Directors and Assistant Director(s)						6
7	Other Administrative Personnel						7
8	Direct Nursing Service						8
9	Nursing Supervisor						9
10	Physical Therapy Service						10
11	Physical Therapy Supervisor						11
12	Occupational Therapy Service						12
13	Occupational Therapy Supervisor						13
14	Speech Pathology Service						14
15	Speech Pathology Supervisor						15
16	Medical Social Service						16
17	Medical Social Service Supervisor						17
18	Home Health Aide						18
19	Home Health Aide Supervisor						19
20	Other (specify)						20
HOM	E HEALTH AGENCY CBSA CODES					·	
21	Enter in column 1 the number of CBSAs where you provided services during the cost repo						21
22	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 22 co				22		

		Full E	Full Episodes			Total	\Box
		Without	With	LUPA	PEP only	(cols. 1	
		Outliers	Outliers	Episodes	Episodes	through 4)	
PPS A	CTIVITY DATA	1	2	3	4	5	
23	Skilled Nursing Visits						23
24	Skilled Nursing Visit Charges						24
	Physical Therapy Visits						25
26	Physical Therapy Visit Charges						26
27	Occupational Therapy Visits						27
	Occupational Therapy Visit Charges						28
	Speech Pathology Visits						29
30	Speech Pathology Visit Charges						30
31	Medical Social Service Visits						31
32	Medical Social Service Visit Charges						32
33	Home Health Aide Visits						33
34	Home Health Aide Visit Charges						34
35	Total Visits (sum of lines 23, 25, 27, 29, 31, and 33)						35
36	Other Charges						36
37	Total Charges (sum of lines 24, 26, 28, 30, 32, 34 and 36)						37
38	Total Number of Episodes (standard/non outlier)						38
39	Total Number of Outlier Episodes						39
40	Total Non-Routine Medical Supply Charges						40

41-310 Rev. 4

08-16				FO	ORM CM	08-16 FORM CMS-2540-10									
SNF-BASED RHC/FQHC STATISTICAL DATA						PROVIDER CCN: PERIOD :							WORKSHE	ET S-5	
							DIIG/EQUA	CON		FROM		_			
							RHC/FQHC	CCN:		10		-			
							•			•			•		
Check applicable box: [] RHC		[] FQHC													
Clinic Address and Identification:															
1 Street:											County:				1
2 City:							State:				Zip Code:				2
3 Designation (for FQHC's only) - "U" for urban	or "R" for rural														3
Source of Federal funds:											Grant	Award	D	ate	
4 Community Health Center (Section 330(d), PH	S Act)														4
5 Migrant Health Center (Section 329(d), PHS A	ct)														5
6 Health Services for the Homeless (Section 340	(d), PHS Act)														6
7 Appalachian Regional Commission															7
8 Look - Alikes															8
9 Other (specify)															9
											1		1	2	ı
10 Does this facility operate as other than an RHC	or FOHC? Enter "Y	" for yes or "	N" for no in c	olumn 1.							1			2	10
If yes, indicate the number of other operations															
Facility hours of operations (1)															
	Su	ınday	Mo	nday	Tue	sday	Wedi	nesday	Thu	rsday	Fr	iday	Satu	ırday	
Type of Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to]
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 Clinic															11

		1	2	4
12 Have you received an approval for an exception to the productivity standard?				12
13 Is this a consolidated cost report in accordance with CMS Pub. 100-04, Chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1.				13
If yes, enter in column 2 the number of RHC/FQHC's included in this report. List the names of all RHC/FQHC's and numbers below.				1
14 RHC/FQHC Name: CCI	N Number:			14

4190	(Cont.)	FORM CMS	-2540-10			08-16
MEN'	BASED COMMUNITY FAL HEALTH CENTER AND OTHER OUTPATIENT ABILITATION FACILITIES STATISTICAL DATA		PROVIDER CCN: COMPONENT CCN:	PERIOD: FROM TO	WORKSHEET S-6	
	Check applicable box: [] CMHC [] COR	RF [] OPT	TOO []	[] OSP		
	Enter the number of hours in your normal workweek					
NUMI	BER OF EMPLOYEES (FULL TIME EQUIVALENT)					
			Staff 1	Contract 2	Total (col. 1 + col. 2)	4
1	Administrator and Assistant Administrator(s)		·	_		1
2	Director(s) and Assistant Director(s)					2
3	Other Administrative Personnel					3
4	Direct Nursing Service					4
	Nursing Supervisor					5
6	Physical Therapy Service					6
7	Physical Therapy Supervisor					7
8	Occupational Therapy Service					8
9	Occupational Therapy Supervisor					9
10	Speech Pathology Service					10
11	Speech Pathology Supervisor					11
12	Medical Social Service					12
13	Madical Carial Carriag Curarriage					12

 $FORM\ CMS-2540-10\ (08/2016)\ (INSTRUCTIONS\ FOR\ THIS\ WORKSHEET\ ARE\ PUBLISHED\ IN\ CMS\ PUB.\ 15-2,\ SECTION\ 4108)$

14 Respiratory Therapy Service

18 Other (specify) 19 Other (specify)

Respiratory Therapy Supervisor
Psychiatric/Psychological Service
Psychiatric/Psychological Service Supervisor

41-312 Rev. 7

11-19 4190 (Cont.)

PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	
		то	

	10		
	RUG GROUPS (Through September 30, 2019)	Days	т—
	1	2	
1	RUX		1
2	RUL		2
3	RVX		3
4	RVL		4 5 6 7
5	RHX RHL		5
7	RMX		7
8	RML		8
9	RLX		9
10	RUC		9
11	RUB		11
12	RUA		12
13	RVC RVB		13
14 15	RVA		14 15
16	RHC		16
17	RHB		17
18	RHA		18 19
19	RMC		19
20	RMB		20
21	RMA	1	21
22	RLB RLA		22
24	ES3		22 23 24 25
25	ES2		25
26	ESI		26
27	HE2		27
28	HE1		28
29	HD2		29
30	HD1		30
31 32	HC2 HC1		31
33	HB2		31 32 33
34	HB1		34
35	LE2		34 35
36	LEI		36
37	LD2		37
38 39	LD1 LC2		38
40	LC1		39 40
41	LB2		41
42	LBI		42
43	CE2		43
44	CEI		44
45	CD2	1	45
46	CD1 CC2	+	46 47
47 48	CC1		48
49	CB2	+	49
50	CBI	1	50
51	CA2		51
52	CA1		52
53	SE3	1	53
54 55	SE2 SE1		54 55
56	SSC SSC		56
57	SSB	†	57
58	SSA		58
59	IB2		59
60	IB1		60
61	IA2	1	61
62	IA1 BB2	+	62 63
64	BB1	+	64
65	BA2		65
66	BAI		66

Rev. 9 41-313

4190 (Cont.) 11-19

\ /			
PROSPECTIVE PAYMENT FOR SNF	PROVIDER CCN:	PERIOD:	WORKSHEET S-7
STATISTICAL DATA		FROM	
		TO	i

	RUG GROUPs (Through September 30, 2019)	Days	
	1	2	
67	PE2		67
68	PE1		68
69	PD2		69
70	PD1		70
71	PC2		71
72	PC1		72
73	PB2		73
74	PB1		74
75	PA2		75
76	PA1		76
99	AAA		99
100 To	otal (Sum of column 2, lines 1 through 99)		100

A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I line 1 column3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (see instructions)

	Expenses	Percentage	Y/N	
	1	2	3	
101 Staffing				101
102 Recruitment				102
103 Retention of employees				103
104 Training				104
105 Other (Specify)				105
106 Total SNF revenue (Wkst. G-2, Pt. I, line 1, col. 3)				106

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4109 - 4109.1)

Rev. 9 41-314

NF-BASED HOSPICE IDENTIFICATION DATA				FROM	FROM		
		HOSPICE CCN:		TO	-	PARTS I, II, III & IV	
		•		•			
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNIN	IG BEFORE OCTOBE	ER 1, 2015					
				Unduplicated	Days		
			Title XVIII	Title XIX		Total	7
			Skilled Nursing	Nursing	All	(sum of	
	Title XVIII	Title XIX	Facility	Facility	Other	col. 1, 2 & 5)	
	1	2	3	4	5	6	
1 Hospice Continuous Home Care							1
2 Hospice Routine Home Care							2
3 Hospice Inpatient Respite Care							3
4 Hospice General Inpatient Care							4
5 Total Hospice Days							5
PART II - CENSUS DATA FOR COST REPORTING PERIODSENDING BEGINS	NING BEFORE OCTO	DBER 1, 2015					
THE I CONSOR SITTING COST NA OKTAVO PARIOSOSINO SEGUI.	I O DEL ORE GOTO	1, 2010	Title XVIII	Title XIX		Total	Т
			Skilled	Nursing	All	(sum of	
	Title XVIII	Title XIX	Nursing facility	Facility	Other	col. 1, 2 & 5)	
	1	2	3	4	5	6	7
6 Number of patients receiving hospice care							6
7 Total number of unduplicated Continuous Care hours billable to Medicare							7
8 Average length of stay (line 5 / line 6)							8
9 Unduplicated census count							9
PART III - ENROLLMENT DAYS BASED ON LEVEL OF CARE FOR COST REPO	ORTING PERIODS BI	EGINNING ON OR AFTE	ER OCTOBER 1, 2015				
	•	•		Unduplica	ited Days		

		Unduplicated Days						
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)			
		1	2.	3	Cols. 1 tilrough 5)	1		
10 Hospice Continuous Home Care		-				10		
11 Hospice Routine Home Care						11		
12 Hospice Inpatient Respite Care						12		
13 Hospice General Inpatient Care						13		
14 Total Hospice Days	_					14		

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

				Total	
				(sum of	
	Title XVIII	Title XIX	Other	cols. 1 through 3)	
	1	2	3	4	1
15 Hospice Inpatient Respite Care					15
16 Hospice General Inpatient Care					16

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

RECL	CLASSIFICATION AND ADJUSTMENT				PROVIDER CCN:		PERIOD:		WORKSHEET A	
OF T	RIAL BA	ALANCE OF EXPENSES					FROM			
							TO			
		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease (from Wkst, A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	В	С	1	2	3	4	5	6	7	Α
GENE	RAL SE	RVICE COST CENTERS								
1		Capital-Related Costs - Buildings & Fixtures								1
2		Capital-Related Costs - Movable Equipment								2
3	0300	Employee Benefits								3
4	0400	Administrative and General								4
5		Plant Operation, Maintenance and Repairs								5
6	0600	Laundry and Linen Service								6
7	0700	Housekeeping								7
8		Dietary								8
9		Nursing Administration								9
10		Central Services and Supply								10
11		Pharmacy								11
12		Medical Records and Library								12
13		Social Service								13
14	1400	Nursing and Allied Health Education								14
15		Other General Service Cost								15
INPA'		COUTINE SERVICE COST CENTERS								
30		Skilled Nursing Facility								30
		Nursing Facility								31
32		ICF/IID								32
33		Other Long Term Care								33
		SERVICE COST CENTERS								
40		Radiology								40
41		Laboratory								41
42		Intravenous Therapy								42
43		Oxygen (Inhalation) Therapy								43
44		Physical Therapy								44
45		Occupational Therapy								45
46	4600	Speech Pathology								46
47	4700	Electrocardiology								47

41-316 Rev. 8

	RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER CCN:		PERIOD : FROM TO	WORKSHEET A (Cont.)		
		Cost Center Description	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS Increase/Decrease (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS TO EXPENSES Increase / Decrease (from Wkst. A-8)	NET EXPENSES FOR COST ALLOCATION (col. 5 +/- col. 6)	
A	В	C	1	2	3	4	5	6	7	
48	4800	Medical Supplies Charged to Patients								48
49		Drugs Charged to Patients								49
50	5000	Dental Care - Title XIX only								50
51	5100	Support Surfaces								51
52		Other Ancillary Service Cost								52
OUTF	PATIENT	SERVICE COST CENTERS								
60	6000	Clinic								60
61	6100	Rural Health Clinic (RHC)								61
62	6200	FQHC								62
63		Other Outpatient Service Cost								63
OTHE	R REIM	BURSABLE COST CENTERS								
70	7000	Home Health Agency Cost								70
71	7100	Ambulance								71
72		Outpatient Rehabilitation (specify)								72
73	7300	CMHC								73
74		Other Reimbursable Cost								74
SPEC		RPOSE COST CENTERS								
80		Malpractice Premiums & Paid Losses							-0-	80
81		Interest Expense							- 0 -	81
82		Utilization Review							- 0 -	82
83		Hospice								83
84		Other Special Purpose Cost								84
89		SUBTOTALS (sum of lines 1 through 84)								89
NON		RSABLE COST CENTERS								
90		Gift, Flower, Coffee Shops and Canteen								90
91		Barber and Beauty Shop						, and the second		91
92		Physicians' Private Offices								92
93		Nonpaid Workers						, and the second		93
94	9400	Patients' Laundry								94
95		Other Nonreimbursable Cost								95
100		TOTAL								100

Rev. 2 41-317

1190 (Comm)	1 014/1 01/15 20 10 10			0, 11
RECLASSIFICATIONS	PROV	OVIDER CCN:	PERIOD :	WORKSHEET A-6
		I	FROM	
		-	TO	

		CODE		INCREAS	E		I	DECREAS	E		
		(1)	COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	
	EXPLANATION OF RECLASSIFICATION(S)	1	2	3	4	5	6	7	8	9	
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											1
11											1
12											1
13											1
14											1
15											1
16											1
17											1
18											1
19											1
20											2
21											2
22 23											2
23											2
24											2
25											2
26											2
27											2
28											2
29											2
30			·								3
31											3
32											3
33											3
34 35											3
35											3
	TOTAL RECLASSIFICATIONS (Sum of columns 4 and sum of columns 8 and 9 (2)	5 must equal									10

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

41-318 Rev. 2

⁽²⁾ Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

ANALYSIS OF CHANGES IN	PROVIDER CCN:	PERIOD:	WORKSHEET A-7
CAPITAL ASSET BALANCES		FROM	
		то	

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

FORM CMS-2540-10 (05/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4115)

Rev. 1 41-319

ADJU	SIMENIS IU EXPENSES	.	PROVIDER CCN:	FROM TO	WORKSHEET A-8	
		Basis for		Expense Classificat to/from which the amou		
	Description (1)	Adjustment (2)	Amount	Cost Center	Line No.	
	0	1	2	3	4	
1	Investment income on restricted funds (Chapter 2)					1
2	Trade, quantity and time discounts					2
_	on purchases (Chapter 8)					
3	Refunds and rebates of expenses Chapter 8)					3
4	Rental of provider space by suppliers Chapter 8)					4
5	Telephone services (pay stations excluded) (Chapter 21)					5
6	Television and radio service (Chapter 21)					6
7	Parking lot (Chapter 21)					7
8	based physician adjustment	Worksheet A-8-2				8
9	Home office costs (Chapter 21)					9
	Sale of scrap, waste, etc. (Chapter23)					10
11	Nonallowable costs related to certain Capital expenditures (Chapter 24)					11
	Adjustment resulting from transactions with related organizations (Chapter 10)	Worksheet A-8-1				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (Chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Utilization reviewphysicians' compensation (Chapter 21)			Utilization Review- SNF	82	22
23	Depreciationbuildings and fixtures			Capital Related Cost- Building	1	23
24	Depreciationmovable equipment			Capital Related Cost-Movable	2	24
25	Other Adjustment					25
100	TOTAL (sum of lines 1 through 99) (transfer to Wkst. A, col. 6, line 100)					100

41-320 Rev. 1

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

STATEMENT OF COSTS OF SERVICES	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-1
FROM RELATED ORGANIZATIONS AND		FROM	
HOME OFFICE COSTS		то	

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

				Amount Allowable	Amount Included in	Adjustments (col. 4 minus	
	Line No.	Cost Center	Expense Items	In Cost	Wkst. A., col. 5	col. 5)	
	Line No.	Cost Center	Expense items	iii Cost	W KSL A., COL 3	COI. 3)	4
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS	(sum of lines 1-9)					10
	(Transfer o	column 6, line 10 to Wkst. A-8, col. 3, line 12)					

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND / OR HOME OFFICE

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part II of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

					Related Organization(s)		
	(1) Symbol	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

- $(1) \ \ Use the followings \ symbols \ to \ indicate \ interrelationship \ to \ related \ organizations:$
 - A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 - B. Corporation, partnership or other organization has financial interest in provider.
 - C. Provider has financial interest in corporation, partnership, or other organization.
 - D. Director, officer, administrator or key person of provider or organization.

