

1800. GENERAL

This cost report provides for the determination of allowable costs which are reimbursable by the health insurance program under title XVIII, Part B, of the Act. These worksheets are used only by rehabilitation agencies, clinics and public health agencies certified as outpatient physical therapy (OPT), outpatient occupational therapy (OOT) and outpatient speech pathology (OSP) providers, comprehensive outpatient rehabilitation facilities (CORF), and community mental health centers (CMHC) providing partial hospitalization services. Form CMS-2088-92 is used only by freestanding providers.

NOTE: Effective for cost reporting periods ending on or after June 30, 2001, CORFs and OPTs (includes OOT and OSP) where 100 percent of the services rendered are reimbursed on a fee schedule basis are no longer required to complete the Form CMS 2088-92 cost report. However, such providers with cost reimbursed services must file a low utilization cost report in accordance with PRM, Part II, Section 110. CMHCs must continue to file cost reports in accordance with PRM, Part II, Section 100.

A. Effective Date.--

1. Rehabilitation agencies, clinics and public health agencies certified as OPT, OOT, or OSP providers must use these worksheets for cost reporting periods ending on or after April 30, 1993.

2. CORFs must use these worksheets for the facility's first cost reporting period which ends on or after April 30, 1993, and for which a facility is certified as a comprehensive outpatient rehabilitation provider.

3. CMHCs must use this cost report for the facility's first cost reporting period on or after October 1, 1991, provided that the CMHC has filed a request for Medicare participation and has met all Federal requirements for partial hospitalization services to be reimbursable by the Medicare program

Reasonable cost as used in this discussion of reimbursement is the remaining reasonable cost after subtracting any applicable deductible.

Effective for services rendered prior to January 1, 1999, OPT, OOT, and OSP providers are reimbursed on the basis of the lower of reasonable cost or customary charges or reasonable cost minus amounts that may be billed to Medicare beneficiaries for providing services to Medicare beneficiaries. In no case may the reimbursement exceed 80 percent of the reasonable cost.

CMHCs are reimbursed (for partial hospitalization services) the lesser of reasonable cost or customary charges, less the amount of coinsurance that may be charged to the beneficiaries. In no case may the reimbursement exceed 80 percent of the reasonable cost.

Effective for services rendered prior to January 1, 1999 (and some services rendered on or after January 1, 1999 that continue to be reimbursed on a cost basis) CORF reimbursement is based on the reasonable cost that remains after subtracting any applicable deductibles and is the lesser of:

- o Eighty percent of the remaining reasonable cost, or
- o The remaining reasonable cost minus 20 percent of reasonable charges.

Part I of the Provider Reimbursement Manual (CMS Pub. §15-I) and the applicable regulations issued by CMS set forth the criteria to use to determine reimbursable costs under the health insurance program.

Form CMS-2088-92 is used to effect provider reimbursement, using cost finding with cost

apportionment based on gross charges.

The gross charges method is the ratio of Medicare program charges to total charges applied to total allowable costs. This ratio is developed for each individual reimbursable cost center. Each of the different types of providers using this cost report has specific services for which they may be

reimbursed under the Act. Therefore, a provider develops the ratio only for those cost centers for which it may be reimbursed.

In order for a provider to properly complete its Medicare cost report, a record of its Medicare billing must be maintained. Providers generally maintain their own records of billings, but in addition, the intermediary keeps a record, known as the Provider Statistical & Reimbursement (PS&R) report. The PS&R report compiles the provider's Medicare claims data and summarizes it for use by the provider in the cost report. Throughout these instructions and the related forms, there have been references to the provider's records as a source for entries in a cost center. In order for any such entries to be accurate, reconcile the provider's records and the intermediary's PS&R.

The cost finding calculations provide for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs subsequently allocated from the remaining general service cost centers. This method of cost finding is the stepdown method.

You may use a more sophisticated method of cost finding designed to allocate costs more accurately upon approval of the intermediary. However, having elected to use the more sophisticated method, you may not thereafter use the stepdown method without approval of the intermediary.

The cost report form contains the methodology in which covered charges, deductibles, and coinsurance amounts for services rendered are considered in the calculation of Medicare reimbursement.

Form CMS-2088-92 consists of 26 pages. Generally, complete these pages in sequence. However, some pages must be started but cannot be completed until some of the succeeding pages are first completed. The instructions point out these differences.

In completing the worksheets, show reductions to expenses in parentheses ().

Where you did not furnish any covered services to Medicare beneficiaries, or where there is low Medicare utilization of such services during the entire cost reporting period, a full cost report need not be filed. Your intermediary may authorize less than a full cost report if you have had low utilization of covered services by Medicare beneficiaries in a reporting period and you received correspondingly low interim reimbursement payments. This authorization is only effective if, prior to the end of the cost reporting period or filing period, the intermediary advises you that you may file less than a full cost report and you give assurance that you will timely file such data as may be required by the intermediary. See CMS Pub. 15-I, Chapter 24, §2414.4 and 42 CFR §413.24(h) for a further explanation of this procedure.

1800.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places
 - a. Percentages
 - b. Averages
 - c. Full time equivalent employees
 - d. Per diems, hourly rates

2. Round to 5 decimal places
 - a. Payment reduction (e.g., outpatient cost reduction)
3. Round to 6 decimal places
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost being allocated. Adjust this residual to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount being allocated.

1801. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2088-92

<u>Step</u>	<u>Worksheet</u>	
1	S	Complete Parts I and IV.
2	S-1	Complete lines 1 through 4.
3	A	Complete columns 1 through 3, all lines.
4	A-1	Complete entire worksheet if applicable.
5	A	Complete columns 4 and 5, all lines.
6	A-3	Complete lines 1 through 12.
7	A-3-1	Complete Part A. If the answer to Part A is "Yes," complete Parts B and C.
8	A-3	Complete lines 13 through 19.
9	Supp. A-8-2	Complete entire worksheet, if applicable.
10	Supp. A-8-3	Complete entire worksheet, if applicable.
11	Supp. A-8-4	Complete entire worksheet, if applicable.
12	Supp. A-8-5	Complete entire worksheet, if applicable.
13	A-3	Complete remainder of Worksheet A-3.
14	A	Complete columns 6 and 7, all lines.
15	B & B-1	Complete entire worksheets.
16	C	Complete entire worksheet.
17	D	Complete lines 1 through 5, 9, 11, 18, and 20 through 29.
18	D	Complete lines 6 through 8, 10, 12 through 17, and 19.
19	G	Complete entire worksheet.
20	S	Complete Part III, then complete Part II.

1802. WORKSHEET S - OUTPATIENT REHABILITATION PROVIDER COST REPORT

The intermediary indicates in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

1802.1 Part I - Identification Data.--

The information required in this section is needed to properly identify the provider.

Line 1.--Enter the Outpatient Rehabilitation Facility name.

Line 1.01.--Enter the street address. and P.O. Box (if applicable) of the facility.

Line 1.02.--Enter the city, state, and zip code of the facility.

Line 1.03.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See §§102.1-102.3 and 110 for situations where you may file a short period cost report.)

Line 2.--

Column 1.--Enter the provider identification number.

Column 2.--Type of Control.--Indicate the ownership or auspices of the provider by entering the number below that corresponds to the type of control of the facility.

Voluntary Nonprofit:	Government (Non-Federal):
1 = Church	7 = State
2 = Other (specify)	8 = Hospital District
Proprietary:	9 = County
3 = Individual	10 = City
4 = Corporation	11 = City-County
5 = Partnership	12 = Other (specify)
6 = Other (specify)	

If item 12 is selected, "Other (specify)" category, specify the type of provider in column 3 of the worksheet.

Column 4.--Type of Provider.--Enter the number which corresponds to the type of provider as defined in the conditions of participation.

