Line 11.--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1.--Enter the amount from Part II, line 8.4.

Line 12.--Enter 80 percent of line 11.2.

Line 13.--Enter the actual coinsurance billed to program patients (from your records).

Line 14.--Enter the amount obtained by subtracting line 13 from line 11.2.

Line 15.--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16.--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-1, §§132ff.) Enter the amount of any excess depreciation taken in parentheses. ().

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that ..."a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...". That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 18.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136ff.)

Line 19--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 20--Enter the amount from line 16 minus the amounts from lines 17 and 18, plus or minus the amount on line 19.

Line 21--Enter any applicable sequestration adjustment. (See §120.)

Line 23--Enter the total interim payments, if applicable. Transfer this amount from Worksheet J-4, column 2, line 4.

Line 24--Enter the balance due the provider/program and transfer this amount to Worksheet S, Part II, column 3, line 5.

Line 25--Enter the program reimbursement effect of nonallowable cost report items, which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

Line 26--Do not use this line for cost reporting periods beginning on or after October 1, 1997.

3554. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED COMPONENT FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each outpatient rehabilitation provider.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your intermediary.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered include amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Transfer the total interim payments to the title XVIII Worksheet J-3, Part III, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: 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.

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 17.

3556. WORKSHEET I-1 - ANALYSIS OF SNF-BASED RURAL HEALTH CLINIC / FEDERALLY QUALIFIED HEALTH CENTER COSTS

Use this worksheet only if you operate a certified rural health clinic (RHC) or Federally qualified health center (FQHC). Only those cost centers that represent services for which the facility is certified are used. If you have more than one SNF-based RHC and/or FQHC, complete a separate worksheet for each facility.

This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 3.--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and is subject to review by your intermediary.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4.--Enter any reclassifications among the cost center expenses listed in column 3 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §3517 for examples of reclassifications that may be needed. Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 4 must equal zero on line 30.

Column 5.--Adjust the amounts in column 3 by the amounts in column 4 (increases or decreases), and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 32.

Column 6.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §3519.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your intermediary, and include this as an adjustment to the appropriate lines on column 6.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6, (increases or decreases) and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9.--Enter the costs of your health care staff .

Line 10.--Enter the sum of the amounts on lines 1 through 9.

Line 11.--Enter the cost of physician medical services furnished under agreement.

Line 12.--Enter the expenses of physician supervisory services furnished under agreement.

Line 14.--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20.--Enter the expenses of other health care costs.

Line 20. --Enter the cost of all allowable direct GME costs if the RHC/FQHC incurred all or substantially all of the training costs. Non-allowable costs must be reported on subscripted line 26. If the RHC/FQHC does not provide all or substantially all of the direct GME training costs, all GME costs must be included on line 27 as non-reimbursable.

NOTE: The BBA of 1997, §4625, provides for the payment to nonhospital providers for their direct cost of medical education beginning with services provided on or after October 1, 1997. If your cost reporting period overlaps this time frame, you must prorate the GME costs incurred for the cost reporting period for services on or after October 1, 1997, and services provided prior to October 1, 1997.

Line 21.--Enter the sum of the amounts on lines 15 through 20.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet I-2, Part II, line 10.

Lines 23 through 27.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27 --Enter the cost of GME training services which are not allowable for reimbursement under Medicare. If the RHC/FQHC does not provide all or substantially all of the direct costs associated with GME training, all of the RHC/FQHC's GME training costs are deemed non-allowable.

Line 28.--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet I-2, line 11.

Line 29.--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30.--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31.--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet I-2, Part II, line 14.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total facility cost.

3558. WORKSHEET I-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

For services beginning on or after January 1, 1998, use this worksheet only if you operate a certified SNF-based RHC or FQHC as part of your complex. If you have more than one SNF-based RHC and/or FQHC, complete a separate worksheet for each facility.

3558.1 Part I - Visits and Productivity.--Worksheet I-2, Part I, summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column Descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS Pub. 27, §503 for a definition of FTEs.)

