

MEDICARE / MEDICAID RECONCILIATION FORM

FACILITY NAME: _____

AIM NUMBER: _____

Medicare Cost Center					
Line 3	Line 4	Line 9	Line 16	Line ____	Line 75
Emp. Benefits	A & G	Nurs. Admin.	Nursing		Total

Filed Medicare Cost Report (Worksheet B, Part I, Col. 0)

Reclassifications

MDS Wage					
Pharmacy Consultant					
Medical Director Fees					
Worker's Comp Insurance					
Other _____					
Other _____					
Other _____					
Other _____					

Adjustments

Directory Advertising Expense					
Cable T.V. Expense					
State Income Tax Expense					
Other _____					
Other _____					
Other _____					
Other _____					

Adjusted Medicare Cost Report (Worksheet B Part I, Col. 0)

Overhead Allocation Methodology Revisions

	Filed Medicare Cost Report	Adjusted Medicare Cost Report
Overhead Allocated to Radiology (Line 21)	YES / NO	YES / NO
Overhead Allocated to Laboratory (Line 22)	YES / NO	YES / NO
Overhead Allocated to Drugs (Line 30)	YES / NO	YES / NO