OPT/OSP/OOT Provider:	
1 = Rehabilitation Agency (CORF)	4 = Comprehensive Outpatient Rehabilitation Facility
2 = Public Health Agency	5 = Community Mental Health Center (CMHC)
3 = Clinic	

OPT, OOT, OSP Provider.--This is a provider furnishing either outpatient physical therapy, outpatient occupational therapy and/or outpatient speech pathology services. These services are furnished through one of the following:

Rehabilitation Agency.--This is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy, occupational therapy or speech pathology services, and a rehabilitation

program which, in addition to OPT, OOT, or OSP services, includes social or vocational adjustment services.

Public Health Agency.--This is an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and, in certain cases, therapeutic services.

Clinic.--This is a facility which is established primarily for the provision of outpatient physicians' services, having two or more physicians practicing medicine together and having at least one physician present at all times during the hours of operation.

Community Mental Health Center (CMHC).--This is an entity that provides the services described in DME1916(c)(4) of the Public Health Service Act and meets applicable licensing or certification requirements for community mental health centers in the State in which it is located.

Comprehensive Outpatient Rehabilitation Facility (CORF).--This is a nonresidential facility established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician.

Although generally all CORF services are required to be rendered onsite to be covered services, one offsite visit is permitted to evaluate the potential impact of the home environment on the rehabilitation goals.

NOTE: In the case of physical therapy, occupational therapy and speech pathology services, there is no requirement that the service be furnished at any single fixed location if the item or service is furnished pursuant to a plan established by a physician and payments are not otherwise made for the item or service under title XVIII.

Column 5.--Date Certified.--Enter the Medicare certification date of the facility.

Line 3.01-3.03.--Enter the amount of malpractice insurance premiums, paid losses and/or self insurance premiums, respectively.

Line 4.--If malpractice premiums are reported in other than the A&G cost center, enter Y (yes) or N (no). If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

1802.2 Part II - Certification by Officer or Administrator of Provider(s).-- This certification is read, prepared, and signed after the cost report has been completed in its entirety. The cost report is not accepted by the fiscal intermediary unless it contains an original signature.

1802.3 Part III - Settlement Summary.--Enter the balance due to or from the complex. Transfer the settlement amounts as follows:

Outpatient Rehabilitation Provider from Worksheet D, Part I, line 19.

1802.4 Part IV - Outpatient Rehabilitation Provider Statistical Data.--

Columns 1 through 3.--Enter on the appropriate lines the number of visits by type of service. The number of visits shown includes all visits on your premises and in the patients' homes. If more than one treatment was furnished to a patient in the same visit, record a separate visit for each different treatment rendered to the patient.

Columns 4 through 6.--Enter on the appropriate lines the total number of individual patients who received services during the cost reporting period, regardless of the number of visits of each individual patient.

For example, if a patient receives both covered services and noncovered services, he or she is counted once as Medicare (title XVIII for covered services), once as other (for noncovered services), and only once as total.

Columns 7 through 10.--Enter on the appropriate line the number of full-time equivalent employees (FTE) for each of your various types of employees. Average number of employees for the period (full-time equivalent) means the sum of the total number of employees on the first payroll at the beginning of each quarter divided by 4. Or, if on a semiannual basis, it is the sum of the total number of employees on the payroll at the beginning of each period divided by 2. To arrive at the full-time equivalent, add the total number of hours worked by all employees on the first payroll at the beginning of the above periods and divide the result by the number of hours in the standard work period.

Line 28--Enter the sum of lines 1 through 27 for all columns as appropriate.

Line 29--Enter in the appropriate column (columns 4 through 6) the unduplicated census count for Medicare patients and all other patients provided by employees of the provider or provided under contract during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program or a patient could be receiving more than one type of service, the total unduplicated census count may not equal the sum of the title XVIII and all other census counts.

NOTE: If Medicare patient visits exist on Worksheet S, Part IV, column 1, for any Medicare covered service, the corresponding Medicare covered service on Worksheet C must contain the corresponding cost and the charge amounts in column 1. Conversely, if costs and corresponding charges exist on Worksheet C, column 1 for Medicare covered services, the corresponding Medicare patient visits must be present on Worksheet S, Part IV, column 1.

1803. WORKSHEET S-1 - ANALYSIS OF PAYMENTS TO OUTPATIENT REHABILITATION PROVIDERS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR §413.64.)

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the outpatient rehabilitation provider. Also include all Prospective Payment System (PPS) payments for CMHC services rendered on or after August 1, 2000. Do not include payments received for services reimbursed on a fee schedule basis. 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 must include amounts withheld from the outpatient rehabilitation provider's interim payments due to an offset against overpayments to the outpatient rehabilitation provider 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. If the outpatient rehabilitation provider is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare 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--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet D, line 18.

DO NOT COMPLETE THE REMAINDER OF SUPPLEMENTAL WORKSHEET S-1. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

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 on line 5.

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, when 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 and 5.99. The amount must equal Worksheet D, line 17.

1804. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets. Each cost center listed does not apply to every provider using these forms. Therefore, use those cost centers applicable to your type of provider.

The worksheets have been revised so that the revenue cost centers are grouped separately for each of the different types of providers using Form CMS-2088-92. Each of the different types of providers are reimbursed under the Medicare program for certain specific services. All providers complete the general service cost centers section, but a provider completes only the revenue cost centers that apply to that provider. For example, on Worksheet A, CORFs enter figures in the lines 15 through 27, CMCHs enter figures in lines 29 through 38 and the other providers (rehabilitation agencies, public health agencies and clinics) enter figures in lines 40 through 43.

Under certain conditions, a provider may elect to use different cost centers for allocation purposes. These conditions are stated in CMS Pub. 15-I, §2313.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If a provider needs to use additional or different cost center descriptions, it may do so by adding additional lines to the cost report. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general services cost centers, corresponding columns must be added to Worksheets B and B-1 for cost finding.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form CMS 2088-92 provides for 40 preprinted cost center descriptions that may apply to CMHC services on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These 27 cost center descriptions are hereafter referred to as the standard cost centers. One additional cost center description with general meaning has been identified. This additional description will hereafter be referred to as a nonstandard label with an "Other..." designation to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, line 38.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. The preparer is required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in Table 5 of the electronic reporting specifications.

Where the cost elements of a cost center are separately maintained on your books, a reconciliation of the costs per the accounting books and records to those on this worksheet must be maintained by you and is subject to review by the intermediary.

Columns 1, 2, And 3.--The expenses listed in these columns must be in accordance with your accounting books and records.

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. The expenses must be detailed between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3. Any needed reclassifications and adjustments must be rendered in columns 4 and 6, as appropriate. Blank lines are provided for additional cost centers, as required.

Column 4.--Enter any reclassifications which are needed to effect proper cost allocation among the cost center expenses in column 3. Worksheet A-1 is provided to compute the reclassifications affecting the expenses specified therein. This worksheet need not be completed by all providers, but only to the extent reclassifications are needed in your particular circumstances. Show reductions to expenses in parentheses (). The net total of the entries in column 4 must equal zero on line 65.

Column 5.--Adjust the amounts entered in column 3 by the amounts entered in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 65.

Column 6.--Enter on the appropriate lines in column 6 the amounts of any adjustments to expenses indicated on Worksheet A-3, column 2. The total on Worksheet A, column 6, line 65 must equal Worksheet A-3, column 2, line 22.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease) and extend the net balances to column 7.

Transfer the amounts in column 7, lines 2 through 65, to the corresponding line on Worksheet B, column 0.

Line Descriptions

The line numbers 28, 39, and 44 are not shown on Worksheets A, B, or B-1, but are used on Worksheet C for compiling totals.

Lines 1 and 2.--These cost centers include depreciation, leases and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care.

Line 4.--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, malpractice costs, and physician's administrative services. The following services of the facility physician constitute CORF services: consultation with and medical supervision of nonphysician staff, establishment and review of the plan of treatment, team conferences and initial evaluations and other medical and facility administrative activities.

