

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN:	PERIOD:	WORKSHEET J-4
	COMPONENT CCN:	FROM _____ TO _____	

Check applicable boxes:	[] Title XVIII
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DESCRIPTION		Part B			
		1	2		
		mm/dd/yyyy	Amount		
1	Total interim payments paid to providers			1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.			2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1). Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	Program to Provider	.01		3.01
			.02		3.02
			.03		3.03
			.04		3.04
			.05		3.05
		Provider to Program	.50		3.50
			.51		3.51
			.52		3.52
			.53		3.53
			.54		3.54
	.99		3.99		
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet J-3, line 27)			4	

TO BE COMPLETED BY INTERMEDIARY					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1). Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	Program to Provider	.01		5.01
			.02		5.02
			.03		5.03
			.50		5.50
		Provider to Program	.51		5.51
			.52		5.52
			.99		5.99
		6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider	.01
.02					6.02
7	Total Medicare liability (see instructions)			7	
8	Name of Contractor	Contractor Number	NPR Date (Month, Day, Year)	8	

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