

COUNTY MEDICAL SERVICES PROGRAM SCHEDULES

Hospital Name

Fiscal Year End

**COUNTY MEDICAL SERVICES PROGRAM
CERTIFICATION**

I hereby certify that the attached schedules for the fiscal period _____ were prepared in accordance with the applicable instructions and, to the best of my knowledge, are a true, correct, and complete statement prepared from the books and records of:

Name of facility

Signed

Date

Title

**SCHEDULE 1
COMPUTATION OF CMSP REIMBURSEMENT SETTLEMENT**

Provider name	Provider number	Fiscal period From: _____ Through: _____
1. Net cost of covered services rendered to CMSP patients (Schedule 3)		\$
2. Excess reasonable cost over charges (Schedule 2)		\$
3. Total cost—reimbursable to provider		\$
4. Amount received and receivable		\$
5. Coinsurance and/or third party payments		\$
6. Other (specify)		\$
7. Balance due provider/(CMSP) for CMSP services		\$

SCHEDULE 2
COMPUTATION OF LESSER OF CMSP REASONABLE COST OR CUSTOMARY CHARGES

Provider name	Provider number	Fiscal period
		From: Through:

1. Net cost of covered services (Schedule 3)	\$
Charges for CMSP Inpatient Services	
2. Inpatient routine service charges	\$
3. Inpatient ancillary service charges	\$
4. Total CMSP inpatient service charges	\$
5. Excess of customary charges over reasonable cost (line 4 minus line 1)*	\$
6. Excess of reasonable cost over customary charges (line 1 minus line 4)	\$
(To Schedule 3)	

* If charges exceed reasonable cost, no further calculation is necessary for this schedule.

**SCHEDULE 3
COMPUTATION OF CMSP NET COST OF COVERED SERVICES**

Provider name	Provider number	Fiscal period
		From: Through:
1. CMSP inpatient ancillary cost (Schedule 5)		\$
2. CMSP inpatient routine cost (Schedule 4)		\$
3. CMSP administrative day cost (Schedule 4A)		\$
4. Subtotal of CMSP cost		\$
5. Reduction: 15% of CMSP cost of line 4		\$
6. Net cost of covered services		\$
		(To Schedule 1 and 2)

**SCHEDULE 4
COMPUTATION OF CMSP INPATIENT ROUTINE SERVICES COST**

Provider name	Provider number	Fiscal period
		From: _____ Through: _____

CMSP

1. Total inpatient routine cost (W/S D-1, Part 1, line 27)	\$
2. Total inpatient days (W/S D-1, Part 1, line 2)	
3. Average per diem cost (W/S D-1, Part II, line 38)	\$
4. CMSP inpatient days	
5. Cost applicable to CMSP	\$

Special Care Units

Special Care Unit: _____	
6. Total inpatient cost (W/S D-1, Part II, Column 1)	\$
7. Total inpatient days (W/S D-1, Part II, Column 2)	
8. Average per diem cost (W/S D-1, Part II, Column 3)	\$
9. CMSP inpatient days	
10. Cost applicable to CMSP	\$

Special Care Unit: _____	
11. Total inpatient cost (W/S D-1, Part II, Column 1)	\$
12. Total inpatient days (W/S D-1, Part II, Column 2)	
13. Average per diem cost (W/S D-1, Part II, Column 3)	\$
14. CMSP inpatient days	
15. Cost applicable to CMSP	\$

Special Care Unit: _____	
16. Total inpatient cost (W/S D-1, Part II, Column 1)	\$
17. Total inpatient days (W/S D-1, Part II, Column 2)	
18. Average per diem cost (W/S D-1, Part II, Column 3)	\$
19. CMSP inpatient days	
20. Cost applicable to CMSP	\$

Total CMSP routine cost (Sum of lines 5, 10, 15, and 20)	\$
--	----

(To Schedule 3)

**SCHEDULE 4A
COMPUTATION OF CMSP ADMINISTRATIVE DAY COST**

Provider name	Provider number	Fiscal period From: _____ Through: _____
---------------	-----------------	---

Routine Services	(1) CMSP Administrative Days	(2) Per Diem Rate	(3) Cost (1) x (2)
1. Administrative days		\$	\$
2. Administrative days		\$	\$
3. Total routine cost for administrative days			\$

(To Schedule 3)

**SCHEDULE 5
SCHEDULE OF ANCILLARY COST**

Provider name	Provider number	Fiscal period
		From: Through:

Ancillary Service Cost Centers	(1) Ratio Cost/Charge	(2) CMSP Ancillary Charges	(3) CMSP Ancillary Cost
37 Operating room		\$	\$
38 Recovery room			
40 Anesthesiology			
41 Radiology—diagnostic			
42 Radiology—therapeutic			
43 Radioisotope			
44 Laboratory			
46 Whole blood			
47 Blood storing, processing			
48 Intravenous therapy			
49 Oxygen (inhalation) therapy			
50 Physical therapy			
51 Occupational therapy			
52 Speech therapy			
53 Electrocardiology			
54 Electroencephalography			
55 Med supply charged patients			
56 Drugs charged to patients			
57 Renal dialysis			
58			
59			
60			
61 Emergency			
Total		\$	\$ (To Schedule 3)