If the physician is paid a salary that compensates him or her for both provider services and professional services, then include the salary in this cost center. The cost attributable to the professional services is subsequently removed by an adjustment computed using Worksheet A-8-2. See Worksheet A-8-2 for the instructions on that adjustment.

If the physician bills the carrier for services to individual CORF patients, then no compensation is payable from the CORF to the physician for these services. Therefore, the cost of these services is not includable in this cost center or on Worksheet A-8-2.

The professional services of physicians, physicians assistants (PA) and clinical psychologists (CP) are not considered as provider services and are not includable as an element of cost in the provider's cost report. These services are billed directly to a carrier for payment. A provider must distinguish between professional services and provider services of the physicians, PA, and CP. The provider

services are includable on the cost report. The payment for services of a physician to providers is discussed in 42 CFR 405.480 and in CMS Pub. 15-I, §2108. Not all provider services of physicians are entered as an administrative and general cost, i.e., if a physician supervises a revenue cost center such as physical therapy, then the physician's salary or part of it is a cost of the physical therapy cost center.

Line 10.--Enter the costs for minor medical or surgical supplies. These are supplies for which patients are not separately charged, and for which the recording of use by each individual patient is extremely time consuming and costly for providers. Examples include cotton balls and alcohol prep.

Line 11.--This cost center includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library must not be included in this cost center, but are reported in the administrative and general cost center.

Line 16.--These services include (1) testing and measurement of the function or dysfunction of the neuromuscular, musculoskeletal, cardiovascular, and respiratory systems; and (2) assessment and treatment related to dysfunction caused by illness or injury and aimed at preventing or reducing disability or pain and restoring lost function.

The establishment of a maintenance therapy program for an individual whose restoration potential has been reached is a physical therapy service.

NOTE: Maintenance therapy is not covered as part of this service.

Line 17.--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 18.--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 19.--These are services for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Line 20.--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 21.--These services include (1) assessment, diagnosis and treatment of an individual's mental and emotional functioning as related to the individual's rehabilitation; (2) psychological evaluations of the individual's response to and rate of progress under the treatment plan; and (3) assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment.

Line 22.--These services include any services necessary to design the device, select the materials and components, measure, fit and align the device, and instruct the patient in its use. Included are (1) prosthetic devices (excluding dental devices and renal dialysis machines), that replace all or

part of an internal body organ or external body member (including contiguous tissue) or that replace all or part of the function of a permanently inoperative or malfunctioning external body member or internal body organ; and (2) orthopedic devices that support or align movable parts of the body, prevent or correct deformities, or improve functioning.

Line 23.--These are drugs and biologicals that are (1) prescribed by a physician and administered by or under the supervision of a physician or a registered professional nurse; and (2) not excluded from Medicare Part B payment for reasons specified in 42 CFR §410.29.

Line 24.--Report the cost of medical supplies that are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 25.--Enter the number of durable medical equipment (DME) items that are sold directly to the patient or individuals when ordered by the facility physician for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME sold to patients or individuals. The DME must be acquired by the beneficiary for use outside of the CORF.

Line 31.--Enter the expenses for the professional services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients. Administrative services, such as supervisory duties, rendered by these individuals are includable in the administrative and general cost center. Any services by these individuals in nonreimbursable activities, such as psychosocial programs, activities therapies, etc., is entered in the appropriate nonreimbursable cost center.

Line 32.--Enter the expenses for individual therapy with physicians, psychologists, or other mental health professionals to the extent authorized under State law. Do not include professional services of physicians, PAs, or CPs if billable to a Medicare carrier.

Line 33.--Enter the expenses for group therapy with physicians, psychologists, or other mental health professionals to the extent authorized under State law. Do not include the expenses of professional services of physicians, PAs, or CPs if billable to a Medicare carrier.

Line 34.--Enter the expenses for individualized activity therapies that are not primarily recreational or diversionary.

Line 35.--Enter the expenses for family counseling services, the primary purpose of which is treatment of the beneficiary's (the patient) condition.

Line 37.--Enter the expenses for patient training and education to the extent the training and educational activities are closely and clearly related to the individual's care and treatment.

Line 45.--Sheltered workshops consist of a program to provide remunerative employment or other occupational activities of an educational, therapeutic nature for individuals whose earning capacity is impaired by physical, mental, and/or social handicaps. Workshops may provide job training, vocational evaluation, sheltered employment, and/or work adjustment services.

Line 52.--A nonreimbursable cost center must be established to accumulate the cost incurred by you for services related to the physicians' private practice. Examples of such costs are depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies and nursing services.

Line 62.--These are programs which are primarily recreational or diversional.

Line 63.--These are community support groups for chronically mentally ill persons for the purpose of social interaction. Partial hospitalization programs may include some psychosocial components, and to the extent these components are not primarily for social purposes, they are covered.

Line 64.--Enter the expenses of services related solely to specific employment opportunities, work skills, or work settings.

1805. WORKSHEET A-1 - RECLASSIFICATIONS

Worksheet A-1 provides for the reclassification by cost centers of certain amounts necessary to effect proper cost allocation.

Some providers may charge some of these amounts to the proper cost centers before the end of the accounting period. Therefore, use Worksheet A-1 only to the extent that expenses have been included in cost centers that effect improper cost allocation.

Any expenses that are includable in the administrative and general or capital related cost centers, e.g., insurance or lease expense, but which were recorded in other cost centers on Worksheet A, must be reclassified on Worksheet A-1.

It may be necessary to reclassify certain expenses pertaining to buildings, fixtures, and movable equipment. These expenses must be directly assigned or allocated on the same basis as the depreciation expense for the respective buildings, fixtures or movable equipment. Examples of these expenses include insurance, rent on buildings, fixtures, or movable equipment, real estate taxes, and personal property taxes. Interest on funds borrowed to purchase buildings, fixtures, or movable equipment are included in these expenses. Interest borrowed for operating funds is not included. Interest on funds borrowed for operating funds must be allocated with administration and general expenses.

Employee health and welfare costs must be considered as part of each employee's compensation and charged to the various cost centers in the same proportion that the salary is charged.

Transfer the amounts on Worksheet A-1, to Worksheet A, column 4, line as appropriate.

1806. WORKSHEET A-3 - ADJUSTMENTS TO EXPENSES

Worksheet A-3 provides for the adjustments to be made to the expense listed on Worksheet A, column 5. Record these adjustments, which are required under the regulations, on this worksheet, and make them on the basis of cost or amount received. Enter the total amount received (revenue) if the cost applicable to such revenue cannot be determined. If the cost can be determined, enter the cost without regard to the amount received. Indicate the basis used in column 1. There are, however, items on the worksheet which are adjusted on one basis only. For these items, the basis for adjustment is printed in column 1. Line descriptions indicate the more common activities which affect allowable cost or result in costs incurred for reasons other than patient care and thus require adjustments.

If any of the adjustments you make on Worksheet A-3 flow from Supplemental Worksheets A-3-1, A-8-2, A-8-3, A-8-4 or A-8-5, complete those worksheets before completing Worksheet A-3.

Line Descriptions

Line 1.--Enter the amounts received for rendering administrative services to others, including physicians and therapists. For example, you may arrange to process billings and collect the proceeds on behalf of such specialists and charge a fee for these services. Reduce allowable costs by the amount of such fees.

Line 2.--Reduce interest expense by investment income, except investment income earned by:

- o Grants, gifts and endowments, (whether restricted or unrestricted),
- o Funded depreciation,
- o Pension funds, and
- o Deferred compensation funds.

The offset of investment income against interest expense cannot exceed the total interest expense included in allowable cost.

Lines 3 and 4.--Enter these discounts, rebates, and refunds on these lines only when such receipts have not already been netted against the appropriate expense in the accounting records.

The recommended offset of these amounts against the administrative and general cost center is appropriate only if the related expense cannot be identified. (See CMS Pub. 15-I, §804.)