- E. Individual is director, officer, administrator or key person of provider and related organization.
- F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify _____

Rev. 7 41-321

1190 (Colli)	1 014.1 01.15 20 .0 10		00 10
PROVIDER - BASED PHYSICIAN ADJUSTMENTS	PROVIDER CCN:	PERIOD:	WORKSHEET A-8-2
		FROM	
		TO	

	Wkst. A Line No.	Cost Center / Physician Identifier 2	Total Remuneration 3	Professional Component 4	Provider Component 5	R C E Amount 6	Physician / Provider Component Hours 7	Unadjusted R C E Limit 8	5 Percent of Unadjusted R C E Limit	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

			Cost of	Provider	Physician	Provider				
		Cost Center /	Memberships	Component	Cost of	Component				
	Wkst. A	Physician	& Continuing	Share of	Malpractice	Share of	Adjusted	RCE		
	Line No.	Identifier	Education	Col. 12	Insurance	Col. 14	R C E Limit	Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	1
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100		TOTAL								100

41-322 Rev. 7

COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD : FROMTO		WORKSHEET B PART I	
	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	CAP. REL BUILDINGS & FIXTURES	CAP. REL MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (sum of cols. 0 - 3)	ADMINIS- TRATIVE & GENERAL	
Cost Center Description	0	1	2	3	3 A	4	
GENERAL SERVICE COST CENTERS							
1 Capital-Related Costs - Buildings & Fixtures							1
2 Capital-Related Costs - Movable Equipment							1
3 Employee Benefits							
4 Administrative and General							4
5 Plant Operation, Maintenance and Repairs							4
6 Laundry and Linen Service							(
7 Housekeeping							1
8 Dietary							8
9 Nursing Administration							Ģ
10 Central Services and Supply							10
11 Pharmacy							1
12 Medical Records and Library							12
13 Social Service							13
14 Nursing and Allied Health Education							14
15 Other General Service Cost							1.5
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							30
31 Nursing Facility							31
32 ICF/IID							32
33 Other Long Term Care							33
ANCILLARY SERVICE COST CENTERS							
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Therapy							43
44 Physical Therapy							44
45 Occupational Therapy							4.5
46 Speech Pathology							40
47 Electrocardiology							4
48 Medical Supplies Charged to Patients							48
49 Drugs Charged to Patients							49
50 Dental Care - Title XIX only							50
51 Support Surfaces							5
52 Other Ancillary Service Cost							52

Rev. 8 41-323

4190 (Cont.)	FORM CM3-	23 4 0-10				'	03-10
COST ALLOCATION - GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD: FROM		WORKSHEET B PART I	
				TO			
	NET EXPENSES FOR COST	CAP. REL	CAP. REL		SUBTOTAL	ADMINIS-	
	ALLOCATION (from Wkst. A, col. 7)	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	(sum of cols. 0 - 3)	TRATIVE & GENERAL	
Cost Center Description	0	1	2	3	3 A	4	-
OUTPATIENT SERVICE COST CENTERS					-		
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
100 Total							100

41-324 Rev. 8

COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART I	
	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
Cost Center Description	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS								_
1 Capital-Related Costs - Buildings & Fixtures								1
2 Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

Rev. 8 41-325

4190 (Cont.)		FORM CMS	-2340-10				'	03-18
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD: FROM TO		WORKSHEET B PART I	
Cost Center Description	PLANT OPER. MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE 6	HOUSE KEEPING	DIETARY 8	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 11	
OUTPATIENT SERVICE COST CENTERS	3	0	/	0	9	10	11	_
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								03
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total						1		100

41-326 Rev. 8

03-18		FORM CMS	- <u>2</u> 340-10				4190	(Cont
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD:		WORKSHEET B	3
					FROM		PART I	
					TO			
			NURSING &	OTHER				
	MEDICAL		ALLIED	GENERAL		POST		
	RECORDS	SOCIAL	HEALTH	SERVICE		STEP-DOWN		
	& LIBRARY	SERVICE	EDUCATION	COST	SUBTOTAL	ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								
2 Capital-Related Costs - Movable Equipment								
3 Employee Benefits								
4 Administrative and General								
5 Plant Operation, Maintenance and Repairs								
6 Laundry and Linen Service								
7 Housekeeping								
8 Dietary								
9 Nursing Administration								
10 Central Services and Supply								1
11 Pharmacy								1
12 Medical Records and Library								1
13 Social Service								1
14 Nursing and Allied Health Education								1
15 Other General Service Cost								1
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								3
31 Nursing Facility								3
32 ICF/IID								3
33 Other Long Term Care								3
ANCILLARY SERVICE COST CENTERS								
40 Radiology								4
41 Laboratory								4
42 Intravenous Therapy								4
43 Oxygen (Inhalation) Therapy								4
44 Physical Therapy								4
45 Occupational Therapy								4
46 Speech Pathology								4
47 Electrocardiology								4
48 Medical Supplies Charged to Patients								4
49 Drugs Charged to Patients								4
50 Dental Care - Title XIX only								5
51 Support Surfaces								5
52 Other Ancillary Service Cost								5

Rev. 8 41-327

4170 (Colit.)		TOKWI CIVIS					T	03-16
COST ALLOCATION - GENERAL SERVICE COSTS			PROVIDER CCN:		PERIOD:		WORKSHEET B	
					FROM		PART I	
					TO			
			NURSING &	OTHER				
	MEDICAL		ALLIED	GENERAL		POST		
	RECORDS	SOCIAL	HEALTH	SERVICE		STEP-DOWN		
	& LIBRARY	SERVICE	EDUCATION	COST	SUBTOTAL	ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

41-328 Rev. 8

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD : FROM		WORKSHEET B - 1	
		CAP. REL.	CAP. REL.	ТО	<u> </u>	ADMINIS-	_
Cost Center Description		BUILDINGS & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	TRATIVE & GENERAL (Accumulated Cost)	
Cost Contest Developation	0	1	2	3	4 A	4	
GENERAL SERVICE COST CENTERS							
Capital-Related Costs - Buildings & Fixtures							
2 Capital-Related Costs - Movable Equipment							
3 Employee Benefits							
4 Administrative and General							
5 Plant Operation, Maintenance and Repairs							
6 Laundry and Linen Service							
7 Housekeeping							
8 Dietary							
9 Nursing Administration							
10 Central Services and Supply]
11 Pharmacy							1
12 Medical Records and Library							1
13 Social Service							1
14 Nursing and Allied Health Education							1
15 Other General Service Cost]
INPATIENT ROUTINE SERVICE COST CENTERS							
30 Skilled Nursing Facility							3
31 Nursing Facility							3
32 ICF/IID							3
33 Other Long Term Care							3
ANCILLARY SERVICE COST CENTERS							
40 Radiology							
41 Laboratory							4
42 Intravenous Therapy							4
43 Oxygen (Inhalation) Therapy							4
44 Physical Therapy							4
45 Occupational Therapy							
46 Speech Pathology							
47 Electrocardiology							4
48 Medical Supplies Charged to Patients							
49 Drugs Charged to Patients							
50 Dental Care - Title XIX only							5
51 Support Surfaces							5
52 Other Ancillary Service Cost							5

Rev. 8 41-329

COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD:		WORKSHEET B - 1	1
				FROM			
				TO			
		CAP. REL.	CAP. REL.			ADMINIS-	
		BUILDINGS	MOVABLE	EMPLOYEE		TRATIVE	
		& FIXTURES	EQUIPMENT	BENEFITS		& GENERAL	
		(Square	(Dollar Value or	(Gross	RECONCIL-	(Accumulated	
Cost Center Description		Feet)	Square Feet)	Salaries)	IATION	Cost)	
	0	1	2	3	4 A	4	1
OUTPATIENT SERVICE COST CENTERS							
60 Clinic							60
61 Rural Health Clinic (RHC)							61
62 FQHC							62
63 Other Outpatient Service Cost							63
OTHER REIMBURSABLE COST CENTERS							
70 Home Health Agency Cost							70
71 Ambulance							71
72 Outpatient Rehabilitation (specify)							72
73 CMHC							73
74 Other Reimbursable Cost							74
SPECIAL PURPOSE COST CENTERS							
83 Hospice							83
84 Other Special Purpose Cost							84
89 Subtotals							89
NON REIMBURSABLE COST CENTERS							
90 Gift, Flower, Coffee Shops and Canteen							90
91 Barber and Beauty Shop							91
92 Physicians' Private Offices							92
93 Nonpaid Workers							93
94 Patients' Laundry							94
95 Other Nonreimbursable Cost							95
98 Cross Foot Adjustments							98
99 Negative Cost Center							99
102 Cost to be allocated (Per Wkst. B, Pt I.)							102
103 Unit Cost Multiplier (Wkst. B, Pt I.)							103
104 Cost to be allocated (Per Wkst. B, Pt. II)							104
105 Unit Cost Multiplier (Wkst B, Pt. II)							105

41-330 Rev. 8

UJ-10		TOKNI CNIS			PERVOR		4170 (
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B -	1
					TO			
	DI ANTE ODED	LAUNDDAY			NURSING	CENTED AT		
	PLANT OPER.	LAUNDRY	HOUGE			CENTRAL		
	MAINTENANCE	& LINEN	HOUSE	DALLE TO A LANGE	ADMINIS-	SERVICES	DYY A DA K A CIV	
	& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY	
	(Square	(Pounds of	(Hours of	(Meals	(Direct	(Costed	(Costed	
Cost Center Description	Feet)	Laundry)	Service)	Served)	Nursing Hrs.)	Requisitions)	Requisitions)	_
GENERAL SERVICE COST CENTERS	3	6	/	8	9	10	11	_
Capital-Related Costs - Buildings & Fixtures								1
2 Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
								9
9 Nursing Administration								
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

Rev. 8 41-331

PLANT OPER	4170 (Cont.)		TORWI CMS-						05-10
PLANT OPER	COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B -	1
PLANT OPER LAUNDRY MAINTENNANCE & LINDRY EPHANT OPER SERVICE & REPRING DIETARY TRATION & SUPPLY PHARMACY Costed Costed						FROM			
MAINTENANCE & LINEN HOUSE KEPING DIETARY TRATION & SUPPLY (Costed Feet Laundry Service Service Nursing Hs.) Requisitions Nursing Hs.) Requisitions Nursing Hs. Nursing Hs. Requisitions Nursing Hs. Nu						TO			
REPAIRS SERVICE KEEPING DIETARY TRATION & SUPPLY PHARMACY Costed Feet Laundry Service Served Nursing Hrs. Requisitions Requisitions Peet Laundry Service Service Served Nursing Hrs. Requisitions Requisitions Peet Laundry Service Service Served Nursing Hrs. Requisitions Requisitions Peet Laundry PhARMACY Costed Costed Requisitions Requisitions Requisitions Peet Requisitions Peet PhARMACY Costed Requisitions Peet PhARMACY Costed Peet PhARMACY PhARMACY Costed Peet PhARMACY PhARMACY Costed Peet PhARMACY PhARMACY PhARMACY PhARMACY Costed Peet PhARMACY		PLANT OPER.	LAUNDRY			NURSING	CENTRAL		
Cost Center Description		MAINTENANCE	& LINEN	HOUSE		ADMINIS-	SERVICES		
Cost Center Description		& REPAIRS	SERVICE	KEEPING	DIETARY	TRATION	& SUPPLY	PHARMACY	
Cost Center Description		(Square	(Pounds of	(Hours of	(Meals	(Direct	(Costed	(Costed	
SECOND SPECIAL PURPOSE COST CENTERS SUBJECT SPECIAL PURPOSE COST CENTERS SUBJECT SPECIAL PURPOSE COST CENTERS SUBJECT SU	Cost Center Description		Laundry)	Service)	Served)	Nursing Hrs.)	Requisitions)	Requisitions)	
60 Clinic 61 Rural Health Clinic (RHC) 62 FQHC 63 Other Outpatient Service Cost 65 Other Outpatient Service Cost 66 Other ReithBURSABLE COST CENTERS 70 Home Health Agency Cost 71 Ambulance 72 Outpatient Rehabilitation (specify) 73 CMHC 74 Other Reimbursable Cost 75 Other Reimbursable Cost 76 Other Reimbursable Cost 77 Other Reimbursable Cost 78 Other Reimbursable Cost 80 Other Special Purpose Cost 81 Other Special Purpose Cost 82 Other Special Purpose Cost 83 Hospice 84 Other Special Purpose Cost 85 Other Special Purpose Cost 86 Other Special Purpose Cost 87 Other Special Purpose Cost 88 Other Special Purpose Cost 89 Subtotals NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	•	5	6	7	8				
61 Rural Health Clinic (RHC) 62 FQHC 63 Other Outpatient Service Cost 63 Other Outpatient Service Cost 64 Other Outpatient Service Cost 65 Other ReimbursABLE COST CENTERS 70 Home Health Agency Cost 71 Ambulance 72 Outpatient Rehabilitation (specify) 73 CMHC 74 Other Reimbursable Cost SPECIAL PURPOSE COST CENTERS 83 Hospice 84 Other Special Purpose Cost 85 Subtotals 86 NON REIMBURSABLE COST CENTERS 87 OUTPATERS 88 Subtotals 89 Subtotals 80 Gift, Flower, Coffee Shops and Canteen 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	OUTPATIENT SERVICE COST CENTERS								
62 FQHC 63 Other Outpatient Service Cost 63 Other Outpatient Service Cost 65 Other Outpatient Service Cost 66 Other ReIMBURSABLE COST CENTERS 77 Home Health Agency Cost 78 I Ambulance 79 Outpatient Rehabilitation (specify) 70 Other Reimbursable Cost 71 Other Reimbursable Cost 72 Other Reimbursable Cost 73 CMHC 74 Other Reimbursable Cost 75 EVECIAL PURPOSE COST CENTERS 76 Other Special Purpose Cost 77 Other Reimbursable Cost 78 Hospice 80 Other Special Purpose Cost 81 Hospic 82 Subtotals 83 Inspice 84 Other Special Purpose Cost 85 Subtotals 86 Office Special Purpose Cost 87 Office Special Purpose Cost 88 Subtotals 89 Subtotals 80 Subtotals 80 Office Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	60 Clinic								60
63 Other Outpatient Service Cost OTHER REIMBURSABLE COST CENTERS 70 Home Health Agency Cost 71 Ambulance 72 Outpatient Rehabilitation (specify) 73 CMHC 74 Other Reimbursable Cost 75 Other Reimbursable Cost 76 Other Reimbursable Cost 77 Other Reimbursable Cost 78 Hospice 80 Hospice 81 Hospice 82 Hospice 83 Hospice 84 Other Special Purpose Cost 89 Subtotals NON REIMBURSABLE COST CENTERS 90 Giff, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	61 Rural Health Clinic (RHC)								61
OTHER REIMBURSABLE COST CENTERS 0 70 Home Health Agency Cost 0 71 Ambulance 0 72 Outpatient Rehabilitation (specify) 0 73 CMHC 0 74 Other Reimbursable Cost 0 SPECIAL PURPOSE COST CENTERS 0 83 Hospice 0 84 Other Special Purpose Cost 0 89 Subtotals 0 NON REIMBURSABLE COST CENTERS 0 90 Gift, Flower, Coffee Shops and Canteen 0 91 Barber and Beauty Shop 0 92 Physicians' Private Offices 0 94 Patients' Laundry 0	62 FQHC								62
70 Home Health Agency Cost	63 Other Outpatient Service Cost								63
71 Ambulance 72 Outpatient Rehabilitation (specify) 72 Outpatient Rehabilitation (specify) 6 73 CMHC 74 Other Reimbursable Cost 74 Other Reimbursable Cost 8 SPECIAL PURPOSE COST CENTERS 8 83 Hospice 8 84 Other Special Purpose Cost 9 85 Subtotals 8 NON REIMBURSABLE COST CENTERS 8 90 Gift, Flower, Coffee Shops and Canteen 9 91 Barber and Beauty Shop 9 92 Physicians' Private Offices 9 93 Nonpaid Workers 9 94 Patients' Laundry 9	OTHER REIMBURSABLE COST CENTERS								
72 Outpatient Rehabilitation (specify)	70 Home Health Agency Cost								70
73 CMHC 74 Other Reimbursable Cost 74 Other Reimbursable Cost 80 CMT CENTERS 83 Hospice 81 Other Special Purpose Cost 84 Other Special Purpose Cost 80 CMT CENTERS 89 Subtotals 80 CMT CENTERS 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 91 Barber and Beauty Shop 91 Pysicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	71 Ambulance								71
74 Other Reimbursable Cost SPECIAL PURPOSE COST CENTERS 83 Hospice Substance 84 Other Special Purpose Cost Substance 89 Subtotals Substance NON REIMBURSABLE COST CENTERS Substance 90 Gift, Flower, Coffee Shops and Canteen Substance 91 Barber and Beauty Shop Substance 92 Physicians' Private Offices Substance 93 Nonpaid Workers Substance 94 Patients' Laundry Substance	72 Outpatient Rehabilitation (specify)								72
SPECIAL PURPOSE COST CENTERS 83 Hospice 84 Other Special Purpose Cost 90 Universe Cost 89 Subtotals 90 Universe Cost NON REIMBURSABLE COST CENTERS 90 Universe Cost 90 Gift, Flower, Coffee Shops and Canteen 90 Universe Cost 92 Physicians' Private Offices 91 Universe Cost 93 Nonpaid Workers 94 Patients' Laundry	73 CMHC								73
83 Hospice 84 Other Special Purpose Cost 84 Other Special Purpose Cost 9 Subtotals NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 9 Physicians' Private Offices 92 Physicians' Private Offices 9 Pitients' Laundry 94 Patients' Laundry 9 Patients' Laundry	74 Other Reimbursable Cost								74
84 Other Special Purpose Cost 89 Subtotals NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	SPECIAL PURPOSE COST CENTERS								
89 Subtotals NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen Shops and Eastly Shop 91 Barber and Beauty Shop Shops and Eastly Shop 92 Physicians' Private Offices Shoppaid Workers 93 Nonpaid Workers Shoppaid Workers 94 Patients' Laundry Shoppaid Workers	83 Hospice								83
NON REIMBURSABLE COST CENTERS 90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry	84 Other Special Purpose Cost								84
90 Gift, Flower, Coffee Shops and Canteen 91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry									89
91 Barber and Beauty Shop 92 Physicians' Private Offices 93 Nonpaid Workers 94 Patients' Laundry									
92 Physicians' Private Offices									90
93 Nonpaid Workers									91
94 Patients' Laundry									92
	93 Nonpaid Workers								93
95 Other Nonreimburgable Cost									94
// Other Promethiodisable Cost	95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments	98 Cross Foot Adjustments								98
99 Negative Cost Center									99
102 Cost to be allocated (Per Wkst. B, Pt I.)									102
103 Unit Cost Multiplier (Wkst. B, Pt I.)									103
104 Cost to be allocated (Per Wkst. B, Pt. II)									104
105 Unit Cost Multiplier (Wkst B, Pt. II)	105 Unit Cost Multiplier (Wkst B, Pt. II)								105

41-332 Rev. 8

COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B	- 1
					FROM TO			
Cost Center Description	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS								
1 Capital-Related Costs - Buildings & Fixtures								
2 Capital-Related Costs - Movable Equipment								
3 Employee Benefits								
4 Administrative and General								
5 Plant Operation, Maintenance and Repairs								
6 Laundry and Linen Service								
7 Housekeeping								
8 Dietary								
9 Nursing Administration								
10 Central Services and Supply								1
11 Pharmacy								1
12 Medical Records and Library								1
13 Social Service								1
14 Nursing and Allied Health Education								1
15 Other General Service Cost								1
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								3
31 Nursing Facility								3
32 ICF/IID								3
33 Other Long Term Care								3
ANCILLARY SERVICE COST CENTERS								
40 Radiology								4
41 Laboratory								4
42 Intravenous Therapy								4
43 Oxygen (Inhalation) Therapy								4
44 Physical Therapy								4
45 Occupational Therapy								4
46 Speech Pathology								4
47 Electrocardiology								4
48 Medical Supplies Charged to Patients								4
49 Drugs Charged to Patients								4
50 Dental Care - Title XIX only								5
51 Support Surfaces								5
52 Other Ancillary Service Cost								5