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Enter a level of 4200 visits for each physician (line 1) and a level of 2100 visits for each nonphysical practitioner (lines 2 and 3), unless you received an exception to these levels. If you were granted an exception to the productivity standards, enter the number of productivity visits approved by the intermediary in lines 1 through 3.

Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the intermediary need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Column 4.--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5.--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line Descriptions

Line 8.--Enter the total of lines 4 through 7.

Line 9.--Enter the number of visits furnished to facility patients by physicians under agreement with you. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

3558.2 Part II - Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Worksheet I-2, Part II, determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet I-1, column 7, line 21, less the total allowable GME costs, on line 20. The allowable GME costs are not subject to the per visit limits.

Line 11.--Enter the total nonreimbursable costs from Worksheet I-1, column 7, line 26.

Line 12.--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13.--Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14.--Enter the total facility overhead costs incurred from Worksheet I-1, column 7, line 29.

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead by the ratio of Intern and Resident visits over total visits. This amount will be deducted from the total facility overhead costs on line 14.

Line 16.--Enter the net facility overhead costs. This is determined by subtracting the amount on line 15 from the amount on line 14.

Line 17.--Enter the overhead cost incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs allocated to the corresponding RHC/FQHC cost center on Worksheets B, Part I column 18, line 35, minus column 14, line 35, minus column 0, line 35.

Line 18.--Enter the sum of lines 16 and 17 to determine the total overhead costs related to the RHC/FQHC.

Line 19.--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20.--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (overhead costs applicable to RHC/FQHC services).

3560. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3560.1 Part I - Determination of Rate For RHC/FQHC Services.--Part I calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter zero on this line. Worksheet I-4 has been eliminated. Do not enter any amount cost of pneumococcal and influenza vaccine.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet I-2, Part I, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.—*The limits are updated every January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (See PM A-03-21)).* Complete columns 1, 2 and *3* of lines 8 and 9*, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods)* to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from CMS Pub. 27, §505 or from your intermediary.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For periods with cost reporting periods beginning on or after January 1, complete column 2 only. For cost reporting periods beginning prior to January 1, amounts will be entered in columns 1 and 2.

3560.2 Part II - Calculation of Settlement.--Use Part II to determine the total payment based on specific title due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider’s cost reporting period begins on or after January 1, then only column 2 is completed. For all other cost reporting periods beginning prior to January 1, both columns 1 and 2 must be completed.

Line Descriptions

Line 10.--Enter the number of program covered visits, excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11.--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13.--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 1/2 percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15. --Enter the total allowable GME pass-through costs. To determine the direct GME cost, divide the program visits performed by Interns and Residents from Worksheet S-5, line 16, column 2, by the total visits from Worksheet I-3, line 6. Multiply the result by the total allowable GME costs from Worksheet I-1, column 7, line 20. Add the applicable overhead costs associated with GME, from Worksheet I-2, line 15. Add the provider facility overhead applicable to GME, from Worksheet B, Part I, column 14, line 35. Enter the result on this line. (If there are no allowable GME pass-through costs, this line is zero.)

Line 16.--Enter the total program cost. This is equal to the sum of the amounts on lines 11 and 14, columns 1 and 2, *(and column 3 if applicable)*, plus the GME pass through costs on line 15.

Line 17.--Enter the amount credited to the RHC program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 from the amount on line 16.

Line 19.--Enter 80 percent of the amount on line 18.

Line 20.--Enter zero on this line. Worksheet I-4 has been eliminated.

Line 21--Enter the total reimbursable program cost. This is equal to the sum of the amounts on line 19 and 20.

Line 22--Enter the total reimbursable bad debts, net of recoveries, from your records.

Line 23.-Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (See CMS Pub 15-1,§ 2146.4), enter the adjustment. Specify the adjustment in the space provided.

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Line 24.--This is the sum of lines 21 and 22 plus or minus line 23.

Line 25--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). Transfer amount from Worksheet I-5, line 4.

Line 25.01—Your Fiscal Intermediary will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 26--Enter the total amount due to/from the program (line 24 minus line 25). Transfer this amount to Worksheet S, Part II, columns 1, 3, or 4 as applicable, line 6.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See PRM-15-1 §115.2).