Line 9.--If the expense applicable to these activities is insignificant, make the adjustment on this line. However, these and similar activities are normally set up as nonreimbursable cost centers on Worksheet B since the amounts involved are usually significant.

Line 13.--Obtain any amount entered on this line from Supplemental Worksheet A-3-1.

Line 14.--Enter the amount obtained from Worksheet A-8-2, column 18, the total line.

NOTE: Make the adjustments on Worksheet A, column 6 for the various cost centers affected by provider-based physicians by referring to the adjustments for the corresponding cost centers on Worksheet A-8-2, column 18. Reasonable compensation equivalent limits do not apply to a medical director, a chief of medical staff, or to the compensation of any physician employed in a capacity not requiring the services of a physician, such as a controller.

Line 15.--Where an outpatient rehabilitation provider purchases respiratory therapy services furnished by an outside supplier prior to April 10, 1998, Supplemental Worksheet A-8-4 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-4, Part V, line 46.

Line 16.--Where an outpatient rehabilitation provider purchases physical therapy services furnished by an outside supplier prior to April 10, 1998, Supplemental Worksheet A-8-3 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-3, Part VI, line 57.

Line 17.--Where an outpatient rehabilitation provider purchases respiratory therapy services furnished on or after April 10, 1998 by an outside supplier, Supplemental Worksheet A-8-5 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-5, Part VI, line 65.

Line 17.1.--Where an outpatient rehabilitation provider purchases physical therapy services furnished on or after April 10, 1998 by an outside supplier, Supplemental Worksheet A-8-5 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-5, Part VI, line 65.

Line 17.2.--Where an outpatient rehabilitation provider purchases occupational therapy services furnished on or after April 10, 1998 by an outside supplier, Supplemental Worksheet A-8-5 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-5, Part VI, line 65.

Line 17.3.--Where an outpatient rehabilitation provider purchases speech pathology services furnished on or after April 10, 1998 by an outside supplier, Supplemental Worksheet A-8-5 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Supplemental Worksheet A-8-5, Part VI, line 65.

Lines 18 and 19.--Enter on any of these lines any adjustments that are not specifically required on any other line.

Lines 20 and 21.--If depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expense per your books, enter the difference on lines 20 and/or 21. (See CMS Pub. 15-I, §100ff.)

Line 22.--Enter the total of lines 1 through 21. Transfer all the amounts on lines 1 through 21, column 2, to the appropriate lines on Worksheet A, column 6.

1807. SUPPLEMENTAL WORKSHEET A-3-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Worksheet A-3-1 provides for the computation of any needed adjustments to costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-I, §1004.)

Part A.--This part must be completed by all providers. If the answer to Part A is "Yes," Parts B and C must also be completed.

Part B.--Costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer would pay for comparable services, facilities or supplies that are purchased elsewhere.

Part C.--This part shows the interrelationship of the provider to organizations furnishing services, facilities or supplies to the provider. The requested data relative to all individuals, partnerships, corporations or other organizations having either a related interest to the provider, a common ownership with the provider, or control over the provider as defined in CMS Pub. 15-I, §1004, must be shown in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship indicated.

Column 1.--Enter the appropriate symbol which describes the interrelationship of the provider to the related organization.

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual in column 2 or the organization in column 4 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 4.--Enter the name of the related corporation, partnership or other organization.

Column 5.--If the individual in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

1808. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND
WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization e.g., other general service cost centers, revenue cost centers, nonreimbursable cost centers - patient care, and other nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 7.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B.

To facilitate the allocation process, the general formats of Worksheets B and B-1 are identical. Each general service cost center has the same line number as its respective column number across the top. Also, the column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each reimbursable and nonreimbursable cost center are identical on the two worksheets. Prepare these worksheets in conjunction with each other.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated.

Most cost centers are allocated on different statistical bases. However, for those cost centers with the same basis (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that were closed.

When closing the general service cost centers, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheets. However, your circumstances may be such that it is more accurate to allocate certain cost centers in a sequence different from that followed on these worksheets.

NOTE: If you wish to change an allocation basis for a particular cost center or the order in which the cost center is allocated, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-I, §2313.)

If the amount of any cost center on Worksheet A, column 7, has a credit balance, show this amount as a credit balance on Worksheet B, column 0. The costs from the applicable overhead cost centers are allocated in the normal manner to such cost center showing a credit balance. If after receiving costs from the applicable overhead cost centers, a general service cost center has a credit balance at the point it is to be allocated, do not allocate such general service cost center. Rather, enter the credit balance in parenthesis on line 65 of the appropriate column, as well as the first line of the column.

This enables you to crossfoot column 17, line 65 to column 0, line 65. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 17, do not carry such credit balance forward to Worksheet C.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated, the total statistical base over which the expenses are to be allocated (e.g., for column 1 (Capital Related - Buildings and Fixtures), enter on line 1 the total square feet of the buildings and fixtures on which depreciation was taken).

Such statistical base does not include any statistics related to services furnished under arrangements except when:

o Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or

o The intermediary determines that the provider is able to gross up the costs and charges for services to non-Medicare patients so that both costs and charges are recorded as if the provider had furnished such services directly to all patients (Medicare and non-Medicare). (See CMS Pub. 15-1, §2314.)

For all cost centers (below the first line of the column) to which the capital-related costs are being allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on line 1.

Enter on line 66 the total expenses of the cost center being allocated. Obtain this amount from the same column and line number on Worksheet B used to enter the total statistical base on Worksheet B-1. (In the case of buildings and fixtures, this amount is on Worksheet B, column 1, line 1.)

Divide the amount entered on line 66 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 67. The unit cost multiplier must show at least six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 66) of all of the cost centers receiving the allocation on Worksheet B must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for each cost center on both Worksheets B and B-1 before proceeding to the next column for the cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 17, the sum of expenses on lines 15 through 65, columns 1 through 16. The total expenses entered in column 17, line 66, must equal the total expenses entered in column 0, line 66.

Transfer the totals in column 17, lines 15 through 43 of Worksheet B to Worksheet C, column 1, corresponding lines (above the dotted rules). Do not transfer the nonreimbursable cost center totals, lines 45 through 65.

NOTE: Whenever an adjustment is required to expenses after cost allocation, submit a supporting worksheet showing the computation of the adjustment, the amount applicable to each cost center, and the cost center balances which are to be carried forward from Worksheet B for cost apportionment to the health care programs.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures e.g., insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square feet of area occupied.

If a clinic, CORF, public health agency, or rehabilitation agency occupies more than one building, it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 1.

Column 2.--If you do not directly assign the depreciation on movable equipment and expenses pertaining to movable equipment, e.g., insurance, interest and rent, as part of your normal accounting systems, you must accumulate the expenses in this cost center. Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 3.--The salary statistics used for employee health and welfare cost allocation must be reconcilable to total salaries and salary by department shown on Worksheet A, column 1. Adjustments are necessary to take into account salaries reclassified in column 4 of Worksheet A and the salaries adjusted in column 6 of Worksheet A.

Column 4.--Allocate the administrative and general expenses on the basis of accumulated cost. Therefore the amount entered in Worksheet B-1, column 4 is the sum of Worksheet B, columns 1 through 3, lines as applicable.

A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Worksheet B-1, Column 4A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 3A, line 66 and the accumulated cost reported on Worksheet B-1, column 4, line 4. Enter any amounts reported on Worksheet B, column 3A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead. In addition, report on line 4 the administrative and general costs reported on Worksheet B, column 4, line 4, since these costs are not included on Worksheet B-1, column 4 as an accumulated cost statistic.

For subscripted A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 4 (A&G), the reconciliation column designation must be 4A.

Worksheet B-1, Column 4--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 4, line 4, is the difference between the amounts entered on Worksheet B, column 4A and Worksheet B-1, column 4A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

1809. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

Worksheet C consists of two pages. Page one is used by providers certified as CORFs, while page two is used by CMHCs and other providers required to file Form CMS-2088-92. On page two, the CMHC completes lines 29 through 39 and the other providers complete lines 40 through 44. The other providers are agencies and clinics certified as OPT, OOT, and OSP.