Rev. 7 41-333

4190 (Colit.)		TOKWI CWIS-	-2340-10					03-16
COST ALLOCATION - STATISTICAL BASIS			PROVIDER CCN:		PERIOD:		WORKSHEET B	- 1
					FROM			
					TO			
	MEDICAL		NURSING &					
	RECORDS	SOCIAL	ALLIED	GENERAL				
	& LIBRARY	SERVICE	HEALTH EDU	SERVICE		POST		
	(Time	(Time	EDUCATION	COST		STEP-DOWN		
Cost Center Description	Spent)	Spent)	(Assigned Time)	COST	SUBTOTAL	ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	_
OUTPATIENT SERVICE COST CENTERS	12	13	17	13	10	17	10	
60 Clinic								60
61 Rural Health Clinic (RHC)	†							61
62 FQHC	†							62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
102 Cost to be allocated (Per Wkst. B, Pt I.)								102
103 Unit Cost Multiplier (Wkst. B, Pt I.)								103
104 Cost to be allocated (Per Wkst. B, Pt. II)								104
105 Unit Cost Multiplier (Wkst B, Pt. II)								105

41-334 Rev. 8

ALLOCATION OF CARITAL PELATED COCTO		PROVIDER CCN: PERIOD:					WORKSHEET B	
ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:						
					FROM		PART II	
	DIRECTLY			1	10		1	—
	ASSIGNED	CAP. REL	CAP. REL.			ADMINIS-	PLANT OPER.	
	CAPITAL	BUILDINGS	MOVABLE		EMPLOYEE	TRATIVE	MAINTENANCE	
	RELATED COSTS	& FIXTURES	EQUIPMENT	SUBTOTAL	BENEFITS	& GENERAL	& REPAIRS	
Cost Center Description	0	1	2	2 A	3	4	& KEFAIKS	
GENERAL SERVICE COST CENTERS	U	1		2 A	3	4	,	
1 Capital-Related Costs - Buildings & Fixtures								
Capital-Related Costs - Movable Equipment								2
3 Employee Benefits								3
4 Administrative and General								4
5 Plant Operation, Maintenance and Repairs								5
6 Laundry and Linen Service								6
7 Housekeeping								7
8 Dietary								8
9 Nursing Administration								9
10 Central Services and Supply								10
11 Pharmacy								11
12 Medical Records and Library								12
13 Social Service								13
14 Nursing and Allied Health Education								14
15 Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Skilled Nursing Facility								30
31 Nursing Facility								31
32 ICF/IID								32
33 Other Long Term Care								33
ANCILLARY SERVICE COST CENTERS								
40 Radiology								40
41 Laboratory								41
42 Intravenous Therapy								42
43 Oxygen (Inhalation) Therapy								43
44 Physical Therapy								44
45 Occupational Therapy								45
46 Speech Pathology								46
47 Electrocardiology								47
48 Medical Supplies Charged to Patients								48
49 Drugs Charged to Patients								49
50 Dental Care - Title XIX only								50
51 Support Surfaces								51
52 Other Ancillary Service Cost								52

Rev. 8 41-335

4190 (Cont.)		FORM CMS-	MS-2540-10					
ALLOCATION OF CAPITAL - RELATED COSTS			F		PERIOD: FROMTO		WORKSHEET B PART II	
	DIRECTLY ASSIGNED CAPITAL RELATED COSTS	CAP. REL BUILDINGS & FIXTURES	CAP. REL. MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	PLANT OPER. MAINTENANCE & REPAIRS	
Cost Center Description	0	ı	2	2 A	3	4	5	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC) 62 FQHC								61
63 Other Outpatient Service Cost								62
OTHER REIMBURSABLE COST CENTERS								0.5
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								, ,
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

41-336 Rev. 8

ALLO	ALLOCATION OF CAPITAL - RELATED COSTS		PROVIDER CCN:	PROVIDER CCN:			WORKSHEET B PART II	
		LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	Cost Center Description	6	7	8	9	10	11	
GEN	ERAL SERVICE COST CENTERS							
	Capital-Related Costs - Buildings & Fixtures							
2	Capital-Related Costs - Movable Equipment							
	Employee Benefits							
	Administrative and General							
5	Plant Operation, Maintenance and Repairs							
6	Laundry and Linen Service							
7	Housekeeping							
	Dietary							
9	Nursing Administration							
10	Central Services and Supply							1
11	Pharmacy							1
12	Medical Records and Library							1
13	Social Service							1
14	Nursing and Allied Health Education							1
	Other General Service Cost							1
INPA	ATIENT ROUTINE SERVICE COST CENTERS							
30	Skilled Nursing Facility							3
31	Nursing Facility							3
32	ICF/IID							3
	Other Long Term Care							3
ANC	ILLARY SERVICE COST CENTERS							
40	Radiology							4
41	Laboratory							4
42	Intravenous Therapy							4
43	Oxygen (Inhalation) Therapy							4
44	Physical Therapy							4
45	Occupational Therapy							4
46	Speech Pathology							4
47	Electrocardiology							4
	Medical Supplies Charged to Patients							4
	Drugs Charged to Patients							4
	Dental Care - Title XIX only							5
51	Support Surfaces							5
	Other Ancillary Service Cost							5

Rev. 8 41-337

ALLOCATION OF CAPITAL - RELATED COSTS		FRO		PERIOD: FROM TO	FROM		WORKSHEET B PART II	
	LAUNDRY & LINEN SERVICE	HOUSE KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
Cost Center Description	6	7	8	9	10	11	_	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic							60	
61 Rural Health Clinic (RHC)							61	
62 FQHC							62	
63 Other Outpatient Service Cost OTHER REIMBURSABLE COST CENTERS							63	
							70	
70 Home Health Agency Cost 71 Ambulance		+					71	
71 Amounance 72 Outpatient Rehabilitation (specify)							72	
72 Outpatient Kenabintation (specify) 73 CMHC							73	
74 Other Reimbursable Cost							74	
SPECIAL PURPOSE COST CENTERS							- / -	
83 Hospice							83	
84 Other Special Purpose Cost							84	
89 Subtotals							89	
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen							90	
91 Barber and Beauty Shop							91	
92 Physicians' Private Offices							92	
93 Nonpaid Workers							93	
94 Patients' Laundry							94	
95 Other Nonreimbursable Cost							95	
98 Cross Foot Adjustments							98	
99 Negative Cost Center							99	
100 Total							100	

41-338 Rev. 8

ALLOCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B PART II		
					TO		TAKT II		
	MEDICAL RECORDS	SOCIAL	NURSING & ALLIED HEALTH	OTHER GENERAL SERVICE		POST STEP-DOWN			
	& LIBRARY	SERVICE	EDUCATION	COST	SUBTOTAL	ADJUSTMENTS	TOTAL		
Cost Center Description	12	13	14	15	16	17	18		
GENERAL SERVICE COST CENTERS									
1 Capital-Related Costs - Buildings & Fixtures								1	
2 Capital-Related Costs - Movable Equipment								2	
3 Employee Benefits								3	
4 Administrative and General								4	
5 Plant Operation, Maintenance and Repairs								5	
6 Laundry and Linen Service								6	
7 Housekeeping								7	
8 Dietary								8	
9 Nursing Administration								9	
10 Central Services and Supply								10	
11 Pharmacy								11	
12 Medical Records and Library								12	
13 Social Service								13	
14 Nursing and Allied Health Education								14	
15 Other General Service Cost								15	
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Skilled Nursing Facility								30	
31 Nursing Facility								31	
32 ICF/IID								32	
33 Other Long Term Care								33	
ANCILLARY SERVICE COST CENTERS									
40 Radiology								40	
41 Laboratory								41	
42 Intravenous Therapy								42	
43 Oxygen (Inhalation) Therapy								43	
44 Physical Therapy								44	
45 Occupational Therapy								45	
46 Speech Pathology								46	
47 Electrocardiology								47	
48 Medical Supplies Charged to Patients								48	
49 Drugs Charged to Patients								49	
50 Dental Care - Title XIX only								50	
51 Support Surfaces								51	
52 Other Ancillary Service Cost								52	

Rev. 8 41-339

ALLOCATION OF CAPITAL - RELATED COSTS			PROVIDER CCN:		PERIOD: FROM		WORKSHEET B PART II	
	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING & ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST	SUBTOTAL	POST STEP-DOWN ADJUSTMENTS	TOTAL	
Cost Center Description	12	13	14	15	16	17	18	
OUTPATIENT SERVICE COST CENTERS								
60 Clinic								60
61 Rural Health Clinic (RHC)								61
62 FQHC								62
63 Other Outpatient Service Cost								63
OTHER REIMBURSABLE COST CENTERS								
70 Home Health Agency Cost								70
71 Ambulance								71
72 Outpatient Rehabilitation (specify)								72
73 CMHC								73
74 Other Reimbursable Cost								74
SPECIAL PURPOSE COST CENTERS								
83 Hospice								83
84 Other Special Purpose Cost								84
89 Subtotals								89
NON REIMBURSABLE COST CENTERS								
90 Gift, Flower, Coffee Shops and Canteen								90
91 Barber and Beauty Shop								91
92 Physicians' Private Offices								92
93 Nonpaid Workers								93
94 Patients' Laundry								94
95 Other Nonreimbursable Cost								95
98 Cross Foot Adjustments								98
99 Negative Cost Center								99
100 Total								100

41-340 Rev. 8

			(
POST STEP DOWN ADJUSTMENTS	PROVIDER CCN:	PERIOD :	WORKSHEET B-2
		FROM	
		TO	

		Works	sheet B		T
	Description	Part No.	Line No.	Amount	
	1	2	3	4	
1					1
2					1 2 3 4 5 6 7 8
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10 11 12
11					11
12					12
13					13 14
14					14
15 16			-		15 16 17
17					10
18					17
19					10
20					20
21					21
22					22
23					23
24					24
25					18 19 20 21 22 23 24 25 26
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					28 29 30 31 32 33 34 35 36 37 38 39
37					37
38					38
39					39
40					40
41					41
43					42 43 44 45 46
43			 		43
45			1		15
46					43
47					40
48					47 48 49 50
49					49
50					50
50			I		50

Rev. 7 41-341

RATIO OF COST TO CHARGES	PROVIDER CCN:	PERIOD:	WORKSHEET C
FOR ANCILLARY AND OUTPATIENT		FROM	
COST CENTERS		то	

	Cost Center Description	Total (from Wkst. B, Pt. I, col. 18)	Total Charges 2	Ratio (col. 1 divided by col. 2)	
ANCI	LLARY SERVICE COST CENTERS				
40	Radiology				40
41	Laboratory				41
42	Intravenous Therapy				42
43	Oxygen (Inhalation) Therapy				43
44	Physical Therapy				44
45	Occupational Therapy				45
46	Speech Pathology				46
47	Electrocardiology				47
48	Medical Supplies Charged to Patients				48
49	Drugs Charged to Patients				49
50	Dental Care - Title XIX only				50
	Support Surfaces				51
					52
	ATIENT SERVICE COST CENTERS				
	Clinic				60
61	Rural Health Clinic (RHC)				61
	FQHC				62
63	Other Outpatient Service Cost				63
71	Ambulance				71
100	Total				100

 $FORM\ CMS-2540-10\ (08/2016)\ \ (INSTRUCTIONS\ FOR\ THIS\ WORKSHEET\ ARE\ PUBLISHED\ IN\ CMS\ PUB.\ 15-2,\ SECTION\ 4123)$

41-342 Rev. 7

APPORTIONMENT OF ANCILLARY ANI	D			PROVIDER CCN:	PERIOD:	WORKSHEET D
OUTPATIENT COST					FROM	PART I
					TO	
Check applicable box:	[] Title V (1)	[] Title XVIII	[] Title XIX (1)			
Check applicable box:	[] SNF	[] NF	[] ICF/IID	[] Other	[] PPS - Must also complete Part II	

PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST

	Ratio of Cost to Charges	Health Care Program Charges		Progra	thcare ım Cost	
	(from Wkst. C,			Part A	Part B	
	col. 3)	Part A	Part B	(col. 1 x col. 2)	(col. 1 x col. 3)	_
Cost Center Description	1	2	3	4	5	-
ANCILLARY SERVICE COST CENTERS						4
40 Radiology						40
41 Laboratory						41
42 Intravenous Therapy						42
43 Oxygen (Inhalation) Therapy						43
44 Physical Therapy						44
45 Occupational Therapy						45
46 Speech Pathology						46
47 Electrocardiology						47
48 Medical Supplies Charged to Patients						48
49 Drugs Charged to Patients						49
50 Dental Care - Title XIX only						50
51 Support Surfaces						51
52 Other Ancillary Service Cost						52
OUTPATIENT COST CENTERS						
60 Clinic						60
61 Rural Health Clinic (RHC)						61
62 FQHC						62
63 Other Outpatient Service Cost						63
71 Ambulance (2)						71
100 Total (sum of lines 40 - 71)						100

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

Rev. 8 41-343

⁽²⁾ Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

4190 (Cont.)	FORM CMS-2540-10	03-18

4190 (Cont.)		FORM CMS-2540-10					03-18
APPORTIONMENT OF AN	CILLARY AND	PROVIDER CCN:		PERIOD:		WORKSHEET D	
OUTPATIENT COST				FROM		PARTS II & III	
				то	_		
TITLE XVIII ONLY							
TITLE AVIII ONL I							
PART II - APPORTIONMI							
	nts - ratio of cost to charges (from Wkst. C, col. 3, line 49)						1
	es (From your records or the PS&R report)						2
3 Program costs (line 1 x	x line 2) (Title XVIII, PPS providers, transfer this amount to Wkst.	. E, Pt. I, line 18)					3
PART III - CALCULATION	N OF PASS THROUGH COSTS FOR NURSING & ALLIED	HEALTH					
				Ratio of Nursing		Part A	
			Nursing &	& Allied Health	Program	Nursing & Allied	
		Total Cost	Allied Health	Costs to Total	Part A Cost	Health Costs for	
		(from Wkst. B,	(from Wkst. B,	Costs - Part A	(from Wkst. D.,	Pass Through	
		Pt. I, col. 18)	Pt. I, col. 14)	(col. 2 / col. 1)	Pt. I, col. 4)	(col. 3 x col. 4)	
	Cost Center Description	1	2	3	4	5	1
ANCILLARY SERVICE COS	T CENTERS						
40 Radiology							40
41 Laboratory							41
42 Intravenous Therapy							42
43 Oxygen (Inhalation) Th	ierapy						43
44 Physical Therapy							44
45 Occupational Therapy							45
46 Speech Pathology							46
47 Electrocardiology							47
48 Medical Supplies Charg	ged to Patients						48
49 Drugs Charged to Patie	ents						49
50 Dental Care - Title XIX	Conly						50
51 Support Surfaces	•			·			51

Other Ancillary Service Cost 100 Total (sum of lines 40 - 52)

41-344 Rev. 8

	PUTATION OF INPATIENT	PROVIDER CCN:	PERIOD:	WORKSHEET D-1
ROUT	INE COSTS		FROM	PARTS I & II
			TO	
	neck applicable box: [] Title V [] Title XVIII [] Title XIX			
Ch	neck applicable box: [] SNF [] NF [] ICF/IID			
DADT	I CALCULATION OF INDATIENT DOUTING COCTO			
	I - CALCULATION OF INPATIENT ROUTINE COSTS TIENT DAYS			
	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				5
	ATE ROOM DIFFERENTIAL ADJUSTMENT			
	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 on line 8 divided by	v private room days on line 2)		9
				10
11	Average semi-private room per diem charge (semi-private room charges on line 1	0 divided by semi-private room	days)	11
	Average per diem private room charge differential (line 9 minus line 11)	, , , , , , , , , , , , , , , , , , ,		12
	Average per diem private room cost differential (line 7 times line 12)			13
				14
15		minus line 14)		15
	RAM INPATIENT ROUTINE SERVICE COSTS	,		
16				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	3)		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, Pt.	. II, col. 18, line 30 for SNF; line	31 for NF; or	20
	line 32 for ICF/IID)			
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 (1)			26
27	Inpatient routine service cost limitation (line 3 times the per diem limitation line 2	26) (1)		27
28	Reimbursable inpatient routine service costs (line 22 plus the lesser of line 25 or l			28
	(Transfer to Wkst. E, Pt. II, line 4) (see instructions)			
PART	II - CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS	FOR PPS PASS-THROUGH		
1	Total inpatient days	•		1
2	Program inpatient days (see instructions)			2
3	Total nursing & allied health costs (see instructions)			3
4	Nursing & allied health ratio (line 2 divided by line 1)			4
5	Program nursing & allied health costs for pass-through (line 3 times line 4)			5

Rev. 9 41-345

 $^{(1) \ \} Lines\ 26,27\ and\ 28\ are\ not\ applicable\ for\ title\ XVIII,\ but\ may\ be\ used\ for\ title\ V\ and\ or\ title\ XIX$

1150 (Cont.)	O1411 C111D 25 10 10			11 1/
CALCULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E	
REIMBURSEMENT SETTLEMENT		FROM	PART I	
FOR TITLE XVIII		то		

'		_
PART	A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT	
1	Inpatient PPS amount (see instructions)	1
2	Nursing and Allied Health Education Activities (pass through payments)	2
3	Subtotal (sum of lines 1 and 2)	3
4	Primary payer amounts	4
5	Coinsurance	5
6	Allowable bad debts (from your records)	6
7	Allowable Bad debts for dual eligible beneficiaries (see instructions)	7
- 8	Reimbursable bad debts (see instructions)	8
9	Recovery of bad debts - for statistical records only	9
10	Utilization review	10
11	Subtotal (see instructions)	11
12	Interim payments (see instructions)	12
13	Tentative adjustment	13
14	Other adjustment (see instructions)	14
14.50	D emonstration payment adjustment amount before sequestration	14.50
14.55	Demonstration payment adjustment amount after sequestration	14.55
14.99	Sequestration amount (see instructions)	14.99
15	Balance due provider/program (see instructions)	15
	(Indicate overpayment in parentheses)	
16	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	16
	B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY	
17	Ancillary services Part B	17
18	Vaccine cost (from Wkst. D, Pt. II, line 3)	18
19	Total reasonable costs (sum of lines 17 and 18)	19
20	Medicare Part B ancillary charges (see instructions)	20
21	Cost of covered services (lesser of line 19 or line 20)	21
22	Primary payer amounts	22
23	Coinsurance and deductibles	23
24	Allowable bad debts (from your records)	24