3562. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

This worksheet must be completed for services furnished on and after January 1, 2003.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet I-1, column 7, line 21. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet I-2, line 16.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet I-3, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet I-3, Part II, line 20.

3563. WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each rural health clinic and federally qualified health center.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your intermediary.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered include amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Transfer the total interim payments to the title XVIII Worksheet I-3, Part II, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET I-5. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: 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.

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet I-3, line 24.

3564. WORKSHEET A-8-5 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See CMS Pub.15-I, chapter 14.) For services rendered on and after January 1, 1999, therapy services are subject to a fee schedule. Therefore for cost reporting periods beginning on or after January 1, 1999 this form is no longer required for all SNF's, except complexes with SNF based home health agencies, or SNF-based community mental health centers.

NOTE: If you furnish therapy services under arrangement with outside suppliers, complete this worksheet. When reimbursement for such therapy services is subject to the provisions of PPS or the TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depends on several factors:

- An initial test to determine whether these services are categorized as intermittent part time or full time services;
- The location where the services are rendered, i.e. at your site or HHA home visit;
- For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3564.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist, or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patient's home are counted only once. (See CMS Pub.15-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3--Enter the number of days in which the supervisor or therapist (report only the therapist for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist, and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit.

Line 6--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7--Enter the standard travel expense rate applicable. (See CMS Pub.15-I, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See CMS Pub.15-I, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category.

Line 10--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS PUB 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of CMS Pub.15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of CMS Pub.15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants aides and trainees respectively) the AHSEA from either the appropriate exhibit found in CMS Pub.15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See CMS Pub.15-I, §1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 10. Enter in column 3 one half of the amount in column 3, line 10. (See CMS Pub.15-I, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, for provider on-site. Time records of visits must be kept. (See CMS Pub.15-I, §§1402.5 and 1403.1.)

Lines 12.01 and 13.01--Enter the number of travel hours and number of miles driven, respectively, for provider off-site. Time records of visits must be kept.

NOTE: There is no travel allowance for aides employed by outside suppliers.

3564.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub.15-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

Line 20--Enter the sum of lines 17 through 19 for respiratory therapy or sum of lines 17 and 18 for all other.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy or 1 through 3 for all others, line 9 is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.) Enter on line 21 the result of line 17 divided by the sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others.

Line 23--If there are no entries on lines 21 and 22, enter the amount from line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy or lines 18 and 22 for all others.

3564.3 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site.--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 - 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See CMS Pub.15-I, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub.15-I, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy occupational therapy and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 - 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13 for respiratory therapy or columns 1, 2, and 3, line 13 for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

3564.4 Part IV - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Off Site.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See CMS Pub.15-I, §§1402ff, 1403.1 and 1412.6.) This part is completed for physical therapy, speech pathology, and occupational therapy only. If there are multiple HHAs, subscript lines where appropriate.

Lines 36-39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 40 - 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 - 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See CMS Pub.15-I, §1402.5.)

3564.5 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub.15-I, §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero, equal to or greater than 2080 for a 12 month cost report, (2240 hours for a 13 month cost report, 2400 hours for a 14 month cost report, or 2560 hours for a 15 month cost report), the overtime computation is not applicable. Make no further entries on lines 48 through 55. (If there is a short period prorate the hours.) Enter zero in each column of line 56. Enter in column 5 the sum of the hours recorded in columns 1, 3 and 4 for respiratory therapy, and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3 for physical therapy, speech pathology and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3 and 4 the AHSEA from Part I, line 10 columns 2, 4, and 5.

Line 56--Enter in column 5 the sum of the amounts recorded in columns 1, 3 and 4 for respiratory therapy and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

3564.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to the therapy service costs in determining the reasonableness of therapy cost.

Line 58--Enter the amount reported on lines 33, 34, or 35

Line 59--Enter the amount reported on lines 44, 45, or 46.

Lines 61 and 62--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in CMS Pub.15-I, §1412.1) is considered an additional allowance in computing the limitation.