To determine the allowable costs applicable to the Medicare program, apportion the costs between the Medicare beneficiaries and the other patients. The basis of the apportionment is the gross amount of charges for each reimbursable cost center.

On this worksheet, the lines in columns 1, 3, and 4 are divided into two parts: The first part resides on subline .01 and the second part resides on subline .02. In each instance, cost data is entered on subline .01. The following column instructions apply to both parts.

Column 1.--Enter on subline .01 of each line the total cost of each cost center as computed on Worksheet B, column 17, corresponding lines. Do not bring forward any cost center with a credit balance from Worksheet B, column 17. However, the charges applicable to such cost centers with a credit balance must be reported on subline .02 of the appropriate line on Worksheet C.

Enter on subline .02 of each line (from your records) the gross total patient charges for each cost center including in the appropriate cost center items reimbursed on a fee schedule (i.e., DME, oxygen, prosthetics and orthotics). However, do not include Medicare charges applicable to those items in the Medicare charges reported in column 3, lines 22, 25 or 26 of the worksheet. If you charge some patients less than the customary charges for services rendered because of the patients' inability to pay or for any other reason, those charges are increased (for apportionment purposes) to reflect the gross amounts.

Thus, for computing reimbursable costs on this worksheet, the individual amounts applicable to Medicare program patients must not differ from the amounts applicable to all other patients for the same services.

When certain services by a provider are furnished under arrangements and an adjustment is made on Worksheet A-3 to gross up costs, the related charges entered on Worksheet C are also grossed up in accordance with CMS Pub. 15-I, 2314.

Column 2.--Divide the cost on subline .01 of each line in column 1 by the gross charges on subline .02 of each line in column 1 to determine the ratio of total cost to total charges for each cost center. Enter the resultant cost center ratios in column 2. Carry the ratio out to six decimal places.

Column 3.--Enter on subline .02 of each line the Medicare program charges (from your records) for each cost center. Multiply the charges for each cost center by the ratio in column 2 (same line) to determine the cost. Enter the result on subline .01 of the line.

Section 4541 of BBA 1997 mandates a fee schedule payment basis for all CORF services (lines 15-27) rendered on or after January 1, 1999. Drugs, biologicals and supplies rendered on or after July 1, 2000, are also reimbursed based on the fee schedule. Section 4541 also mandates a fee schedule payment basis for other outpatient physical therapy (which includes outpatient speech pathology) and outpatient occupational therapy services (lines 40-42) rendered on or after January 1, 1999. These outpatient services are reimbursed the lesser of the applicable fee scheduled amount or the actual charge for the service on a claim-by-claim basis. Additionally, the three outpatient therapy services are subject to a statutory financial limitation which is applied on a beneficiary specific basis through the Medicare claims system. As such, the Medicare (title XVIII) charges for these services must **not** be included in column 3, subline .02. However, the Medicare (title XVIII) charges applicable to those remaining services reimbursed on a reasonable cost basis

are still required in column 3, subline .02. Contact your intermediary for specific services reimbursed on a fee schedule.

Line 22.--Do **not** enter the charges for prosthetic or orthotic devices as these devices are reimbursed on a fee schedule.

Lines 25 and 26.--Do **not** enter the charges for DME as these devices are reimbursed on a fee schedule.

Column 4.--Enter on subline .02 of each line the non-Medicare program charges (from your records) for each cost center. Multiply the charges for each cost center by the ratio in column 2 (same line) to determine the cost. Enter the result on subline .01 of the line.

For CMHCs only (excluding CORFs and OPTs), sublines .01 and .02 in column 3 and 4 of each line must total to sublines .01 and .02 in column 1 of each line.

Enter on line 28.01, columns 1, 3, and 4, respectively, the sum of lines 15.01 through 27.01. Enter on line 28.02, columns 1, 3, and 4, respectively, the sum of lines 15.02 through 27.02.

Enter on line 39.01, columns 1, 3, and 4, respectively, the sum of lines 29.01 through 38.01. Enter on line 39.02, columns 1, 3, and 4, respectively, the sum of lines 29.02 through 38.02.

Enter on line 44.01, columns 1, 3, and 4, respectively, the sum of lines 40.01 through 43.01. Enter on line 44.02, columns 1, 3, and 4, respectively, the sum of lines 40.02 through 43.02.

Outpatient Therapy Cost Reduction Computation.--For CORF services (lines 15-27) and other outpatient therapy providers (lines 40-42), columns 5 through 7 compute the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) as required by DME1834(k) of the Act and enacted by §4541 of the Balanced Budget Act (BBA) of 1997. The amount of the reduction is 10 percent for services rendered January 1, 1998 **through December 31, 1998. However, the 10 percent reduction still applies to vaccines (drugs cost center) administered on or after January 1, 1999, which are reimbursed on a reasonable cost basis.** The reduction does not apply to CMHC services.

Column 5, lines 15-27 and 40-42.--For each cost center, enter the title XVIII charges (from your records) for services rendered January 1, 1998 **through December 31, 1998. CORFs complete all lines (15 - 27) as all cost reimbursed CORF services are subject to the 10 percent reduction. Enter the applicable title XVIII charges for vaccines (line 23) rendered on or after January 1, 1999.**

Column 6, lines 15-27 and 40-42.--Determine the title XVIII cost for services rendered on or after January 1, 1998 by multiplying the charges in column 5 by the ratio in column 2, and enter the result.

Column 7, lines 15-27 and 40-42.--Determine the reduction amount by multiplying the cost in column 6 by 10% (.10), and enter the result.

Column 8, lines 15-27 and 40-42.--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 7 from the amount in column 3, subline .01. For lines 29 through 38 and line 43, transfer the cost from column 3, subline .01 to the corresponding line in column 8.

Line 28.--Enter the total of lines 15 through 27, columns 5 through 8. See the instructions for Worksheet D, Part I, lines 1 and 1.1 to determine the amounts to transfer to Worksheet D.

Partial hospitalization services provided by CMHCs reimbursed based on a Prospective Payment System (PPS).--For CMHC services (lines 29-38) rendered on or after August 1, 2000, reimbursement is based on PPS subject to a transitional corridor payment. Vaccines furnished by CMHCs are reimbursed based on outpatient PPS. **To facilitate completion of this worksheet, the heading for columns 5, 6, and 8 will change (identified as the pre transition, date and the on or after date) based on the cost reporting period.**

Column 5, lines 29-38.--For each cost center, enter the Title XVIII charges (from your records) for services rendered on or after August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004.** For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 6, lines 29-38.--Determine the title XVIII cost for services rendered on or after August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004** by multiplying the charges in column 5 by the ratio in column 2, and enter the result. **For cost reporting periods beginning on or after January 1, 2004, enter zero (0).**

Column 8, lines 29-38.--Determine the title XVIII pre transition date (August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**) cost by subtracting the amount in column 6 from the amount in column 3, subline .01, and enter the result. For lines 29 through 38 and line 43, transfer the cost from column 3, subline .01 to the corresponding line in column 8. **For cost reporting periods beginning on or after January 1, 2004, this column must equal zero (0).**

Line 39.--Enter the total of lines 29 through 38, and transfer the amount on line 39 **in accordance with the instructions for Worksheet D, Part I, line 1.**

Line 43.--Enter in column 8 the cost from column 3, subline .01 to the corresponding line in column 8.

Line 44.--Enter the total of lines 40 through 43, columns 5 through 8 and transfer the amount on line 44, column 8 to Worksheet D **in accordance with the instructions for Worksheet D, Part I, line 1.**

1810. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES - TITLE XVIII

Worksheet D applies to title XVIII only and provides for the reimbursement calculation of outpatient rehabilitation services rendered to Medicare beneficiaries.