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4130)

41-346 Rev. 9

	CULATION OF	PROVIDER CCN:	PERIOD:	WORKSHEET E
	BURSEMENT SETTLEMENT		FROM	PART II
FOR	TITLE V and TITLE XIX ONLY		то	
	Check applicable box: [] Title V [] Title XIX			
	Check applicable box: [] SNF [] NF [] ICF/IID		
	Check applicable box. [] SIM [] IM] ICI / IID		
COM	PUTATION OF NET COST OF COVERED SERVICES			
1				1
2	Nursing & Allied Health Cost (from Wkst. D-1, Pt. II, line 5)			2
3				3
4	*			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 accommodations and less			7
	than semiprivate accommodations			
8	Subtotal (line 6 minus line 7)			8
9	Primary payer amounts			9
10	Total reasonable cost (line 8 minus line 9)			10
REAS	ONABLE CHARGES			
11	Inpatient ancillary service charges			11
12	Outpatient service charges			12
	Inpatient routine service charges			13
14	Differential in charges between semiprivate accommodations and less			14
	than semiprivate accommodations			
15	Total reasonable charges			15
	OMARY CHARGES			
16	Aggregate amount actually collected from patients liable for payment for			16
	services on a charge basis			
17	1 1 7			17
10	on a charge basis had such payment been made in accordance with 42 CFR 413	3.13(e)		10
18				18
	Total customary charges (see instructions) PUTATION OF REIMBURSEMENT SETTLEMENT			19
20	Cost of covered services (see instructions)			20
21	Deductibles			21
22	Subtotal (line 20 minus line 21)			21
23	Coinsurance			23
	Subtotal (line 22 minus line 23)			23
	Allowable bad debts (from your records)			25
26	Subtotal (sum of lines 24 and 25)			26
27				27
	based on correction of cost limit			-
28	Recovery of excess depreciation resulting from provider termination or a decrea	ase		28
	in program utilization			
29	Other adjustments (Specify) (see instructions)			29
30				30
	depreciable assets (if minus, enter amount in parentheses)			
31	Subtotal (line 26 plus or minus lines 29, and 30, minus lines 27 and 28)			31
32	Interim payments			32
33	Balance due provider/program (line 31 minus line 32)		<u> </u>	33
	(indicate overpayments in parentheses) (see instructions)			

Rev. 8 41-347

FROM	1 2
Inpatient Part A Part B	2
Description I Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero. I List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period to .03 Also show date of each payment. If none, write "NONE," or enter a zero. (1) Provider .51 Interim payments payable on individual bills, either submitted or to be submitted to the interim rate for the cost reporting period to .03 Provider .04 Provider .51 Frogram .53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	2
Description 1 Total interim payments paid to provider 2 Interim payments payable on individual bilis, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero. 2 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) Provider 1.005	2
1 Total interim payments paid to provider 2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero. 2 List separately each retroactive lump sum adjustment amount based on subsequent revision of to 0.03 the interim rate for the cost reporting period to 0.03 to 0.03 to 0.05 to	2
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary/contractor for services rendered in the cost reporting period. If none, enter zero. 2 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) Provider 50 Provider 51 to 52 Program 53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	2
or to be submitted to the intermediarry/contractor for services rendered in the cost reporting period. If none, enter zero. 2 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period to .03 Also show date of each payment. If none, write "NONE," or enter a zero. (1) Provider .51 to .52 Provider .51 to .52 Program .53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	
rendered in the cost reporting period. If none, enter zero.	3.01
2 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.	3.01
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) Provider 1.04 Provider 1.05 Provider 1.50 Provider 1.51 1.50 Program 1.52 Program 1.53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	3.01
the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE," or enter a zero. (1) Provider .04 .05 .05 Provider .50 Provider .51 to .52 Program .53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 1, 2 & 3.99) 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	
Also show date of each payment. If none, write "NONE," or enter a zero. (1) Provider .04 .05 .05 Provider .50 Provider .51 to .52 Program .53 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	3.02
If none, write "NONE," or enter a zero. (1)	3.03
Provider .50	3.04
Provider to .51	3.05
to	3.50
Program .53 .54 .54 .54 .54 .54 .59 .54 .59 .59 .59 .59 .59 .59 .59 .59 .59 .59	3.51
54 SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) .99 .9	3.52
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98) .99 4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99) .99	3.53
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2 & 3.99)	3.54
	3.99
(Transfer to Wkst. E, Pt. I, line 12 for Part A, and line 26 for Part B.)	4
TO BE COMPLETED BY CONTRACTOR	
5 List separately each tentative settlement Program .01	5.01
payment after desk review. Also show to .02	5.02
date of each payment. Provider .03	5.03
If none, write "NONE," or enter a zero. (1) Provider .50	5.50
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 (balance Program to Provider .01	6.01
due) based on the cost report (1) Provider to Program .02	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)	7
8 Name of Contractor Contractor Contractor	8

41-348 Rev. 8

⁽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	PROVIDER CCN:	PERIOD:	WORKSHEET G
(If you are nonproprietary and do not maintain fund-type		FROM	
accounting records, complete the "General Fund" column only.)		TO	

			Specific	.	This is	
		General Fund	Purpose	Endowment	Plant	
	Assets	Fund	Fund 2	Fund 3	Fund 4	_
CLIDE	RENT ASSETS	1	2	3	4	
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	()	()	()	()	6
	and accounts receivable	,	,			
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS					11
	(sum of lines 1 - 10)					
FIXE	O ASSETS					
	Land					12
	Land improvements					13
	Less: Accumulated depreciation	()	()	()	()	14
15	Buildings					15
	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
	Less: Accumulated depreciation	()	()	()	()	22
	Major movable equipment					23
24	Less: Accumulated depreciation	()	()	()	()	24
25	Minor equipment - Depreciable					25
	Minor equipment nondepreciable					26
27	Other fixed assets					27
28	TOTAL FIXED ASSETS					28
OTH	(sum of lines 12 - 27)					
						29
29 30	Investments Deposits on leases					30
31	Due from owners/officers			+		31
32	Other assets					32
33	TOTAL OTHER ASSETS	-				33
33	(sum of lines 29 - 32)					33
34	TOTAL ASSETS					34
54	(sum of lines 11, 28 and 33)					J+
	(sum of mics 11, 20 and 33)	<u> </u>			ı	

^{() =} contra amount

Rev. 8 41-349

BALANCE SHEET	PROVIDER CCN:	PERIOD:	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type		FROM		
accounting records, complete the "General Fund" column only.)		TO		

			Specific			
		General	Purpose	Endowment	Plant	
	Liabilities and Fund	Fund	Fund	Fund	Fund	
	Balances	1	2	3	4	
	RENT LIABILITIES					
	Accounts payable					35
	Salaries, wages & fees payable					36
	Payroll taxes payable					37
38	Notes & loans payable (short term)					38
39	Deferred income					39
40	Accelerated payments					40
41	Due to other funds					41
42	Other current liabilities					42
43	TOTAL CURRENT LIABILITIES					43
	(sum of lines 35 - 42)					
LONG	G TERM LIABILITIES					
44	Mortgage payable					44
45	Notes payable					45
46	Unsecured loans					46
47	Loans from owners:					47
48	Other long term liabilities					48
49	Other (specify)					49
50	TOTAL LONG TERM LIABILITIES					50
	(sum of lines 44 - 49)					
51	TOTAL LIABILITIES					51
	(sum of lines 43 and 50)					
CAPI	TAL ACCOUNTS					
52	General fund balance					52
	Specific purpose fund					53
	Donor created - endowment fund					54
	balance - restricted					
55	Donor created - endowment fund					55
	balance - unrestricted					
56	Governing body created - endowment					56
	fund balance					
57						57
58	Plant fund balance - reserve for					58
20	plant improvement, replacement and					
	expansion					
59	TOTAL FUND BALANCES			 		59
3)	(sum of lines 52 thru 58)					
60	TOTAL LIABILITIES AND			 		60
00	FUND BALANCES					000
	(sum of lines 51 and 59)					
	(sum of fines 31 and 39)		I .			

() = contra amount

41-350 Rev. 8

00 10	1 01111 01112 20 10 10			.170 (00110.)
STATEMENT OF CHANGES IN FUND BALANCES		PROVIDER CCN:	PERIOD:	WORKSHEET G - 1
			FROM	
			TO	

		Genera	al Fund	Special Purpose Fund		Endowment Fund		Plant Fund		Т
		1	2	3	4	5	6	7	8	1
1 Fu	und balances at beginning of period									1
	fet income (loss) (from Wkst. G-3, line 31)									2
3 To	otal (sum of line 1 and line 2)									3
4 Ac	dditions (credit adjustments)									4
5										5
6										6
7										7
8										8
9										9
10 To	otal additions (sum of lines 5 - 9)									10
	ubtotal (line 3 plus line 10)									11
12 De	reductions (debit adjustments)									12
13										13
14										14
15										15
16										16
17										17
	otal deductions (sum of lines 13 - 17)									18
19 Fu	und balance at end of period per balance sheet (line 11 - line 18)									19

Rev. 7 41-351

1190 (Cont.)	1 01011 01110 25 10 1				00 10
STATEMENT OF PATIENT REVENUES	PROVIDER CCI	V:	PERIOD:	WORKSHEET G-2	
AND OPERATING EXPENSES			FROM	PARTS I & II	
			то		
	•		_		

		TO	······································	
RT I - PATIENT REVENUES				
	INPATIENT	OUTPATIENT	TOTAL	Т
Revenue Center	1	2	3	7
eneral Inpatient Routine Care Services				
1 Skilled nursing facility				
2 Nursing facility				
3 ICF/IID				
4 Other long term care				
5 Total general inpatient care services				
(sum of lines 1 - 4)				
ll Other Care Service				
6 Ancillary services		_		
7 Clinic				
8 Home health agency				
9 Ambulance		+		1
10 RHC/FQHC		+		+-
11 CMHC		+		1
12 Hospice				1
13 Other (specify)				1
14 Total patient revenues (sum of lines 5 - 13)				1
(transfer to Wkst. G-3, col. 3, line 1)				
2 Add (Specify)				H
3				
4				
5				
6		_		
7		+ +		Н
8 Total Additions (sum of lines 2 - 7)				+
9 Deduct (Specify)				
10				
11		1		1
12		+		1
13		+ +		1
14 Total Deductions (sum of lines 9 - 13)				1
				1

15 Total Operating Expenses (sum of lines 1 and 8, minus line 14)

41-352 Rev. 7

15

	EMENT OF REVENUES EXPENSES	PROVIDER CCN:	PERIOD : FROMTO	WORKSHEET G-3
1	Total patient revenues (from Wkst. G-2, Pt. 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 (form Wkst. G-2, Pt. II, line 15)			4
5	Net income from service to patients (line 3 minus 4)			5
	Other income:			
6	Contributions, donations, bequests, etc.			6
7	Income from investments			7
8	Revenues from communications (telephone and internet service)			8
9	Revenue from television and radio service			9
10	Purchase discounts			10
11	Rebates and refunds of expenses			11
12	Parking lot receipts			12
13	Revenue from laundry and linen service			13
14	Revenue from meals sold to employees and guests			14
15	Revenue from rental of living quarters			15
16	Revenue from sale of medical and surgical supplies to other than	patients		16
17	Revenue from sale of drugs to other than patients			17
18	Revenue from sale of medical records and abstracts			18
19	Tuition (fees, sale of textbooks, uniforms, etc.)			19
20	Revenue from gifts, flower, coffee shops, canteen			20
21	Rental of vending machines			21
22	Rental of skilled nursing space			22
23	Governmental appropriations			23
25	Other miscellaneous revenue (specify) Total other income (sum of lines 6 - 24)			24
26				25
27	Other expenses (specify)			27
29				28
	Total other expenses (sum of lines 27 - 29)			30
	Net income (or loss) for the period (line 26 minus line 30)			31
31	rice income (or ioss) for the period (line 20 fillings line 30)			31

Rev. 7 41-353

	LYSIS OF SNF-BASED E HEALTH AGENCY COSTS						PROVIDER CCN HHA CCN:	:	PERIOD : FROM TO		WORKSHEET H	
		SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	10	
	ERAL SERVICE COST CENTERS											
	Capital Related - Bldgs. and Fixtures											1
	Capital Related - Movable Equipment											2
	Plant Operation & Maintenance											3
4	Transportation (see instructions)											4
	Administrative and General											5
	REIMBURSABLE SERVICES											
	Skilled Nursing Care											6
	Physical Therapy											7
	Occupational Therapy											8
	Speech Pathology											9
_	Medical Social Services											10
	Home Health Aide											11
	Supplies (see instructions)											12
	Drugs											13
	DME											14
	Telemedicine											15
	NONREIMBURSABLE SERVICES											
	Home Dialysis Aide Services											16
	Respiratory Therapy											17
	Private Duty Nursing											18
	Clinic											19
	Health Promotion Activities											20
	Day Care Program											21
	Home Delivered Meals Program											22
23	Homemaker Service											23
	All Others											24
25	Total (sum of lines 1-24)						1	1				25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

41-354 Rev. 7

0000			1 OIU	1 CIVID 23 10 1			PERIOR		THE THE THE	
COS	Γ ALLOCATION - HHA GENERAL SERVICE COST				PROVIDER CCN:		PERIOD :		WORKSHEET H-1	i
					HILA CON		FROM TO		PART I	
					HHA CCN:		10			
		NET EXPENSES	CAP	PITAL					+	T
		FOR COST	RELATE	D COSTS						
		ALLOCATION			PLANT			ADMINIS-		
		(from Wkst. H,	BLDGS. &	MOVABLE	OPERATION &	TRANS-	SUBTOTAL	TRATIVE	TOTAL	
		col. 10)	FIXTURES	EQUIPMENT	MAINTENANCE	PORTATION	(cols. 0 through 4)	& GENERAL	(cols. 4A + 5)	
		0	1	2	3	4	4A	5	6	1
GEN	ERAL SERVICE COST CENTERS									
1	Capital Related - Bldgs. and Fixtures									1
2	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA	REIMBURSABLE SERVICES									
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
	Drugs									13
14	DME									14
15	Telemedicine									15
HHA	NONREIMBURSABLE SERVICES									
16	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
	Health Promotion Activities									20
21	Day Care Program									21
22	Home Delivered Meals Program									22
23	Homemaker Service									23
24	All Others									24
25	Total (sum of lines 1-24)									25

Rev. 9 41-355

COST ALLOCATION - HHA STATISTICAL BASIS					PROVIDER CCN:		PERIOD : FROM		WORKSHEET H-1, PART II	
					HHA CCN:		то			
			CAF	PITAL					+	Т
				ED COSTS	PLANT			ADMINIS-		
			BLDGS. &	MOVABLE	OPERATION &			TRATIVE		
		NET EXPENSES	FIXTURES	EQUIPMENT	MAINTENANCE	TRANS-		& GENERAL		
		FOR COST	(Square	(Dollar Value	(Square	PORTATION	RECONCIL-	(Accumulated		
		ALLOCATION	Feet)	or Square Feet)	Feet)	(Mileage)	IATION	Cost)	TOTAL	
		0	1	2	3	4	5A	5	6	_
GENI	ERAL SERVICE COST CENTERS									
1	Capital Related - Bldgs. and Fixtures									1
	Capital Related - Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
HHA	REIMBURSABLE SERVICES									
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
	Medical Social Services									10
11	Home Health Aide									11
12	Supplies									12
13	Drugs									13
	DME									14
15	Telemedicine									15
HHA	NONREIMBURSABLE SERVICES									
	Home Dialysis Aide Services									16
17	Respiratory Therapy									17
18	Private Duty Nursing									18
19	Clinic									19
20	Health Promotion Activities									20
21	Day Care Program									21
	Home Delivered Meals Program									22
	Homemaker Service									23
	All Others									24
25	Total (sum of lines 1-24)									25
	Cost to be allocated									26
	Unit Cost Multiplier				1					2.7

41-356 Rev. 9

11-12			FUKI	VI CIVIS-2340-			T		4190 (0	
ALLOCATION OF GENERAL SERVICE					PROVIDER CCN:		PERIOD:	WORKSHEET H-2,		
COSTS TO HHA COST CENTERS							FROM		PART I	
					HHA CCN:		то			
-	From		I CA	PITAL		Γ		Γ		1
	Wkst.	ННА		ED COSTS						
	H-1,	TRIAL	KELATI	D C0313	-	SUBTOTAL	ADMINIS-		LAUNDRY	
	Pt. I,	BALANCE	BLDGS. &	MOVABLE	EMPLOYEE	(cols. 0	TRATIVE &	OPERATION	& LINEN	
	col. 6,	(1)	FIXTURES	EQUIPMENT	BENEFITS	through 3)	GENERAL	OF PLANT	SERVICE	
HHA COST CENTER	line	0	1	2	3	3A	A	5	6	+
1 Administrative and General	5	0	1		3	371	7			1
2 Skilled Nursing Care	6								+	2
3 Physical Therapy	7			 		 		 	†	3
4 Occupational Therapy	8			<u> </u>		<u> </u>		<u> </u>	+	4
5 Speech Pathology	9									5
6 Medical Social Services	10									6
7 Home Health Aide	11									7
8 Supplies	12									8
9 Drugs	13									9
10 DME	14									10
11 Telemedicine	15									11
12 Home Dialysis Aide Services	16									12
13 Respiratory Therapy	17									13
14 Private Duty Nursing	18									14
15 Clinic	19									15
16 Health Promotion Activities	20									16
17 Day Care Program	21									17
18 Home Delivered Meals Program	22									18
19 Homemaker Service	23									19
20 All Others	24									20
21 Totals (sum of lines 1-20) (2)										21
22 Unit Cost Multiplier: column 18, line 1										22
divided by the sum of column 18,										
line 21, minus column 18, line 1,										
rounded to 6 decimal places.										

⁽¹⁾ Column 0, line 21 must agree with Wkst. A, col. 7, line 70.

Rev. 4 41-357

⁽²⁾ Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS					PROVIDER CCN: HHA CCN:		PERIOD: FROM TO		2,
	HHA COST CENTER	HOUSE KEEPING	DIETARY 8	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY 11	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	Administrative and General	,	Ü		10	11	12	+ 13	1
2	Skilled Nursing Care							+	2
3	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
	Drugs								9
	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1								22
	divided by the sum of column 18,								
	line 21, minus column 18, line 1,								
	rounded to 6 decimal places.								