Line 64--Enter the amounts paid and/or payable to the outside suppliers for the hospital and home health agency, if applicable, for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. Add all subscripted lines together for purposes of calculating the amount to be entered on this line

Line 65--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero.

3564.7 Part VII - Allocation of Therapy Excess Cost Over Limitation for Non-Shared Therapy Department Services.--This part provides for the computation of the excess cost of SNF services and other subprovider services over the limitation for outside suppliers.

Lines 66 --Enter on line 66 the total cost of services supplied by the outside suppliers for your SNF, from your records.

Line 67-- Enter the total cost of services supplied by outside suppliers for your SNF-based CORF, from your records. If you have more than SNF-based CORF that contracts therapy services, subscript line 67 to report the cost of services supplied by the outside suppliers for each SNF-based CORF.

Line 68--Enter the total cost of services supplied by outside suppliers for your SNF-based CMHC, from your records. If you have more than SNF-based CMHC that contracts therapy services, subscript line 68 to report the cost of services supplied by the outside suppliers for each SNF-based CMHC.

Line 69--Enter the total cost of services supplied by outside suppliers for your SNF-based OPT, from your records. If you have more than SNF-based OPT that contracts therapy services, subscript line 69 to report the cost of services supplied by the outside suppliers for each SNF-based OPT.

Line 70--Enter the total cost of services supplied by outside suppliers for your SNF-based HHA, from your records. If you have more than one SNF-based HHA that contracts therapy services, subscript line 70 to report the cost of services supplied by the outside suppliers for each SNF-based HHA.

Line 71--Enter the sum of lines 66-70, and enter on this line.

Line 72 -- To determine the ratio of SNF cost of outside suppliers to total cost, divide the amount on line 66 by the amount on line 71, and enter the result on this line.

Line 73--To determine the ratio of CORF cost of outside suppliers to total cost, divide the amount on line 67 by the amount on line 71, and enter the result on this line. If you subscripted line 67, subscript this line to accommodate more than CORF.

Line 74--To determine the ratio of CMHC cost of outside suppliers to total cost, divide the amount on line 68 by the amount on line 71, and enter the result on this line. If you subscripted line 68, subscript this line to accommodate more than CMHC.

Line 75--To determine the ratio of OPT cost of outside suppliers to total cost , divide the amount on line 69 by the amount on line 71, and enter the result on this line. If you subscripted line 69, subscript this line to accommodate more than OPT.

Line 76--To determine the ratio of HHA cost of outside suppliers to total cost , divide the amount on line 70 by the amount on line 71, and enter the result on this line. If you subscripted line 70, subscript this line to accommodate more than HHA.

Line 77--This line identifies the excess of SNF cost over the limitation. To determine the excess cost applicable, multiply line 65 by the ratio line 72 and enter the result on this line. Transfer this amount to the applicable line on Worksheet A-8. A separate worksheet must be completed for each therapy service provided.

Line 78--This line identifies the excess of SNF-based CORF cost over the limitation. To determine the excess cost applicable, multiply line 65 by the ratio line 73 and enter the result on this line. Transfer this amount tothe applicable line on Worksheet A-8. A separate worksheet must be completed for each therapy service provided.

Line 79--This line identifies the excess of SNF-based CMHC cost over the limitation. To determine the excess cost applicable, multiply line 65 by the ratio line 74 and enter the result on this line. Transfer this amount to the applicable line on Worksheet A-8. A separate worksheet must be completed for each therapy service provided.

Line 80--This line identifies the excess of SNF-based OPT cost over the limitation. To determine the excess cost applicable, multiply line 65 by the ratio line 75 and enter the result on this line. Transfer this amount to the applicable line on Worksheet A-8. A separate worksheet must be completed for each therapy service provided.

Line 81--This line identifies the excess of SNF-based HHA cost over the limitation. To determine the excess cost applicable, multiply line 65 by the ratio line 76 and enter the result on this line. Transfer this amount to the applicable line on Worksheet A-8. A separate worksheet must be completed for each therapy service provided.

Line 82--Enter the sum of lines 77-81. This amount should equal the amount on line 65.