NOTE: CORFs with cost reporting periods overlapping January 1, 1998, complete Part I and lines 22 through 27 of Part II for services rendered prior to January 1, 1998. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29 as applicable as the Lesser of Reasonable Cost or Customary Charges (LCC) applies to these services.

Worksheet D consists of two parts:

- Part I - Computation of Reimbursement Settlement
- Part II - Computation of the Lesser of Reasonable Cost or Customary Charges

1810.1 Part I - Computation of Reimbursement Settlement.--

Line Descriptions

Line 1.--Enter the total expenses applicable to the health insurance program obtained from Worksheet C, column 8, line as appropriate (other providers from line 44). CORFs & OPTs use column 1 only. CORFs enter cost of services provided on or after January 1, 1998 by subtracting the amount in column 7, line 28 from the amount in column 6, line 28.

CMHCs with cost reporting periods ending prior to August 1, 2000, enter the applicable cost from Worksheet C, column 3, line 39.01. CMHCs with cost reporting periods overlapping August 1, 2000, enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet C, column 8, line 39 and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet C, column 6, line 39. CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

NOTE: For CMHCs only, column 1 is subscripted for lines 1 through 12 for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, and December 31, 2003, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

Lines 1.01 through 1.05 are to be completed by CMHCs for title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio (to 3 decimal places) provided by your intermediary.

Line 1.03.--Line 1, column 1.01 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered on or after August 1, 2000 through December 31, 2001:

- a. If line 1.04 is => 90% but < 100% enter 80% of the result of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
- c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
- d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered on or after January 1, 2002 through December 31, 2002:

- a. If line 1.04 is => 90% but < 100% enter 70% of the result of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
- c. If line 1.04 is < 80% enter 13% of line 1.03.

For services rendered on or after January 1, 2003 through December 31, 2003:

- a. If line 1.04 is => 90% but < 100% enter 60% of the result of line 1.03 minus line 1.01.
- b. If line 1.04 is < 90% enter 6% of line 1.03.

Line 1.1.--CORFs with cost reporting periods overlapping January 1, 1998, enter the total expenses for services provided prior to January 1, 1998 by subtracting the amount in column 6, line 28 from the amount in column 3, line 28.01. CORFs with cost reporting periods beginning on or after January 1, 1998, enter zero (0). CMHCs and OPTs make no entry on this line.

Line 2.--Enter the amounts paid or payable by primary payers when Medicare liability is secondary to that of the primary payer. There are several situations, as explained fully in 42 CFR 411, in which Medicare liability is secondary to a primary payer.

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Medicare is not the primary payer under the following situations:

1. If the items of services have been, or can reasonably be expected to be paid under a worker's compensation law of a State or of the United States, including the Federal Black Lung Program;
2. If the items of services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance;
3. If the beneficiary is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an employer group health plan (EGHP), Medicare is the secondary payer for the first 18 months (See §1862(b)(1)(C) of the Act);
4. If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP; and
5. If the beneficiary is under age 65 and disabled and is covered by a large group health plan (LGHP) as a current employee, self-employed individual, or family member of such an employee, or self-employed individual.

When payment by the primary payer satisfies the total liability of the beneficiary, the services are treated as if they were non-Medicare services. The patient charges are included in total patient charges but are not included in Medicare charges, and no primary payer payment is entered on line 2.

If the primary payment does not satisfy the beneficiary's liability, include the covered charges in Medicare charges, and include the total charges in total charges for cost apportionment purposes. Enter the primary payment on line 2 to the extent the primary payer payment is not applied to the beneficiary's deductible and coinsurance.

Any part of the payment by the primary payer that satisfies some or all of the beneficiary's Medicare deductible and coinsurance is applied against the deductible and coinsurance. Do not enter primary payer payments that are applied against the deductible or the coinsurance on line 2. The providers must familiarize themselves with primary payer situations because they have a legal responsibility to attempt to recover their costs from the primary payer before seeking payment from Medicare. The primary payer rules are more fully explained in 42 CFR 411.

Line 3.--For cost based CMHC services rendered prior to August 1, 2000, enter in the applicable column the total expenses for CMHC services by subtracting line 2 from line 1. Enter in the applicable column the total PPS payment for CMHC services furnished on or after August 1, 2000, by adding lines 1.01 and 1.05 minus line 2. CORFs and OPTs enter the result of line 1 plus line 1.1 minus line 2.

Line 4.--Enter the total amount of deductibles billed to program patients.

Line 6.--CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year) enter in the applicable column the amount from line 29 of Part II. For CMHCs with cost reporting periods beginning on or after August 1, 2000, do not complete this line as PPS reimbursed services are not subject to LCC. CORFs, and other providers enter in column 1 the amount from line 29 of Part II.

Line 8.--CORFs, OPTs, and CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year), enter in the applicable column 80 percent of the amount shown on line 7. CMHCs enter 0 (zero) for services reimbursed under PPS.

Line 9.--CORFs and OPTs enter in the applicable column the coinsurance amount billed to Medicare beneficiaries, but this amount may not exceed 20 percent of the customary charges as shown on line

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27, Part II. For CMHCs, enter in the applicable the column the gross coinsurance amount billed to Medicare beneficiaries.

Line 11.--Enter reimbursable bad debts, net of bad debt recoveries, applicable to any Medicare deductibles and coinsurance. The amount entered applicable to CMHC PPS must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 11.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 11. (12/31/2004)

Line 12.--CORFs, OPTs and CMHCs for cost reimbursed services only, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 8 or 10. For CMHC PPS reimbursed services, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 7 or 10.

Line 15.--Enter the sum of columns 1 and 1.01, line 12 plus line 14.

Line 16.--Enter the sequestration adjustment as required by the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177). (See §120 of CMS Pub. 15-II).

Line 16.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4)

Line 17.--Subtract lines 16 and 16.5 from line 15 and enter the result.

Line 18.--Enter the total interim payments applicable to this cost reporting period from Worksheet S-1, line 4. For intermediary final settlement, report on line 18.5 the amount from Worksheet S-1, line 5.99.

Line 19.--Subtract the total amount entered on line 18 from the amount entered on line 17 and enter the resulting amount. This represents the amount due to or from the provider before any tentative or final settlement. Transfer this amount to Worksheet S, Part III, line 6.

1810.2 Part II - Computation of Lesser of Reasonable Cost or Customary Charges.--Part II provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: For CORF services rendered prior to January 1, 1998, complete lines 22 through 27 as these services are not subject to LCC but are reimbursed based on Reasonable Costs. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29, as these services are subject to LCC.

Line Descriptions

Line 21.--CMHCs enter the reasonable cost of Title XVIII services as follows: Reporting periods overlapping August 1, 2000, from Part I, line 1, column 1; Reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. For CORFs this line represents the reasonable cost of Title XVIII services rendered on or after January 1, 1998 from line 1. OPTs enter the reasonable cost of Title XVIII services from Worksheet C, column 8, line 44.

Line 21.1.--This line is the CORF reasonable cost of Title XVIII services rendered prior to January 1, 1998 from Part I, line 1.1.

Line 22.--This line provides for the charges which relate to the reasonable cost on line 21. CMHCs with cost reporting periods which overlap August 1, 2000, enter the result of Worksheet C, column 3, line 39.02 minus column 5, line 39 and for reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. OPTs enter the amount from Worksheet C, column 3, line

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44.02. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement. CORFs enter the total charges for Medicare services provided on or after January 1, 1998 from Worksheet C, column 5, line 28.

Line 22.1.--This line provides for CORF charges prior to January 1, 1998, which relate to the reasonable cost on line 21.1. Enter the result of Worksheet C, column 3, line 28.02 minus Worksheet C, column 5, line 28. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement.