41-358 Rev. 4

⁽²⁾ Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

11-12		FORM	CMS-2540-10	<i>)</i>				4190 (C	<i>ν</i> ΟΠι. <i>)</i>
ALLOC	CATION OF GENERAL SERVICE			PROVIDER CCN:		PERIOD:		WORKSHEET H-2,	,
COSTS	TO HHA COST CENTERS					FROM		PART I	
				HHA CCN:		TO			
		NURSING		SUBTOTAL			ALLOCATED		
		AND ALLIED	OTHER	(sum of	POST		HHA		
		HEALTH	GENERAL	cols. 3A	STEPDOWN	SUBTOTAL	A&G	TOTAL	
		EDUCATION	SERVICE	through 15)	ADJUSTMENTS	(cols. 16 ± 17)	(see Pt. II)	HHA COSTS	
	HHA COST CENTER	14	15	16	17	18	19	20	
	Administrative and General								1
	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
	Medical Social Services								6
7	Home Health Aide								7
8 5	Supplies								8
	Drugs								9
10	DME								10
	Telemedicine								11
	Home Dialysis Aide Services								12
	Respiratory Therapy								13
	Private Duty Nursing								14
	Clinic								15
	Health Promotion Activities								16
	Day Care Program						<u> </u>		17
	Home Delivered Meals Program								18
	Homemaker Service								19
	All Others								20
	Totals (sum of lines 1-20) (2)								21
	Unit Cost Multiplier: column 18, line 1								22
	divided by the sum of column 18,						1		4
	line 21, minus column 18, line 1,						1		4
1	rounded to 6 decimal places.						1		4

⁽²⁾ Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

Rev. 4

	OCATION OF GENERAL SERVICE IS TO HHA COST CENTERS			PROVIDER CCN:		PERIOD : FROM		WORKSHEET H-2 PART II	2,
STAT	TISTICAL BASIS			HHA CCN:		то			
			PITAL						T
			D COSTS			ADMINIS-		LAUNDRY	
		BLDGS. &	MOVABLE	EMPLOYEE		TRATIVE &	OPERATION	& LINEN	
		FIXTURES	EQUIPMENT	BENEFITS		GENERAL	OF PLANT	SERVICE	
		(Square	(Dollar Value	(Gross	RECONCIL-	(Accumulated	(Square	(Pounds of	
		Feet)	or Square Feet)	Salaries)	IATION	Cost)	Feet)	Laundry)	
	HHA COST CENTER	1	2	3	4A	4	5	6	
	Administrative and General								1
	Skilled Nursing Care								2
	Physical Therapy								3
	Occupational Therapy								4
	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
	Supplies								8
9	Drugs								9
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
	Total cost to be allocated								22
23	Unit Cost Multiplier								23

41-360 Rev. 4

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	T ORD	I CMS-2340-10	PROVIDER CCN: HHA CCN:		PERIOD : FROMTO		WORKSHEET H-2, PART II	
HHA COST CENTER	HOUSE- KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS- TRATION (Direct Nursing Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)	
1 Administrative and General			,	10	- 11	12	13	1
2 Skilled Nursing Care								2
3 Physical Therapy								3
4 Occupational Therapy								4
5 Speech Pathology								5
6 Medical Social Services								6
7 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Telemedicine								11
12 Home Dialysis Aide Services								12
13 Respiratory Therapy								13
14 Private Duty Nursing								14
15 Clinic								15
16 Health Promotion Activities								16
17 Day Care Program								17
18 Home Delivered Meals Program								18
19 Homemaker Service								19
20 All Others								20
21 Totals (sum of lines 1-20)								21
22 Total cost to be allocated								22
23 Unit Cost Multiplier								23

Rev. 4

+170 (Com.)	TORM	CM5-25-0-1			PERIOD :			1-12
ALLOCATION OF GENERAL SERVICE				PROVIDER CCN:			WORKSHEET H-2,	
COSTS TO HHA COST CENTERS					FROM		PART II	
STATISTICAL BASIS			HHA CCN:		то			
		1		1				
	NURSING							
	AND ALLIED	OTTED	ar in more in a					
	HEALTH	OTHER	SUBTOTAL	родт		111 OG 1 PPP		
	EDUCATION	GENERAL	(sum of	POST		ALLOCATED		
	(Assigned	SERVICE	cols. 3A	STEPDOWN	SUBTOTAL	HHA A&G	TOTAL	
ANNA COORT OF ATTER	Time)	(SPECIFY)	through 15)	ADJUSTMENTS	(cols. 16 ± 17)	(see Pt. II)	HHA COSTS	-
HHA COST CENTER	14	15	16	17	18	19	20	+
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 Home Health Aide								7
8 Supplies								8
9 Drugs								9
10 DME								10
11 Telemedicine								11
12 Home Dialysis Aide Services								12
13 Respiratory Therapy								13
14 Private Duty Nursing								14
15 Clinic								15
16 Health Promotion Activities								16
17 Day Care Program								17
18 Home Delivered Meals Program								18
19 Homemaker Service								19
20 All Others								20
21 Totals (sum of lines 1-20)								21
22 Total cost to be allocated								22
23 Unit Cost Multiplier								23

41-362 Rev. 4

APPC	APPORTIONMENT OF PATIENT SERVICE COSTS									PERIOD : FROM TO		WORKSHEET H-3, Parts I & II			
											10				
	Check applicable box:		[] Title V	[] Title	XVIII	[] Title XIX					•		•		
PART	I - COMPUTATION OF	THE AG	GREGATE PI	ROGRAM C	OST										
Cost	Per Visit Computation	From,	Facility	Shared	Total		Average		Program Visits			Cost of Services			
		Wkst.	Costs	Ancillary	HHA		Cost		Part I	3		I	Part B	Total	
		H-2,	(from	Costs	Costs		Per Visit		Not Subject	Subject		Not Subject	Subject	Program Cost	
		Pt. I,	Wkst. H-2.	(from	(col. 1 +	Total	(col. 3		to Deductibles	to Deductibles		to Deductibles	to Deductibles	(sum of	
		col. 20,	Pt. I)	Pt. II)	col 2)	Visits	÷ col. 4)	Part A	& Coinsurance	& Coinsurance	Part A	& Coinsurance	& Coinsurance	cols. 9-10)	
	Patient Services	line -	1	2	3	4	5	6	7	8	9	10	11	12	1
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
3	Occupational Therapy	4													3
4	Speech Pathology	5													4
5	Medical Social Services	6													5
	Home Health Aide	7													6
	Total (sum of lines 1-6)														7
			•												•
Patien	t Services by CBSA												Program Visits		
														Part B	1
													Not Subject	Subject	1
											CBSA		to Deductibles	to Deductibles	
											No. (1)	Part A	& Coinsurance	& Coinsurance	
											1	2	3	4	1
8	Skilled Nursing Care										•				8
	Physical Therapy														9
	Occupational Therapy														10
	Speech Pathology														11
	Medical Social Services														12
	Home Health Aide														13
	Total (sum of lines 8-13)														14
	Total (sum of mes o 15)														
Suppl	ies and Drugs Cost			Facility					Pro	gram Covered Cha	rges		Cost of Services		
	utations			Costs	Shared		Total			Part I			Part E	3	t
comp			From	(from	Ancillary	Total	Charges			Not Subject	Subject		Not Subject	Subject	t
			Wkst. H-2,	Wkst.	Costs	HHA	(from	Ratio		to	to		to	to	
			Pt. I,	H-2,	(from	Cost	HHA	(col. 3		Deductibles &	Deductibles &		Deductibles &	Deductibles &	
			col. 20,	Pt. I)	Pt. II)	(cols. 1 + 2)	records)	÷ col. 4)	Part A	Coinsurance	Coinsurance	Part A	Coinsurance	Coinsurance	
	Other Patient Services		line -	1 (.1)	2	3	4	5	6	7	8	9	10	11	1
15	Cost of Medical Supplies		8			,	7	3	0	,	0		10	11	15
16	Cost of Drugs		9												16
10	Cost of Diugs		,												10
DADT	II - APPORTIONMENT	OF COST	L OE HHY SE	DVICES EI	IDMICHED	DV CHADED	CVILLED MIII	DCING EACH I	TV DEDARTMEN	тс					
FAKI	II - AFFORTIONMENT	Or COS	OF HHA SI	KVICES I'C	KNISHED	BI SHAKED					Classia	IIIIA Classada		T	1
							From	Cost to		Total HHA			Ancillary Costs	Transfer to	
							Wkst. C,		ntio	(from provid	er records)	(col. 1 x		Pt. 1 -	ł
1	Di						col. 3, line -	1		2		3		-	—
1	Physical Therapy						44							col. 2, line 2	1
2							45							col. 2, line 3	2
	Speech Pathology						46							col. 2, line 4	3
	Cost of Medical Supplies						48							col. 2, line 15	4
5	Cost of Drugs						49							col. 2, line 16	5
(1) T	The CBSA numbers flow from	wkst. S-	4, line 22, and s	ubscripts as i	ndicated show	ald be replicated	d on lines 8-13.								

 $\overline{\text{FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4144)}\\$

Rev. 9 41-363

4190	(Cont.) FORM	M CMS-2540-10					
CALCU	JLATION OF SNF-BASED HHA SURSEMENT SETTLEMENT	PROVIDER CCN: HHA CCN:	PERIOD : FROMTO	WORKSHEET H-4, Parts I & II	11-19		
	Check applicable box: [] Title V [] Title XVIII	[] Title XIX					
DADT	I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU	USTOMARY CHARGES					
17111	1 - COMPONITION OF THE ELEGEN OF REASONABLE COST ON CO	estownic charges	P	art B	Т		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	Description	1	2	3			
	able Cost of Part A & Part B Services				1 1		
2	Reasonable cost of services (see instructions) Total charges				1 2		
	ary Charges			_			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3		
4	Amount that would have been realized from patients liable				4		
	for payment for services on a charge basis had such						
	payment been made in accordance with 42 CFR 413.13(b)						
					5		
6	, , ,				6		
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7		
8	Excess of reasonable cost over customary charges				8		
O	(complete only if line 1 exceeds line 6)						
9	Primary payer amounts				9		
DADE	H. COMPUTATION OF ONE DAGED HAD DEPONDED FOR CONTRACT OF	A CENTER					
PAKI	II - COMPUTATION OF SNF-BASED HHA REIMBURSEMENT SETTLEM	MENI	Part A Services	Part B Services	т —		
	Description		1	2	-		
10	Total reasonable cost (see instructions)		1		10		
11	Total PPS Reimbursement - Full Episodes without Outliers				11		
12	Total PPS Reimbursement - Full Episodes with Outliers				12		
13	Total PPS Reimbursement - LUPA Episodes				13		
14	Total PPS Reimbursement - PEP Episodes				14		
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers				15 16		
16 17	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				17		
	DME Payments				18		
19	Oxygen Payments				19		
20	Prosthetic and Orthotic Payments				20		
	Part B deductibles billed to Medicare patients (exclude coinsurance)				21		
22	Subtotal (sum of lines 10 through 20 minus line 21)				22		
23	Excess reasonable cost (from line 8)				23		
24	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				24 25		
	Net cost (line 24 minus line 25)				26		
27	Allowable bad debts (from your records)				27		
28	Allowable bad debts for dual eligible beneficiaries (see instructions)				28		
29	Total costs - current cost reporting period (line 26 plus line 27)	-			29		
30	Other adjustments (see instructions) (specify)				30		
30.50	Demonstration payment adjustment amount before sequestration			+	30.50		
30.55	Demonstration payment adjustment amount after sequestration			+	30.55		
30.99	Sequestration amount (see instructions) Subtotal (see instructions)			+	30.99		
	· · · · · · · · · · · · · · · · · · ·			1	32		
					33		

34 Balance due provider/program (see instructions)
 35 Protested amounts (nonallowable cost report items) in accordance with

CMS Pub. 15-2, section 115.2

41-364 Rev. 9

34 35

HHA	LYSIS OF PAYMENTS TO SNF-BASED FOR SERVICES DERED TO PROGRAM BENEFICIARIES			PROVIDER CCN: HHA CCN:	PERIOD: FROM TO	WORKSHEET H-5		
					Part A		Part B	
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Description			1	2	3	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/contractor for services rendered in the cost reporting period. If none, enter zero.							2
3	List separately each retroactive lump sum							3.01
	adjustment amount based on subsequent revision of	Program	.02					3.02
	the interim rate for the cost reporting period	to	.03					3.03
	Also show date of each payment.	Provider	.04					3.04
	If none, write "NONE," or enter a zero. (1)		.05					3.05
			.50					3.50
		Provider	.51					3.51
		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) (Transfer to Wkst. H-4, Part II, column as appropriate, line 32)							4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement	Program	.01					5.01
	payment after desk review. Also show	to	.02					5.02
	date of each payment.	Provider	.03					5.03
	If none, write "NONE," or enter a zero. (1)	Provider	.50					5.50
		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 (balance	Program to Provider	.01					6.01
	due) based on the cost report (1)	Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7
8	Name of Contractor		Contra	actor Number				8

Rev. 7 41-365

⁽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.

ANALYSIS OF SNF-BASED RHC/FQHC COSTS			PROVIDER CCN: RHC/FQHC CCN:		PERIOD : FROM TO	WORKSHEET I-1			
	Check applicable box: [] RHC	[] FQHC							
		COMPEN- SATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 +/- col. 4)	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 +/- col.6) 7	
	TH CARE STAFF COSTS								
	Physician								1
	Physician Assistant								2
	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other health care staff costs								9
10	Subtotal (sum of lines 1 - 9)								10
	S UNDER AGREEMENT								
11	Physician Services Under Agreement								11
	Physician Supervision Under Agreement								12
	Other costs under agreement								13
	Subtotal (sum of lines 11 - 13)								14
	ER HEALTH CARE COSTS								
	Medical Supplies								15
	Transportation (Health Care Staff)								16
	Depreciation - Medical Equipment								17
	Professional Liability Insurance								18
	Other health care costs								19
	Subtotal (sum of lines 15 - 19)								21
	Total cost of health care services							 	22
	(sum of lines 10, 14, and 21)								1 22
COST	S OTHER THAN RHC / FQHC SERVICES								
	Pharmacy								23
	Dental								24
	Optometry							 	25
	All other non reimbursable costs							 	26
	Total nonreimbursable costs (sum of lines 23 - 26)							 	28
	FOHC OVERHEAD								20
	RHC/FQHC costs								29
	Administrative costs				 			 	_
					-			 	30
	Total RHC/FQHC overhead (sum of lines 29-30)							 	31

41-366 Rev. 7

^{*} The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total RHC/FQHC costs in column 7, line 32 of this worksheet.

11-1	1-19			FORM CM	S-2540-10	4190 (Cont.)			
	OCATION OF OVERHI NF-BASED RHC/FQHO			PROVIDER C		PERIOD : FROM TO		WORKSHEET I-2	<u> </u>
C	heck applicable box:	[] RHC	[] FQHC	•		•			
PART	I - VISITS AND P	RODUCTIVITY							
				Number of FTE Personnel	Total Visits	Productivity Standard (1) 3	Minimum Visits (col. 1 x col. 3)	Greater of Column 2 or Column 4	
1	Physicians					4200			1
2	Physician Assistants					2100			2
3	Nurse Practitioners					2100			3
4	Subtotal (sum of lines	: 1 - 3)							4
5	Visiting Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worke	r							7
	Medical Nutrition The								8
9	Diabetes Self Manage	ment Training (FQHC only	7)						9
10	Total FTEs and visits								10
11	Physician Services Un	der Agreements							11
			VABLE COST APPLICAE	BLE TO SNF-BASE	ED RHC / FQHO	C SERVICES			
		are services (from Wkst. I							12
		costs (from Wkst I-1, col							13
		excluding overhead (sum o							14
		services (line 12 divided b							15
	_	erhead (from Wkst. I-1, co							16
17	Darant provider overhe	and allocated to PHC/FOH	C (can instructions)					I	17

18 Total overhead (sum of lines 16 and 17)

Total allowable cost of RHC/FQHC services (lines 15 X line 18)
 Total allowable cost of RHC/FQHC services (sum of lines 12 and 19)

Rev. 9 41-367

⁽¹⁾ Productivity standards established by CMS are: 4200 visits for each physician, and 2100 visits for each nonphysician practitioner.