Lines 23 through 27.--These lines provide for the reduction of Medicare charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 24 through 26, but enter on line 27 the amount from line 22 and enter on line 27.1 the amount from line 22.1. See 42 CFR 413.13(b). In no instance may the customary charges on line 27 exceed the actual charges on line 22, or the customary charges on line 27.1 exceed the actual charges on line 22.1.

1812. WORKSHEET G - STATEMENT OF REVENUE AND EXPENSES

Worksheet G is prepared from your accounting books and records. Additional worksheets may be supplied if necessary.

Worksheet G is completed by all providers.

You may substitute your own forms for Worksheet G. However, you must provide the minimum detail contained in Worksheet G.

1813. SUPPLEMENTAL WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider. 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Supplemental Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services, e.g., research. Only provider services are reimbursable to you through the cost report. If you are a CORF, see 42 CFR 410.100(a) for an explanation of which services constitute provider services. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet is to apply the

RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

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Columns 2 and 11.--Enter (on the same line as the cost center) the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, each physician must be listed on successive lines below the cost center. Each physician must be listed using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to the fiscal intermediary upon audit.

When RCE limits are applied on a departmental basis, insert the word "aggregate" instead of the physician identifiers on the line below the cost center description.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by the provider for each cost center. Physician compensation is monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications or as a cost paid by a related organization through Worksheet A-3-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5.--For each cost center, enter the amount of the total remuneration included in column 3 which is applicable to general services to the provider (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider and nonallowable services such as research. A physician's nonallowable services must not be included in columns 4 or 5 above. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-3.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent

(RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments.

The RCE limits are updated annually on the basis of updated economic index data. A notice is published in the **Federal Register**, which sets forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable (non metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million).

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Column 7.--Enter, for each line of data, the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040.

The hours entered are the actual hours for which the physician is compensated by the provider for furnishing services of a general benefit to its patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records, or other documentation that supports this allocation, must be available for verification by the intermediary upon request. (See CMS Pub. 15-I, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--Enter, for each line of data, five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider.

Enter, for each line of data, the actual amounts of these expenses which you paid.

Column 13.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 12 and divide the result by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians,) services to your patients. In making this adjustment, the intermediary determines the ratio of that portion of compensated physician time spent in furnishing services in the provider (both to you and to your patients) to the physician's total working time in the provider and adjusts the total malpractice expense proportionately.

Enter, for each line of data, the actual amounts of these malpractice expenses which you paid.

Column 15.--Enter, for each line of data, the result of multiplying the amount in column 5 by the amount in column 14 and divide the result by the amount in column 3.

Column 16.--Enter, for each line of data, the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from the provider component remuneration in column 5. If the result is a negative amount, enter zero in this column.

Column 18.--The adjustment for each cost center to be entered represents the provider-based physician (PBP) elimination from provider costs entered on Worksheet A-3, column 2, line 14. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line Descriptions

Total Line.--Total the amounts in columns 3 through 5, 7 through 9 and 12 through 18.

1814. SUPPLEMENTAL WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

COMPLETE THIS WORKSHEET ONLY FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998. FOR SERVICES PROVIDED ON OR AFTER APRIL 10, 1998, COMPLETE WORKSHEET A-8-5.

Supplemental Worksheet A-8-3 provides for the computation of any needed adjustments to costs applicable to physical therapy services furnished by outside suppliers. The information required on this worksheet must provide for, in the aggregate, all data for physical therapy services furnished by all outside suppliers in determining the reasonableness of physical therapy costs.

NOTE: Any provider furnishing physical therapy services under arrangement with outside suppliers must complete this supplemental worksheet. Physical therapy is not a covered service for CMHCs. Therefore, this worksheet is inapplicable for CMHCs. **Prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. (See 42 CFR § 413.106.)**

If a provider contracts with an outside supplier for physical therapy services, the potential for limitation and the amount of payment a provider can receive depends on the following factors:

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

1814.1 Part I - General Information.--This part provides for furnishing certain information concerning physical therapy services furnished by outside suppliers.

Line 1.--Enter the number of weeks that services were performed at the provider 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 to CORF patients by supervisors, therapists, or assistants. Count weeks when services were performed both at the provider's site and at the patient's home only once.

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 was at the provider's site. Only count 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 was at the treatment site. Do not include in the count days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day of which 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 offsite 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 offsite 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.

Line 8--Do not complete this line.

Line 9--Enter in the appropriate columns the total number of hours worked for physical therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 10--Enter in each column on this line the appropriate adjusted hourly salary equivalency amount (AHSEA). These amounts are the prevailing hourly salary rate plus the fringe benefit and expense factor. These amounts are determined on a periodic basis for appropriate geographical areas.

Enter in column 1 the supervisor AHSEA, adjusted for administrative and supervisory responsibilities, which is determined in accordance with the provisions of CMS Pub. 15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, and aides respectively) the AHSEA from the appropriate exhibit found in CMS Pub. 15-I, chapter 14 or from the latest publication of rates. When the prevailing hour rate in the area for therapy assistants is unobtainable, use no more than 75 percent of the therapist adjusted hourly salary equivalency amount (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 the provider's employees of comparable classification and/or qualification, e.g., nurses aides. (See CMS Pub. 15-I, DME1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA as follows. 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, if time records of visits are kept. Lines 12 and 13 are subscripted into two categories of, provider site and provider offsite. (See CMS Pub. 15-I, §§1402.5 and 1403.1.)

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

1814.2 Part II - Salary Equivalency Computation--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When the provider furnishes physical therapy services by outside suppliers for health care program patients but simply arranges for such services for nonhealth care program patients and does not pay the nonhealth care program portion of such services, its books reflect only the cost of the health care program portion. If the provider can gross up its costs and charges in accordance with provisions of CMS Pub. 15-I, § 2314, it completes Part II, lines 14 through 19 and 22 in all cases, and lines 20 and 21 when appropriate. However, if the provider cannot gross up its costs and charges, it must complete lines 14 through 19 and line 22.

Lines 14 through 19.--Complete these lines 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, and aides.

Lines 20 and 21.--Complete these lines if the sum of hours in columns 1 through 3, line 9, is less than or equal to the product found on line 2.

Line 22.--When there are no entries on lines 20 and 21, enter the amount on line 19. Otherwise enter the sum of the amounts on lines 18 and line 21.

1814.3 Part III - Standard Travel Allowance and Standard Travel Expense - Computation - Provider Site.--This part provides for the computation of the standard travel allowance and standard travel expense for services rendered at the provider site.

Lines 23 through 27.--These lines provide for the computation of the standard travel allowance and standard travel expense for physical therapy services performed at the provider site. One standard travel allowance is recognized for each day an outside supplier performs skilled physical therapy services at the provider site. For example, if a contracting organization sends three therapists to a provider 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 standard travel expense.)

Line 23.--Enter the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors appropriately does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub. 15-I, §1402.4.)

1814.4 Part IV - Standard Travel Allowance and Standard Travel Expense - Services.--This part provides for the computation of both the standard travel allowance and standard travel expense. (See CMS Pub. 15-I, §§1402.4, 1403.1 and 1412.6.)

Lines 28 through 31.--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Use these lines only 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 32 through 35.--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with offsite services only. Compute the optional travel allowance on lines 32 through 34. Compute the optional travel expense on line 35.

Lines 36 through 38.--Choose and complete only one of the options on lines 36 through 38. However, use lines 37 and 38 only if you maintain time records of visits. (See CMS Pub. 15-I, §1402.5.)

1814.5 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 the provider in excess of the provider's standard work week. No overtime allowance may be given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-I, §1412.4.)

Line 39.--Enter in the appropriate columns the total overtime hours worked. If the total hours in column 4 are either zero, equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 40 through 47. Enter zero in each column of line 48. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 40.--Enter, in the appropriate column, the overtime rate (the AHSEA from line 10, column as appropriate) multiplied by 1.5.

Line 42.--Enter the percentage of overtime hours, by class of employee, by dividing each column on line 39 by the total overtime hours in column 4, line 39.