4190 (C	ont.) FOR	FORM CMS-2540-10				
	TION OF REIMBURSEMENT ENT FOR SNF-BASED RHC/FQHC SERVICES	PROVIDER CCN: RHC/FQHC CCN:	PERIOD: FROMTO	WORKSHEET I-3		
	Charles Table Law] Title XIX				
	Check applicable box: [] Title V [] Title XVIII [Check applicable box: [] RHC [] F	FOHC				
	Check applicable box. [] KHC [] I	·QHC				
PART I -	DETERMINATION OF RATE FOR SNF-BASED RHC/FQHC SERVICE	ES				
1	Total allowable cost of RHC/FQHC services (from Wkst. I-2, Pt. II, line 20)				1	
2	Cost of vaccines and their administration (from Wkst. I-4, line 15)				2	
3	Total allowable cost excluding vaccine (line 1 minus line 2)				3	
4	Total FTEs and visits (from Wkkst. I-2, col. 5, line 10)				4	
5	Physicians' visits under agreement (from Wkst. I-2, col. 5, line 11)				5	
6	Total adjusted visits (line 4 plus line 5)				6	
7	Adjusted cost per visit (line 3 divided by line 6)				7	
CALCULA	ATION OF LIMIT		Prior to	On or after		
Lines 8 thre	ough 14: Fiscal year RHC/FQHC use columns 1 and 2.		January 1	January 1		
Lines 8 thre	ough 14: Calendar year RHC/FQHC use column 2 only.		1	2		
	Rate per visit limit (from your contractor)				8	
9	Rate for Program covered visits (see instructions)				9	
	CALCULATION OF SETTLEMENT FOR SNF-BASED RHC/FQHC SER					
	Program covered visits excluding mental health services (from contractor reco	ords)			10	
	Program cost excluding costs for mental health services (line 9 x line 10)				11	
	Program covered visits for mental health services (from contractor records)				12	
13	Program covered cost for mental health services (line 9 x line 12)				13	
	Limit adjustment for mental health services (see instructions)				14	
15	Total Program cost (sum of line 11 cols. 1 and 2, plus line 14 cols. 1 and 2)				15	
15.01	Total Program charges (see instructions) (from contractor records)				15.01	
15.02	Total Program preventive charges (see instructions) (from provider records)				15.02	
15.03	Total Program preventive costs ((line 15.02/line 15.01) times line 15)				15.03	
15.04	Total Program non-preventive costs ((line 15 minus lines 15.03 and 17) times	.80)			15.04	
15.05	Total Program cost (see instructions)				15.05	
	Primary payer amounts				16	
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor				17	
18 19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (fr	om contractor records)			18 19	
20	Net Program cost excluding vaccines (see instructions)				20	
20	Program cost of vaccines and their administration (from Wkst. I -4, line 16)				20	
22	Total reimbursable Program cost (line 19 plus 20) Allowable bad debts				21	
22.01	Reimbursable bad debts (see instructions)				22.01	
22.01	Allowable bad debts for dual eligible beneficiaries (see instructions)				23	
24	Other adjustments				24	
24.50	Demonstration payment adjustment amount before sequestration				24.50	
24.55	Demonstration payment adjustment amount after sequestration Demonstration payment adjustment amount after sequestration			+	24.55	
25	Net reimbursable amount (see instructions)				25	
	Sequestration amount (see instructions)			+	25.01	
26	Interim payments (from Wkst. I-5, line 4)				26	
	1 2 1 1 1 1 1 1 1 1					

Tentative settlement (for contractor use only)
 Balance due RHC/FQHC/Program (see instructions)
 Protested amounts (nonallowable cost report items) in accordance with CMS Publ. 15-2, § 115.2

41-368 Rev. 9

CALC	CULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. I-1, col. 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the RHC/FQHC (from Wkst. I-1, col. 7, line 22)			6
7	Total overhead (from Wkst. I-2, line 19)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and their administration (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of			15
	cols. 1 and 2, line 10) (transfer to Wkst. I-3, line 2)			
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of			16
	cols. 1 and 2, line 14) (transfer to Wkst. I-3, line 20)			

Rev. 7 41-369

4190	J (Colit.)	OKM CMS-2340-10				06-10
ANA	LYSIS OF PAYMENTS TO	PROVIDER CCN:		PERIOD :	WORKSHEET I - 5	
SNF-	BASED RHC/FOHC FOR SERVICES RENDERED		1	FROM		
		RHC/FOHC CCN:		ТО		
				-		
			-			
	Check applicable box: [] RHC	[] FQHC				
				mm/dd/yyyy	Amount	
	Description		-	1	2	
1	Total interim payments paid to RHC/FQHC					1
2	Interim payments payable on individual bills, either submitted					2
	or to be submitted to the intermediary/contractor for services					
	rendered in the cost reporting period. If none, enter zero.					
3	List separately each retroactive lump sum		.01			3.01
	adjustment amount based on subsequent revision of	Program	.02			3.02
	the interim rate for the cost reporting period	to	.03			3.03
	Also show date of each payment.	RHC/FQHC	.04			3.04
	If none, write "NONE," or enter a zero. (1)		.05			3.05
			.50			3.50
		RHC/FQHC	.51			3.51
		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 Wkst. I-3, line 26)					
	TO BE COMPLETED BY CONTRACTOR	_				
5	List separately each tentative settlement	Program	.01			5.01
	payment after desk review. Also show	to	.02			5.02
	date of each payment.	RHC/FQHC	.03			5.03
	If none, write "NONE," or enter a zero. (1)	RHC/FQHC	.50			5.50
		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 (balance	Program to RHC/FQHC	.01			6.01
	due) based on the cost report (1)	RHC/FQHC to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
- 8	Name of Contractor	Contrac	tor Number		8	

41-370 Rev. 7

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

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC		PROVIDER CCN: COMPONENT CCN:		PERIOD : FROM TO		WORKSHEET J-1 PART I		
	COMPONENT COST CENTER	NET EXPENSES FOR COST ALLOCATION 0	CAPITAL REI BUILDS. & FIXTURES 1	ATED COST MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 3	SUBTOTAL (cols. 0 through 3)	ADMINIS- TRATIVE & GENERAL 4	
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 Therapy							11
12	Family Counseling							12
	Diagnostic Services							13
14	Appr. Patient Training & Education							14
	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

Totals (sum of lines 1-21) (1)Unit Cost Multiplier (see instructions)

⁽¹⁾ Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

117	o (cont.)	CIVID 23 10 10					11 12
	OCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:		PERIOD :		WORKSHEET J-1	
ТО	COST CENTERS FOR CMHC	COMPONENT CCN:		FROM TO		PART I	
		L		1			
		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE - KEEPING	DIETARY	NURSING ADMINIS- TRATION	
	COMPONENT COST CENTER	5	6	7	8	9	
	Administrative and General						1
	Skilled Nursing Care						2
	Physical Therapy						3
	Occupational Therapy						4
	Speech Pathology				<u> </u>		5
	Medical Social Services						6
	Respiratory Therapy						7
	Psychiatric/Psychological Services						8
9	Individual Therapy						9
	Group Therapy						10
	Individualized Activity Therapy						11
	Family Counseling						12
	Diagnostic Services						13
	Appr. Patient Training & Education						14
	Prosthetic and Orthotic Devices						15
16	Drugs and Biologicals						16
17	Medical Supplies						17
18	Medical Appliances						18
	Durable Medical Equipment - Rented						19
	Durable Medical Equipment - Sold						20
21	All Other						21
22	Totals (sum of lines 1-21) (1)						22
23	Unit Cost Multiplier (see instructions)						23

41-372 Rev. 4

⁽¹⁾ Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

	· -	10111					(, - 0 - 1 - 1
	OCATION OF GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD:		WORKSHEET J-1	
TO C	COST CENTERS FOR CMHC				FROM		PART I	
			COMPONENT CCN:		то			
					1	NURSING &	T	\neg
		CENTRAL		MEDICAL		ALLIED	OTHER	
		SERVICES		RECORDS	SOCIAL	HEALTH	GENERAL	
		& SUPPLY	PHARMACY	& LIBRARY	SERVICES	EDUCATION	SERVICE	
	COMPONENT COST CENTER	10	11	12	13	14	15	
1	Administrative and General							1
2	Skilled Nursing Care							2
	Physical Therapy							3
	Occupational Therapy							4
	Speech Pathology							5
	Medical Social Services							6
	Respiratory Therapy							7
	Psychiatric/Psychological Services							8
	Individual Therapy							9
	Group Therapy							10
	Individualized Activity Therapy							11
	Family Counseling							12
	Diagnostic Services							13
	Appr. Patient Training & Education							14
	Prosthetic and Orthotic Devices							15
	Drugs and Biologicals							16
	Medical Supplies							17
	Medical Appliances							18
	Durable Medical Equipment - Rented							19
	Durable Medical Equipment - Sold							20
	All Other							21
	Totals (sum of lines 1-21) (1)							22
23	Unit Cost Multiplier (see instructions)							23

Rev. 4 41-373

⁽¹⁾ Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC		PROVIDER CCN: COMPONENT CCN:			PERIOD: FROM TO		WORKSHEET J-1 PART I	
	COMPONENT COST CENTER	SUBTOTAL 16	POST STEP-DOWN ADJUSTMENTS 17	SUBTOTAL 18	ALLOCATED A & G (see Pt. II) 19	TOTAL (sum of cols. 18 and 19 ()		
1	Administrative and General						1	
	Skilled Nursing Care						2	
	Physical Therapy						3	
	Occupational Therapy						4	
	Speech Pathology						5	
	Medical Social Services						6	
7	Respiratory Therapy						7	
	Psychiatric/Psychological Services						8	
	Individual Therapy						9	
	Group Therapy						10	
	Individualized Activity Therapy						11	
12	Family Counseling						12	
13	Diagnostic Services						13	
14	Appr. 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 Other						21	
	Totals (Sum of lines 1-21) (1)						22	
23	Unit Cost Multiplier (see instructions)						23	

41-374 Rev. 4

⁽¹⁾ Columns 0 through 18, line 22 must agree with the corresponding columns of Worksheet B, Part I, line 73, (subscripted line).

ALLOCATION OF GENERAL SERVICE COSTS TO COST CENTERS FOR CMHC		PERIOD: FROM	WORKSHEET J-1 PART II
	COMPONENT CCN:	TO	

	CAPITAL I	RELATED			ADMINIS-	T
	BUILDS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)	EMPLOYEE BENEFITS (Gross Salaries)	RECONCIL- IATION	TRATIVE & GENERAL (Accumulated Cost)	
COMPONENT COST CENTER	1	2	3	4A	4	
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 Therapy						11
12 Family Counseling						12
13 Diagnostic Services						13
14 App. 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 Other						21
22 Totals (sum of lines 1-21)						22
23 Total cost to be allocated						23
24 Unit Cost Multiplier						24

117	o (cont.)	1 Oldvi Civis 25 to 10					11 12
	OCATION OF GENERAL SERVICE COSTS	PROVIDER CCN:		PERIOD:		WORKSHEET J-1	
TO 0	COST CENTERS FOR CMHC			FROM	_	PART II	
		COMPONENT CCN:		то	_		
		PLANT	LAUNDRY			NURSING	
		OPERATION	& LINEN	HOUSE -		ADMINIS-	
		MAINTENANCE	SERVICE	KEEPING	DIETARY	TRATION	
		& REPAIRS	(Pounds of	(Hours of	(Meals	(Direct Nursing	
		(Square Feet)	Laundry)	Service)	Served)	Hours of Service)	
	COMPONENT COST CENTER	5	6	7	8	9	
	Administrative and General						1
	Skilled Nursing Care						2
	Physical Therapy						3
	Occupational Therapy						4
	Speech Pathology						5
	Medical Social Services						6
	Respiratory Therapy						7
	Psychiatric/Psychological Services						8
	Individual Therapy						9
	Group Therapy						10
	Individualized Activity Therapy						11
12	Family Counseling						12
13	Diagnostic Services						13
	App. Patient Training & Education						14
	Prosthetic and Orthotic Devices						15
	Drugs and Biologicals						16
	Medical Supplies						17
18	Medical Appliances						18
19	Durable Medical Equipment - Rented						19
20	Durable Medical Equipment - Sold						20
	All Other						21
22	Totals (sum of lines 1-21)						22
23	Total cost to be allocated						23
24	Unit Cost Multiplier					· I	24

41-376 Rev. 4

	OCATION OF GENERAL SERVICE COSTS		PROVIDER CCN:		PERIOD :		WORKSHEET J-1	-
10 (COST CENTERS FOR CMHC		COMPONENT CCN:		FROMTO	 	PART II	
				•				$\overline{}$
		CENTRAL SERVICES & SUPPLY (Costed Requisitions)	PHARMACY (Costed Requisitions)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICES (Time Spent)	NURSING & ALLIED HEALTH EDUCATION (Assigned Time)	OTHER GENERAL SERVICE ()	
	COMPONENT COST CENTER	10	11	12	13	14	15	Ь.
	Administrative and General						<u> </u>	1
	Skilled Nursing Care							1 2
3	Physical Therapy						 	3
	Occupational Therapy							4
	Speech Pathology Medical Social Services							1 3
							 	
	Respiratory Therapy						 	- /
	Psychiatric/Psychological Services Individual Therapy						+	9
	Group Therapy	+						10
	Individualized Activity Therapy						+	11
	Family Counseling						+	12
	Diagnostic Services						+	13
	App. Patient Training & Education						+	14
	Prosthetic and Orthotic Devices						+	15
	Drugs and Biologicals						+	16
	Medical Supplies							17
	Medical Appliances						+	18
	Durable Medical Equipment - Rented						+	19
	Durable Medical Equipment - Sold						+	20
	All Other	†	†				† 	21
	Totals (sum of lines 1-21)	†					†	22
	Total cost to be allocated	†					†	23
	Unit Cost Multiplier	†		†	†	†	+	24

4190 (Cont.)	FORM CMS-2540-10	11-12

1150 (Cont.)	1 Oldvi Civis 25 10 10		11 12
COMPUTATION OF CMHC	PROVIDER CCN:	PERIOD:	WORKSHEET J - 2
REHABILITATION COSTS		FROM	PART I
	COMPONENT CCN:	TO	

PART I -	ADDODTIONMENT	OF CMHC COST CENTERS	7

	Total Costs		Ratio of	Title	e V	Title	XVIII	Title XIX		
	(from Wkst. J-1,	Total	Costs to		Costs		Costs		Costs	1
	Pt. I, col. 20)	Charges	Charges	Charges	(col. 3 x col. 4)	Charges	(col. 3 x col. 6)	Charges	(col. 3 x col. 8)	
	1	2	3	4	5	6	7	8	9	1
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 Therapy										1
12 Family Counseling										1
13 Diagnostic Services										1
14 App. 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 Other										2
22 Totals (sum of lines 2-21)										2

41-378 Rev. 4

1117	20.010		1170 (Come		
COMPUTATION OF CMHC	PROVIDER CCN:	PERIOD:	WORKSHEET J - 2		
REHABILITATION COSTS		FROM	PART II		
	COMPONENT CCN:	TO			

PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED BY SHAF	RED DEPARTMENTS							
	Ratio of	Title	e V	Title XVIII		Title XIX		
	Costs to		Costs		Costs		Costs	1
	Charges	Charges	(col. 3 x col. 4)	Charges	(col. 3 x col. 6)	Charges	(col. 3 x col. 8)	
	3	4	5	6	7	8	9	
23 Oxygen (Inhalation) Therapy								23
24 Physical Therapy								24
25 Occupational Therapy								25
26 Speech Pathology								26
27 Medical Supplies Charged to Patients								27
28 Drugs Charged to Patients								28
29 Other Costs Furnished by shared Departments								29
30 Total (sum of lines 23 through 29)								30
31 Total component cost (sum of Pt. I, line 22 and Pt. II, line 30)						_		31
(Transfer to Wkst. J-3)								

⁽¹⁾ Part II - From Wkst. C, col. 3, lines as applicable

Rev. 9 41-379

1170 (Cont.)	ORIVI CIVID 2540 10			10 17	
FOR SN	LATION OF REIMBURSEMENT SETTLEMENT F-BASED COMMUNITY MENTAL HEALTH CENTER	PROVIDER CCN:	PERIOD : FROM	WORKSHEET J-3		
SERVIC	ES	COMPONENT CCN:	то	—		
	Check applicable box: [] Title V [] Title XVIII [] T	itle XIX				
	eneck application box. [] That i [] The Zi in [] T	Hie Alfa				
				PROGRAM		
				COST		
1	Cost of component services (from Wkst. J-2, Pt. II, line 31)				1	
2	PPS payments received excluding outliers				2	
3	Outlier payments				3	
4	Primary payer payments				4	
5	Total reasonable cost (see instructions)				5	
CUSTO	MARY CHARGES			<u>-</u>		
6	Total charges for program services				6	
7	Excess of customary charges over reasonable cost (see instructions)				7	
	Excess of reasonable cost over customary charges (see instructions)				8	
COMPU	TATION OF REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)				9	
	Part B deductible billed to program patients				10	
	Part B coinsurance billed to program patients (from provider records)				11	
12					12	
	Allowable bad debts (from provider records) (see instructions)				13	
13.01	Reimbursable bad debts (see instructions)				13.01	
14					14	
15					15	
16	2				16	
	Demonstration payment adjustment amount before sequestration				16.50	
16.55	,				16.55	
17	Total cost (see instructions)				17	
	Sequestration amount (see instructions)				17.01	
18	Interim payments (see instructions)				18	
19					19	
20					20	
2.1	Protested amounts (nonallowable cost report items) in accordance with CM	IS Pub. 15-2, section 115.2			21	

 $FORM\ CMS-2540-10\ (10/2019)\ (INSTRUCTIONS\ FOR\ THIS\ WORKSHEET\ ARE\ PUBLISHED\ IN\ CMS\ PUB.\ 15-2,\ SECTION\ 4155)$

41-380 Rev. 9

08-16	FORM CMS-2540-10		4190 (Cont.)				
ANALYSIS OF PAYMENTS TO	PROVIDER CCN:	PERIOD :	WORKSHEET J - 4				
SNF-BASED CMHC		FROM					
FOR SERVICES RENDERED	COMPONENT CCN:	ТО					
TO PROGRAM BENEFICIARIES							
		mm/dd/yyyy	Amount				
Description		1	2				
1 Total interim payments paid to CMHC				1			
2 Interim payments payable on individual bills, either submitted				2			
or to be submitted to the intermediary/contractor for services							
rendered in the cost reporting period. If none, enter zero.							
3 List separately each retroactive lump sum		.01		3.01			
adjustment amount based on subsequent revision of	Program	.02		3.02			
the interim rate for the cost reporting period	to	.03		3.03			
Also show date of each payment.	Provider	.04		3.04			
If none, write "NONE," or enter a zero. (1)		.05		3.05			
		.50		3.50			
	Provider	.51		3.51			
	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		.99		3.99			
4 TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)	1			4			
(Transfer to Wkst. J-3: Pt. I, line 18)							
TO BE COMPLETED BY CONTRACTOR							
5 List separately each tentative	Program	.01		5.01			
settlement payment after desk review.	to	.02		5.02			
	Provider	.03		5.03			
Also show date of each payment.	Provider	.50		5.50			
If none, write "NONE," or enter a 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 (balance	Program to Provider	.01		6.01			
due) based on the cost report (1)	Provider to Program	.02		6.02			
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructi	ons)			7			
8 Name of Contractor		Contractor Number		8			
1							

⁽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.

Rev. 7 41-381

ANALYSIS OF HOSPICE COSTS							PROVIDER CCN:		PERIOD:		WORKSHEET K	
								FROM				
						HOSPICE CCN:		TO				
				CON-								
		EMPLOYEE		TRACTED								
	SALARIE		TRANSPOR-	SERVICES		TOTAL		SUBTOTAL		TOTAL		
	(from	(from	TATION	(from		(cols. 1	RECLASSI-	(col. 6	ADJUST-	(col. 8		
	Wkst. K-1) Wkst. K-2)	(see instruct.)	Wkst. K-3)	OTHER	through 5)	FICATION	± col. 7)	MENTS	± col. 9)		
COST CENTER DESCR		2	3	4	5	6	7	8	9	10		
GENERAL SERVICE COST CENTER	RS											
1 Capital Related Costs-Bldg. and	Fixt.										1	
2 Capital Related Costs-Movable	Equip.										2	
3 Plant Operation and Maintenance	ce										3	
4 Transportation - Staff											4	
5 Volunteer Service Coordination											5	
6 Administrative and General											6	
INPATIENT CARE SERVICE												
7 Inpatient - General Care											7	
8 Inpatient - Respite Care											8	
VISITING SERVICES												
9 Physician Services											9	
10 Nursing Care											10	
11 Nursing Care-Continuous Home	Care										11	
12 Physical Therapy	Caro										12	
13 Occupational Therapy											13	
14 Speech/ Language Pathology											14	
15 Medical Social Services											15	
16 Spiritual Counseling											16	
17 Dietary Counseling											17	
18 Counseling - Other											18	
19 Home Health Aide and Homem	aker										19	
20 HH Aide & Homemaker-Cont.											20	
21 Other	Home Care										21	
OTHER HOSPICE SERVICE COSTS											21	
22 Drugs, Biological and Infusion	Therany										22	
23 Analgesics	петару										23	
24 Sedatives / Hypnotics											24	
25 Other - Specify											25	
26 Durable Medical Equipment/Ox	vgen										26	
27 Patient Transportation	7,5011										27	
28 Imaging Services											28	
29 Labs and Diagnostics											29	
30 Medical Supplies											30	
31 Outpatient Services (including I	E/R Dent)		+	 	1				 		31	
32 Radiation Therapy	/R Dept.)										32	
33 Chemotherapy			1		1		1			1	33	
34 Other			+	 	1						34	
HOSPICE NONREIMBURSABLE SE	PVICE										34	
35 Bereavement Program Costs	KVICE										35	
36 Volunteer Program Costs		_	+								36	
37 Fundraising		_	+								37	
38 Other Program Costs		_	+								38	
38 Other Program Costs	9)	_	+	 					 	+	38	

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4157)

41-382 Rev. 7

	ICE COMPENSATION ANALYSIS RIES AND WAGES					PROVIDER CCN: HOSPICE CCN:		FROM TO		WORKSHEET K-1	
		ADMINIS- TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
	ΓΙΕΝΤ CARE SERVICE										
	Inpatient - General Care										7
	Inpatient - Respite Care										8
	ING SERVICES										
	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
13	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services										15
	Spiritual Counseling										16
	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
	HH Aide & Homemaker-Cont. Home Care										20
	Other										21
	ER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
31	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
34	Other										34
HOSP	ICE NONREIMBURSABLE SERVICE									.00	
	Bereavement Program Costs										35
	Volunteer Program Costs					1					36
	Fundraising										37
	Other Program Costs										38
39	Total (sum of lines 1 through 38)										39

⁽¹⁾ Transfer the amount in column 9 to Wkst. K, col. 1

	OYEE BENEFITS (PAYROLL RELATED)					HOSPICE CCN:		FROMTO	WORRSHILL I K-2		
		ADMINIS- TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	ALL OTTIEK	9	-
GENE	ERAL SERVICE COST CENTERS	1	-	3	7	,	O O	,	,		
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
	Administrative and General										6
	ΓΙΕΝΤ CARE SERVICE										
	Inpatient - General Care										7
	Inpatient - Respite Care										8
	ING SERVICES										
	Physician Services										9
	Nursing Care										10
	Nursing Care-Continuous Home Care										11
	Physical Therapy										12
	Occupational Therapy										13
	Speech/ Language Pathology										14
	Medical Social Services										15
	Spiritual Counseling										16
	Dietary Counseling										17
	Counseling - Other										18
	Home Health Aide and Homemaker										19
	HH Aide & Homemaker-Cont. Home Care										20
	Other										21
OTHE	ER HOSPICE SERVICE COSTS										
	Drugs, Biological and Infusion Therapy										22
	Analgesics										23
24	Sedatives / Hypnotics										24
25	Other - Specify										25
26	Durable Medical Equipment/Oxygen										26
27	Patient Transportation										27
28	Imaging Services										28
29	Labs and Diagnostics										29
	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
	Other										34
	ICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs										35
	Volunteer Program Costs										36
	Fundraising										37
	Other Program Costs										38
39	Total (sum of lines 1 through 38)										39

41-384 Rev. 4

⁽¹⁾ Transfer the amounts in column 9 to Wkst. K, col. 2

	CONTRATED SERVICES / PURCHASED SERVICES							FROM TO		WORKSHEET K-3	
		ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	8	9	
	ERAL SERVICE COST CENTERS										
	Capital Related Costs-Bldg. and Fixt.										1
	Capital Related Costs-Movable Equip.										2
	Plant Operation and Maintenance										3
	Transportation - Staff										4
	Volunteer Service Coordination										5
6	Administrative and General										6
	ΓΙΕΝΤ CARE SERVICE										
	Inpatient - General Care										7
	Inpatient - Respite Care										8
	ING SERVICES										
	Physician Services										9
10	Nursing Care										10
11	Nursing Care-Continuous Home Care										11
12	Physical Therapy										12
13	Occupational Therapy										13
14	Speech/ Language Pathology										14
	Medical Social Services										15
16	Spiritual Counseling										16
17	Dietary Counseling										17
18	Counseling - Other										18
19	Home Health Aide and Homemaker										19
20	HH Aide & Homemaker-Cont. Home Care										20
21	Other										21
OTHE	ER HOSPICE SERVICE COSTS										
22	Drugs, Biological and Infusion Therapy										22
23	Analgesics										23
24	Sedatives / Hypnotics										24
	Other - Specify										25
	Durable Medical Equipment/Oxygen										26
	Patient Transportation										27
	Imaging Services										28
29	Labs and Diagnostics										29
30	Medical Supplies										30
	Outpatient Services (including E/R Dept.)										31
32	Radiation Therapy										32
33	Chemotherapy										33
	Other										34
HOSE	ICE NONREIMBURSABLE SERVICE										
	Bereavement Program Costs										35
	Volunteer Program Costs					İ		1	1	1	36
	Fundraising										37
	Other Program Costs					İ		1	1	1	38
	Total (sum of lines 1 through 38)										39

Rev. 4 41-385

⁽¹⁾ Transfer the amounts in column 9 to Wkst. K, col. 4

COST ALLOCATION - HOSPICE GENERAL SERVICE COST					PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM TO		WORKSHEET K-4 PART I	
	NET EXPENSES FOR COST ALLOC. (1) (from	CAPITAL REI BUILDS. &	MOVABLE	PLANT OPERATION	TRANS-	VOLUNTEER SERVICE COORDI-	SUBTOTAL (cols. 0	ADMINIS- TRATIVE &		
	Wkst. K, col. 10)	FIXTURES	EQUIPMENT	& MAINT.	PORTATION	NATOR	through 5)	GENERAL	TOTAL	_
COST CENTER DESCRIPTIONS	0	1	2	3	4	5	5A	6	7	$\overline{}$
GENERAL SERVICE COST CENTERS										_
1 Capital Related Costs-Bldg. and Fixt.										1
2 Capital Related Costs-Movable Equip.										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff 5 Volunteer Service Coordination										5
6 Administrative and General									4	6
INPATIENT CARE SERVICE										6
										7
7 Inpatient - General Care 8 Inpatient - Respite Care									+	7 8
										8
VISITING SERVICES										9
9 Physician Services									+	_
10 Nursing Care									+	10 11
11 Nursing Care-Continuous Home Care									+	12
12 Physical Therapy									+	13
13 Occupational Therapy									+	13
14 Speech/ Language Pathology 15 Medical Social Services									+	15
16 Spiritual Counseling									+	16
17 Dietary Counseling					+				+	17
17 Dietary Counseling 18 Counseling - Other									+	18
19 Home Health Aide and Homemaker									+	19
20 HH Aide & Homemaker-Cont. Home Care									+	20
21 Other					+				+	20
OTHER HOSPICE SERVICE COSTS										21
22 Drugs, Biological and Infusion Therapy										22
22 Drugs, Biological and Illusion Therapy 23 Analgesics									+	23
24 Sedatives / Hypnotics									+	24
25 Other - Specify									+	25
26 Durable Medical Equipment/Oxygen									+	26
27 Patient Transportation									+	27
28 Imaging Services									+	28
29 Labs and Diagnostics									+	29
30 Medical Supplies									+	30
31 Outpatient Services (including E/R Dept.)					+				+	31
32 Radiation Therapy					+				+	32
33 Chemotherapy									+	33
34 Other									+	34
HOSPICE NONREIMBURSABLE SERVICE										77
35 Bereavement Program Costs										35
36 Volunteer Program Costs									+	36
37 Fundraising	+		 	1	1	1		 	 	37
38 Other Program Costs									+	38
20 Total (sum of lines 1 through 29)	+		†	1	+	1	1		+	20

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

41-386 Rev. 4

COST ALLOCATION - HOSPICE STATISTICAL BASIS					PROVIDER CCN:		PERIOD :		WORKSHEET K-4 PART II	
SIAI	ISTICAL BASIS				TANGER CONT		FROM		PARTII	
					HOSPICE CCN:		то			
		CADITAL DE	T ATTEN COOT	1				A D) (II) III		
		CAPITAL RE	LATED COST	DI ANIT		MOLUNTEED		ADMINIS-		
		DIW Da	MOVABLE	PLANT	TTD + NYG	VOLUNTEER		TRATIVE &		
		BUILDS.	EQUIPMENT	OPERATION	TRANS-	SERVICE		GENERAL		
		& FIXTURES	(Dollar Value or	& MAINT.	PORTATION	COORDINATOR	RECONCI-	(Accumulated		
		(Square Feet)	Square Feet)	(Square Feet)	(Mileage)	(Hours)	LIATION	Cost)	TOTAL	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6A	6	7	
	ERAL SERVICE COST CENTERS									
	Capital Related Costs-Bldg. and Fixt.									1
	Capital Related Costs-Movable Equip.									2
	Plant Operation and Maintenance									3
	Transportation - Staff									4
	Volunteer Service Coordination									5
	Administrative and General									6
	TIENT CARE SERVICE									
	Inpatient - General Care									7
8	Inpatient - Respite Care									8
VISIT	TING SERVICES									
9	Physician Services									9
10	Nursing Care									10
11	Nursing Care-Continuous Home Care									11
	Physical Therapy									12
	Occupational Therapy									13
	Speech/ Language Pathology									14
	Medical Social Services									15
	Spiritual Counseling									16
	Dietary Counseling									17
	Counseling - Other									18
	Home Health Aide and Homemaker									19
	HH Aide & Homemaker-Cont. Home Care									20
	Other									21
	ER HOSPICE SERVICE COSTS									
	Drugs, Biological and Infusion Therapy									22
	Analgesics									23
	Sedatives / Hypnotics									24
	Other - Specify							 	_	25
	Durable Medical Equipment/Oxygen							 	_	26
	Patient Transportation							 	_	27
	Imaging Services									28
	Labs and Diagnostics									29
	Medical Supplies									30
	Outpatient Services (including E/R Dept.)									31
	Radiation Therapy									32
	Chemotherapy									33
	Other							 		34
	OTHER PICE NONREIMBURSABLE SERVICE									34
	Bereavement Program Costs									25
								1		35
	Volunteer Program Costs							1		36
	Fundraising Other Program Control							1		
38	Other Program Costs							1		38
	Cost to be allocated (per Wkst. K-4, Pt. I) Unit Cost Multiplier							1		39 40
40	Onit Cost Multiplier	1	1	ı				ī		40

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4161)

	ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		FROM			PERIOD : FROM		WORKSHEET K-5, PART I		
				HOSPICE CCN:		ТО	_			
		From Wkst. K-4,	HOSPICE		RELATED		SUBTOTAL	ADMINIS-		
		Pt. I,	TRIAL	BLDGS. &	MOVABLE	EMPLOYEE	(cols. 0	TRATIVE &		
	MOGRAGE GOOT GENTER (1)	col. 7,	BALANCE	FIXTURES	EQUIPMENT	BENEFITS	through 3)	GENERAL	_	
	HOSPICE COST CENTER (1) Administrative and General	line -	0	ı	2	3	3A	4		
	Inpatient - General Care	6 7				_			2	
	Inpatient - General Care Inpatient - Respite Care	8							3	
	Physician Services	9							4	
	Nursing Care	10				_			5	
	Nursing Care Nursing Care- Continuous Home Care	11				+				
	Physical Therapy	12				+			7	
	Occupational Therapy	13				+			8	
	Speech/ Language Pathology	13							9	
	Medical Social Services - Direct	15							10	
	Spiritual Counseling	16							11	
	Dietary Counseling	17							12	
	Counseling - Other	18							13	
	Home Health Aide and Homemakers	19							14	
	HH Aide & Homemaker - Cont. Home Care	20							15	
	Other	21							16	
	Drugs, Biologicals and Infusion	22							17	
	Analgesics	23							18	
	Sedative/Hypnotics	24							19	
	Other - Specify	25							20	
	Durable Medical Equipment/Oxygen	26							21	
	Patient Transportation	27							22	
	Imaging Services	28							23	
	Labs and Diagnostics	29							24	
	Medical Supplies	30							25	
	Outpatient Services (incl. E/R Dept.)	31							26	
	Radiation Therapy	32							27	
	Chemotherapy	33							28	
	Other	34							29	
	Bereavement Program Costs	35							30	
	Volunteer Program Costs	36							31	
	Fundraising	37							32	
	Other Program Costs	38							33	
	Totals (sum of lines 1 through 33)								34	
35	Unit Cost Multiplier								35	

41-388 Rev. 4

⁽¹⁾ Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

	OCATION OF GENERAL SERVICE 'S TO HOSPICE COST CENTERS		PROVIDER CCN: HOSPICE CCN:		PERIOD : FROMTO	WORKSHEET K-5 Part I			
		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	HOSPICE COST CENTER (1)	5	6	7	8	9	10	11	
	Administrative and General								1
	Inpatient - General Care								2
	Inpatient - Respite Care								3
	Physician Services								4
	Nursing Care								5
	Nursing Care- Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services - Direct								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemakers								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

Rev. 4 41-389

⁽¹⁾ Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

	OCATION OF GENERAL SERVICE		PROVIDER CCN:		PERIOD :		WORKSHEET K-5		
COS	IS TO HOSPICE COST CENTERS			HOGDIGE GGN		FROM	Part I		
				HOSPICE CCN:		ТО	_		
				NURSING &				 	
		MEDICAL		ALLIED	OTHER	SUBTOTAL	ALLOCATED	TOTAL	
		RECORDS &	SOCIAL	HEALTH	GENERAL	(sum of cols.	HOSPICE A & G	HOSPICE	
		LIBRARY	SERVICE	EDUCATION	SERVICE	3A through 15)	(see Pt. II)	COSTS	
	HOSPICE COST CENTER (1)	12	13	14	15	16	17	18	
1	Administrative and General		-						1
	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care- Continuous Home Care								6
7	Physical Therapy								7
	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services - Direct								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemakers								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biologicals and Infusion								17
18	Analgesics								18
19	Sedative/Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
	Imaging Services								23
24	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (incl. E/R Dept.)								26
	Radiation Therapy								27
	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising		-						32
	Other Program Costs								33
	Totals (sum of lines 1 through 33)								34
35	Unit Cost Multiplier								35

41-390 Rev. 4

⁽¹⁾ Columns 0 through 16, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 83.

11-1	2 FORM	CMS-2540-10	4190 (0	Cont.)			
ALLO	ALLOCATION OF GENERAL SERVICE COSTS			PERIOD:		WORKSHEET K-5,	
TO F	IOSPICE COST CENTERS - STATISTICAL BASIS			FROM		PART II	
		HOSPICE CCN:		то			
		CAPITAL	CAPITAL			ADMINIS-	\top
		RELATED	RELATED			TRATIVE &	
		BLDGS. &	MOVABLE	EMPLOYEE		GENERAL	
		FIXTURES	EQUIPMENT	BENEFITS	RECONCIL-	(Accumulated	
		(Square Feet)	(Dollar Value)	(Gross Salaries)	IATION	Cost)	
	HOSPICE COST CENTER (1)	(Square rect)	2	(Gross Salaries)	4a	4	4
	Administrative and General	1	2	3	+a	+	1
	Inpatient - General Care						2
	Inpatient - General Care						3
	Physician Services						4
	Nursing Care						5
	Nursing Care- Continuous Home Care						6
	Physical Therapy	+				+	7
	Occupational Therapy						
							8
	Speech/ Language Pathology Medical Social Services - Direct						
							10
	Spiritual Counseling						11
	Dietary Counseling						12
	Counseling - Other						13
	Home Health Aide and Homemakers						14
	HH Aide & Homemaker - Cont. Home Care						15
	Other						16
	Drugs, Biologicals and Infusion						17
	Analgesics						18
	Sedative/Hypnotics						19
	Other - Specify						20
	Durable Medical Equipment/Oxygen						21
	Patient Transportation						22
	Imaging Services						23
	Labs and Diagnostics						24
	Medical Supplies						25
	Outpatient Services (incl. E/R Dept.)						26
	Radiation Therapy						27
28	Chemotherapy						28
29	Other						29
	Bereavement Program Costs						30
31	Volunteer Program Costs						31
	Fundraising						32
33	Other Program Costs						33
34	Totals (sum of lines 1 through 33)						34
35	Total cost to be allocated						35
36	Unit Cost Multiplier						36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS		PROVIDER CCN: HOSPICE CCN:		PERIOD : FROM TO	_	WORKSHEET K-5 PART II			
			HOSFIEL CEIV.			_			
		PLANT OPERATION MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE (Pounds of	HOUSE KEEPING (Hours of	DIETARY	NURSING ADMINIS- TRATION (Direct Nursing	CENTRAL SERVICES & SUPPLY (Costed	PHARMACY (Costed	
		(Square Feet)	Laundry)	Service)	(Meals Served)	Hours)	Requisitions)	Requisitions)	
	HOSPICE COST CENTER (1)	5	6	7	8	9	10	11	7
1	Administrative and General								1
	Inpatient - General Care								2
	Inpatient - Respite Care								3
	Physician Services								4
	Nursing Care								5
	Nursing Care- Continuous Home Care								6
	Physical Therapy								7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services - Direct								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemakers								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biologicals and Infusion								17
	Analgesics								18
	Sedative/Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
	Imaging Services								23
	Labs and Diagnostics								24
	Medical Supplies								25
	Outpatient Services (incl. E/R Dept.)								26
	Radiation Therapy								27
	Chemotherapy								28
	Other								29
	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1 through 33)								34
	Total cost to be allocated								35
36	Unit Cost Multiplier	1	1	I	1		1		36

41-392 Rev. 4

11-1	L		FURIVI	CMS-2540-10				4190 ((Cont.)
ALLC	ALLOCATION OF GENERAL SERVICE COSTS					PERIOD:	WORKSHEET K-5		
TO H	OSPICE COST CENTERS - STATISTICAL BASIS					FROM	PART II		
				HOSPICE CCN:		то			
							_		
				NURSING &					Т
		MEDICAL		ALLIED	OTHER				
		RECORDS &	SOCIAL	HEALTH	GENERAL			TOTAL	
		LIBRARY	SERVICE	EDUCATION	SERVICE		ALLOCATED	HOSPICE	
		(Time Spent)	(Time Spent)	(Assigned Time)	(Specify)	SUBTOTAL	HOSPICE A&G	COSTS	
	HOSPICE COST CENTER (1)	12	13	(Assigned Time)	15	16	17	18	-
	Administrative and General	12	13	14	13	10	17	10	1
	Inpatient - General Care								2
	Inpatient - General Care Inpatient - Respite Care								3
	Physician Services								4
	Nursing Care								5
	Nursing Care- Continuous Home Care Physical Therapy			-					7
	Occupational Therapy								8
	Speech/ Language Pathology								9
	Medical Social Services - Direct								10
	Spiritual Counseling								11
	Dietary Counseling								12
	Counseling - Other								13
	Home Health Aide and Homemakers								14
	HH Aide & Homemaker - Cont. Home Care								15
	Other								16
	Drugs, Biologicals and Infusion								17
	Analgesics								18
	Sedative/Hypnotics								19
	Other - Specify								20
	Durable Medical Equipment/Oxygen								21
	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
	Other								29
30	Bereavement Program Costs								30
	Volunteer Program Costs								31
	Fundraising								32
	Other Program Costs								33
	Totals (sum of lines 1 through 33)								34
	Total cost to be allocated	1		İ					35
	Unit Cost Multiplier	1		İ					36
36	Unit Cost Multiplier								

417	J (Cont.)	TOKWI	CM3-2340-10			11-12
APPO	ORTIONMENT OF HOSPICE SHARED SERVICES		PROVIDER CCN:	PERIOD : FROM	WORKSHEET K-5 Part III	
			HOSPICE CCN:	TO		
					1	
PART	'III - COMPUTATION OF TOTAL HOSPICE SHARED CO	STS				
		Wkst. C,	Cost to	Total Hospice	Hospice Shared	
		col. 3,	Charge	Charges	Ancillary Costs	
	COST CENTER	line:	Ratio	(from provider records)	(col. 1 x col. 2)	
		0	1	2	3	
ANC	ILLARY SERVICE COST CENTERS					
1	Physical Therapy	44				1
2	Occupational Therapy	45				2
3	Speech/ Language Pathology	46				3
4	Drugs, Biologicals and Infusion	49				4
5	Labs and Diagnostics	41				5
6	Medical Supplies	48				6
7	Radiation Therapy	40				7
8	Other	52				8
9	Total (sum of lines 1-8)					9

FORM CMS-2540-10 (11/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4162)

41-394 Rev. 4

12

13

Other unduplicated days

(line 3 times line 12)

(Wkst. S-8, line 5, col. 5) Average cost for other days

12

13

Rev. 9 41-395

ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE CONTINUOUS HOME CARE								ORKSHEET O-1	
					HOSPICE CCN:	FROM TO			
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)		
	1	2	3	4	5	6	7	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25 Inpatient Care - Contracted								25	
26 Physician Services								26	
27 Nurse Practitioner								27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								31	
32 Speech/ Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								35	
36 Counseling - Other								36	
37 Hospice Aide and Homemaker Services								37	
38 Durable Medical Equipment/Oxygen								38	
39 Patient Transportation								39	
40 Imaging Services								40	
41 Labs and Diagnostics								41	
42 Medical Supplies-Non-routine								42	
43 Outpatient Services								43	
44 Palliative Radiation Therapy								44	
45 Palliative Chemotherapy								45	
46 Other Patient Care Services								46	
100 Total *								100	

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 50

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.1)

41-398 Rev. 8

ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE ROUTINE HOME CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-2	
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
	1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								3
32 Speech/ Language Pathology								32
33 Medical Social Services								3:
34 Spiritual Counseling								34
35 Dietary Counseling								3:
36 Counseling - Other								3
37 Hospice Aide and Homemaker Services								3'
38 Durable Medical Equipment/Oxygen								3
39 Patient Transportation								35
40 Imaging Services								40
41 Labs and Diagnostics								4
42 Medical Supplies-Non-routine								4:
43 Outpatient Services								43
44 Palliative Radiation Therapy								4
45 Palliative Chemotherapy								4:
46 Other Patient Care Services								4
100 Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.1)

Rev. 9 41-399

4190 (Cont.)	FORM CMS-2540-1 FORM CMS-2540-10	11-19

ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE INPATIENT RESPITE CARE					PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-3	
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
	1	2	3	4	5	6	7	_
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy								45
46 Other Patient Care Services								46
100 Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.1)

41-400 Rev. 9

ANALYSIS OF SNF-BASED HOSPICE COSTS HOSPICE GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD: FROM	WORKSHEET O-4	
HOSTEE GELEKIE HVIVIEW CHIE					HOSPICE CCN:	TO		
	SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS	TOTAL (col. 5 ± col. 6)	
	1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech/ Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Outpatient Services								43
44 Palliative Radiation Therapy								44
45 Palliative Chemotherapy		•						45
46 Other Patient Care Services								46
100 Total *								100

^{*} Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

FORM CMS-2540-10 (11/2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.1)

4190	(Cont.)	FORM CMS-2540-10			11-19
	ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE EXPENSES FOR ALLOCATION	PROVIDER CCN: HOSPICE CCN:	PERIOD: FROM TO	WORKSHEET O-5	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
	Descriptions	1	2	3	
GENE	RAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt				1
2	Cap Rel Costs-Mvble Equip				2
3	Employee Benefits				3
4	Administrative & General				4
5	Plant Operation and Maintenance				5
6	Laundry & Linen Service				6
7	Housekeeping				7
8	Dietary				8
9	Nursing Administration				9
10	Routine Medical Supplies				10
11	Medical Records				11
12	Staff Transportation				12
13	Volunteer Service Coordination				13
14	Pharmacy				14
15	Physician Administrative Services				15
16	Other General Service				16
17	Patient/Residential Care Services				17
LEVE	L OF CARE				
50	Hospice Continuous Home Care				50
51	Hospice Routine Home Care				51
52	Hospice Inpatient Respite Care				52
	Hospice General Inpatient Care				53
NONR	EIMBURSABLE COST CENTERS				
60	Bereavement Program				60
61	Volunteer Program				61
	Fundraising				62
	Hospice/Palliative Medicine Fellows				63
64	Palliative Care Program				64
65	Other Physician Services				65
66	Residential Care				66
67	Advertising				67
68	Telehealth/Telemonitoring				68
	Thrift Store				69
	Nursing Facility Room & Board				70
	Other Nonreimbursable				71
99	Negative Cost Center				99
100	Total				100

03-18	FORM CMS-2540-10	4190 (Cont.)

						PROVIDER CCN: HOSPICE CCN:		PERIOD: FROM		WORKSHEET O-6 PART I		
							HOSPICE CCN:		TO		PART I	
-			CAP REL	CAP REL	EMPLOYEE		ADMINIS-	PLANT	LAUNDRY	HOUSE-	DIETARY	$\overline{}$
		TOTAL	BLDG	MVBLE	BENEFITS		TRATIVE &	OP &	& LINEN	KEEPING	DILITIKI	
		EXPENSES	& FIX	EQUIP	DEPARTMENT	SUBTOTAL	GENERAL	MAINT	CC ELI (ELI (TLLLI II VO		
	Descriptions	0	1	2	3	3A	4	5	6	7	8	
GENERAL SERVI	ICE COST CENTERS							-				
1 Cap Rel Co												1
	sts-Mvble Equip											2
3 Employee E												3
4 Administrat												4
5 Plant Opera	tion and Maintenance											5
6 Laundry &	Linen Service									1		6
7 Housekeepi	ing											7
8 Dietary												8
9 Nursing Ad	ministration											9
10 Routine Me												10
11 Medical Re	cords											11
12 Staff Transp	oortation											12
13 Volunteer S	Service Coordination											13
14 Pharmacy												14
15 Physician A	dministrative Services											15
16 Other Gene	ral Service											16
17 Patient/Resi	idential Care Services											17
LEVEL OF CARE	3											
50 Hospice Co	ntinuous Home Care											50
51 Hospice Ro	utine Home Care											51
52 Hospice Inc	oatient Respite Care											52
53 Hospice Ge	neral Inpatient Care											53
NONREIMBURSA	BLE COST CENTERS											
60 Bereavemen												60
61 Volunteer F												61
62 Fundraising												62
	lliative Medicine Fellows											63
64 Palliative C												64
65 Other Physi												65
66 Residential												66
67 Advertising												67
68 Telehealth/												68
69 Thrift Store												69
	cility Room & Board											70
71 Other Nonre												71
99 Negative Co	ost Center											99
100 Total												100

FORM CMS-2540-10 (03/2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4164.3)

Rev. 8 41-403

COST ALLOCATION - SNF-BASED HOSPICE GENERAL SERVICE COSTS							PROVIDER CCN:		PERIOD:		WORKSHEET O-6	
							HOSPICE CCN:		FROM		Part I	
									TO			
		NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /		
		ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
		TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS	TOTAL	_
	Descriptions	9	10	11	12	13	14	15	16	17	18	
	RAL SERVICE COST CENTERS											
	Cap Rel Costs-Bldg & Fixt											1
	Cap Rel Costs-Mvble Equip											2
	Employee Benefits											3
	Administrative & General											4
	Plant Operation and Maintenance											5
	Laundry & Linen Service											6 7
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies											10
	Medical Records											11
	Staff Transportation											12 13
	Volunteer Service Coordination											13
	Pharmacy											14
	Physician Administrative Services											15
	Other General Service											16
17	Patient/Residential Care Services											17
LEVE	L OF CARE											
50	Continuous Home Care											50
	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
NONE	REIMBURSABLE COST CENTERS											
	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
	Palliative Care Program											64
	Other Physician Services											65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store											69
	Nursing Facility Room & Board											70
	Other Nonreimbursable											71
	Negative Cost Center											99
	Total	1	t	1	1			1	1	†	†	100
100	1000		1	I .	I .			I .	I .	1	1	100

							ER CCN: PERIOD:			WORKSHEET O-6	
						HOSPICE CCN:		FROM		PART II	
		CARRE	CARRE	EL OVEE	1	1 D) M) HG	DI ANTE	TO	HOUSE	DIETHDY	_
		CAP REL BLDG	CAP REL MVBLE	EMPLOYEE BENEFITS		ADMINIS- TRATIVE &	PLANT OP &	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	
								& LINEN	KEEPING		
		& FIX	EQUIP	DEPARTMENT	DECONOR	GENERAL	MAINT	(I. F. T.	4.0	(I. E. T.	
		(Square	(Dollar Value)	(Gross Salaries)	RECONCIL- IATION	(Accum. Cost)	(Square	(In-Facility	(Square	(In-Facility Days)	
	Cost Center Descriptions	Feet)	value)	3	4A	4	Feet)	Days)	Feet)	Bays)	-
CEN	ERAL SERVICE COST CENTERS	1	2	3	4A	4	3	0	/	•	_
	Cap Rel Costs-Bldg & Fixt										-
				4							1
2	Cap Rel Costs-Mvble Equip Employee Benefits										3
	Administrative & General										3
	Plant Operation and Maintenance							<u>-</u>			4
											4 5 6 7
	Laundry & Linen Service									_	7
	Housekeeping										8
	Dietary										9
10	Nursing Administration Routine Medical Supplies										10
10	Medical Records										11
											11
	Staff Transportation										
	Volunteer Service Coordination										13
	Pharmacy										14 15
	Physician Administrative Services										
	Other General Service										16
	Patient/Residential Care Services										17
	EL OF CARE										- 50
	Hospice Continuous Home Care										50
	Hospice Routine Home Care										51
	Hospice Inpatient Respite Care										52
	Hospice General Inpatient Care										53
	REIMBURSABLE COST CENTERS										
	Bereavement Program										60
	Volunteer Program										61
	Fundraising										62
	Hospice/Palliative Medicine Fellows										63 64
	Palliative Care Program										
	Other Physician Services										65
	Residential Care										66
	Advertising										67
	Telehealth/Telemonitoring					1					68
	Thrift Store										69
	Nursing Facility Room & Board										70
	Other Nonreimbursable										71
	Negative Cost Center										99
	Cost to be allocated (per Wkst. O-6, Part I)									_	101
102	Unit cost multiplier										102

 $FORM\ CMS-2540-10\ (03/2018)\ (INSTRUCTIONS\ FOR\ THIS\ WORKSHEET\ ARE\ PUBLISHED\ IN\ CMS\ PUB.\ 15-2,\ SECTION\ 4164.3)$

COS	ALLOCATION - SNF-BASED HOSPICE G	PROVIDER CCN:		PERIOD:	WORKSHEET O-6							
							HOSPICE CCN:		FROM		Part II	
									TO			
		NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMACY	PHYSICIAN	OTHER	PATIENT /		T
		ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
		TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS		
		(Direct	(Patient	(Patient		(Hours of		(Patient	(Specify	(In-Facility		
		Nurs. Hrs.)	Days)	Days)	(Mileage)	Service)	(Charges)	Days)	Basis)	Days)	TOTAL	
	Cost Center Descriptions	9	10	11	12	13	14	15	16	17	18	1
GEN	ERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits											3
4	Administrative & General											4
5	Plant Operation and Maintenance											
	Laundry & Linen Service											5
	Housekeeping											7
	Dietary											8
	Nursing Administration											9
	Routine Medical Supplies											10
	Medical Records											11
	Staff Transportation											12
	Volunteer Service Coordination						1					13
	Pharmacy											14
	Physician Administrative Services					+			1			15
	Other General Service											16
	Patient/Residential Care Services											17
	EL OF CARE											17
	Continuous Home Care											50
	Routine Home Care											51
	Inpatient Respite Care											52
	General Inpatient Care					-						53
	REIMBURSABLE COST CENTERS											33
	Bereavement Program											60
	Volunteer Program					 						61
	Fundraising					-						62
	Hospice/Palliative Medicine Fellows					 						63
	Palliative Care Program				1	 	 		 			64
	Other Physician Services					-						65
	Residential Care											66
	Advertising											67
	Telehealth/Telemonitoring											68
	Thrift Store					-						69
												70
	Nursing Facility Room & Board											
	Other Nonreimbursable											71
	Negative Cost Center											99
	Cost to be allocated (per Wkst. O-6, Part I)											101
102	Unit cost multiplier											102

		()
APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE	PROVIDER CCN: PERIOD: WOR	KSHEET O-7
	HOSPICE CCN: FROM	
	TO	

	Wkst. C,	Cost to	Char	ges by LOC (fro	om Provider Rec	ords)	Shared Service Costs by LOC				
	col. 3,	Charge					HCHC	HRHC	HIRC	HGIP	1
	line	Ratio	HCHC	HRHC	HIRC	HGIP	(col. 1 x col. 2)	(col. 1 x col. 3)	(col. 1 x col. 4)	(col. 1 x col. 5)	
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	1
ANCILLARY SERVICE COST CENTERS											
1 Physical Therapy	44										
2 Occupational Therapy	45										
3 Speech/ Language Pathology	46										T
4 Drugs, Biological and Infusion Therapy	49										T
5 Durable Medical Equipment/Oxygen	51										
6 Labs and Diagnostics	41										
7 Medical Supplies	48										
8 Outpatient Services (including E/R Dept.)	63										
9 Radiation Therapy	40										
10 Other	52										1
11 Totals (sum of lines 1 through 10)											1

4190 (Cont.) FORM CMS-2540-10 08-16

4170 (Cont.)	1 OKWI CWI5-25-0-1	10	'	00-10
CALCULATION OF SNF-BASED HOSPICE PER DIEM COST	PROVIDER CCN:	PERIOD: FROM	WORKSHEET O	-8
	HOSPICE CCN:	ТО		
	TITLE XVIII	TITLE XIX		
	MEDICARE	MEDICAID 2	TOTAL 3	_
HOSPICE CONTINUOUS HOME CARE	l	2	3	
1 Total cost (Wkst. O-6, Part I, col 18, line 50 plus Wkst. O-7, col. 6, line 11)				1
2 Total unduplicated days (Wkst. S-8, col. 4, line 10)				2
3 Total average cost per diem (line 1 divided by line 2)				3
4 Unduplicated program days (Wkst. S-8, col. as appropriate, line 10)				4
5 Program cost (line 3 times line 4)				5
HOSPICE ROUTINE HOME CARE				
6 Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)				6
7 Total unduplicated days (Wkst. S-8, col. 4, line 11)				7
8 Total average cost per diem (line 6 divided by line 7)				8
9 Unduplicated program days (Wkst. S-8, col. as appropriate, line 11)				9
10 Program cost (line 8 times line 9)				10
HOSPICE INPATIENT RESPITE CARE				
11 Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)				11
12 Total unduplicated days (Wkst. S-8, col. 4, line 12)				12
13 Total average cost per diem (line 11 divided by line 12)				13
14 Unduplicated program days (Wkst. S-8, col. as appropriate, line 12)				14
15 Program cost (line 13 times line 14)				15
HOSPICE GENERAL INPATIENT CARE				
16 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)				16
17 Total unduplicated days (Wkst. S-8, col. 4, line 13)				17
18 Total average cost per diem (line 16 divided by line 17)				18
19 Unduplicated program days (Wkst. S-8, col. as appropriate, line 13)				19
20 Program cost (line 18 times line 19)				20
TOTAL HOSPICE CARE				
21 Total cost (sum of line 1 + line 6 + line 11 + line 16)				21
22 Total unduplicated days (Wkst. S-8, col. 4, line 14)				22
23 Average cost per diem (line 21 divided by line 22)				23