Line 43.--This line is for the allocation of a provider's standard work year for one full-time employee. Enter the numbers of hours in the standard work year for one full-time employee in column 4 of this line. Multiply the standard work year in column 4 by the percentage on line 42 and enter the result in the corresponding columns of this line.

Line 44.--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.

1814.6 Part VI - Computation of Physical Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy costs.

Line 51.--Enter the amount reported on lines 36, 37, or 38.

Lines 53 and 54.--When the outside supplier provides the equipment and supplies used in furnishing direct services to the provider's patients, the actual cost of the equipment and supplies incurred by the outside supplier (see CMS Pub. 15-I, §1412.1) may be considered as an additional allowance in computing the limitation.

Line 56.--Enter the amounts paid and/or payable to the outside suppliers for physical 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 physical therapy services for the provider.

Line 57.--Enter the excess cost over the limitation, i.e., line 56 minus line 55. If the result is negative, enter zero. Transfer this amount to Worksheet A-3, line 16.

1815. SUPPLEMENTAL WORKSHEET A-8-4 - REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

COMPLETE THIS WORKSHEET ONLY FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998. FOR SERVICES PROVIDED ON OR AFTER APRIL 10, 1998, COMPLETE WORKSHEET A-8-5.

Supplemental Worksheet A-8-4 provides for the computation of any needed adjustments to costs applicable to respiratory therapy services furnished by outside suppliers. The information required on this supplemental worksheet must provide for, in the aggregate, all data for respiratory therapy services furnished by all outside suppliers in determining the reasonableness of respiratory therapy costs.

NOTE Any provider furnishing respiratory therapy services under arrangements with outside suppliers must complete this worksheet. Respiratory therapy is not a covered service for CMHCs and outpatient rehabilitation providers (OPTs, OOTs and OSPs). Therefore, this worksheet is not applicable for CMHCs and outpatient rehabilitation providers. Prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. (See 42 CFR § 413.106.)

If a provider contracts with an outside supplier for respiratory therapy services, the potential for limitation and the amount of payment a provider can receive depends on the following factors:

- o An initial test to determine whether these services are categorized as intermittent part-time or full-time services;
- o Add-ons for supervisory functions, aides, trainees, overtime, equipment, and supplies; and
- o Intermediary determination of reasonableness of rates charged by the supplier compared with the going rates in the area.

1815.1 Part I - General Information.--This part provides for furnishing certain information concerning respiratory therapy services furnished by outside suppliers.

Line 1.--Enter the number of weeks during which respiratory therapy services were performed at the provider site. Count only those weeks during which a registered therapist supervisor, certified therapist supervisor, nonregistered/noncertified therapist supervisor, registered therapist, certified therapist, or nonregistered/noncertified therapist was onsite.

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.

Lines 3 through 5.--Enter on the appropriate line the number of unduplicated days on which services were rendered on the provider's site. Enter those days on which that category has the highest AHSEA of all supplier respiratory therapy staff onsite that day. For example, when a registered therapist has a higher AHSEA than a certified therapist, and both are onsite in the same day, record one day for the registered therapist. If two certified therapists are onsite in one day, count only one day for a certified therapist.

Line 6.--Enter the standard travel expense rate as published in CMS Pub. 15-I, DME1412.6.

Line 7.--Enter (in the appropriate columns) the total number of hours worked at the provider's site for each category.

Line 8.--Enter (in the appropriate columns) the AHSEA for each category.

These amounts are the prevailing hourly salary rates plus the fringe benefit and expense factors. These amounts are determined on a periodic basis for appropriate geographical areas and are published as exhibits at the end of CMS Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in columns 1 through 3 the appropriate AHSEA adjusted for administrative and supervisory responsibility. (See CMS Pub. 15-I, §1412.5.) Enter in columns 4 through 6 the AHSEA for those categories from the exhibit in chapter 14 or from the latest publication of rates. Evaluate the cost of services of a respiratory therapy aide or trainee at the hourly rate not to exceed the hourly rate paid to the provider's employees of comparable classification and/or qualification, e.g., nurses aides. Adjust the base hourly rate by the appropriate fringe benefit and expense factor. (See CMS Pub. 15-I, §1412.2.) In no case, however, may an aide or trainee be considered as a nonregistered/noncertified therapist. (See CMS Pub. 15-I, §1403.)

Line 9.--Enter the standard travel allowance equal to one half of the AHSEA (see CMS Pub. 15-I, §1402.4) as follows. Enter in columns 1 through 3 one half of the amounts in columns 4 through 6, respectively, line 8 (the supervisory allowance does not enter into the travel allowance). Enter in columns 4 through 6 one half of the amounts in columns 4 through 6, respectively, line 8.

1815.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary.

When the provider furnishes respiratory therapy services by outside suppliers for health care program patients but simply arranges for such services for nonhealth care program patients and does not pay the nonhealth care program portion of such services, its books reflect only the cost of the health care program portion. If you can gross up your costs and charges in accordance with the provisions of CMS Pub. 15-I, §2314, complete Part II, lines 10 through 19 and 22 in all cases and lines 20 and 21, where appropriate. However, if you cannot gross up your costs and charges, complete lines 10 through 19 and 22 only. (See CMS Pub. 15-I, §1404.)

Lines 10 through 19.--Complete these lines to compute the total salary equivalency allowance amounts by multiplying the total hours worked for each category (line 7) by the AHSEA for supervisory registered therapist, supervisory certified therapist, supervisory nonregistered/noncertified therapist, registered therapist, certified therapist, nonregistered/noncertified therapist, aides, and trainees.

Lines 20 and 21.--Complete these lines if the sum of the hours in columns 1 through 6, line 7 is less than or equal to the hours on line 2. Do not complete these lines if you cannot gross up your costs and charges.

Line 22.--If there are no entries on lines 20 and 21, enter the amount on line 19. Otherwise, enter the sum of the amounts on lines 17, 18, and 21.

1815.3 Part III - Standard Travel Allowance and Standard Travel Expense Computation.--This part provides for the computation of the standard travel allowance and standard travel expense.

Lines 23 through 26.--These lines provide for the computation of the standard travel allowance for registered therapists, certified therapists, and nonregistered/noncertified therapists and the total standard travel allowance, respectively, for services performed at the provider's site. The travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. Therefore, supervisory therapists are combined with their category of therapists (e.g., include a supervisory registered therapist with registered therapists).

One standard travel allowance is recognized for each day an outside supplier performed skilled respiratory therapy services at the provider's site. The allowance is based on the rate for the supplier's staff with the highest AHSEA onsite that day. (See the instructions for lines 3 through 5. See CMS Pub. 15-I, §1403.1, for a discussion of the travel allowance.)

Line 27.--Enter the standard travel expense for services rendered at the provider's site. Compute this amount as the sum of the days on lines 3 through 5 multiplied by the amount on line 6.

1815.4 Part IV - Overtime Computation.--This part provides for the computation of an overtime allowance when employees of the outside supplier perform services for the provider in excess of the provider's standard work week. No overtime allowance may be given to a therapist who receives an additional allowance for supervisory or administrative duties.

Line 29.--Enter in the appropriate columns the total overtime hours worked. If the total hours in column 6 are either zero, equal to or greater than 2080 hours, the overtime computation is not applicable. Make no further entries on lines 30 through 37. Enter zero in each column of line 38. Enter the sum of the hours recorded in columns 1 through 5 in column 6.

Line 30.--Enter in the appropriate column the overtime rate. This rate is the AHSEA from Part I, line 8, column as appropriate, multiplied by 1.5.

Line 32.--Enter the percentage of overtime hours by class of employee. This is determined by dividing each column on line 29 by the total overtime hours in column 6, line 29, in the appropriate column.

Line 33.--This line is for the allocation of a provider's standard work year for one full-time employee. Enter the number of hours in the provider's standard work year for one full-time employee in column 6 of this line. Multiply the number of hours in column 6 by the percentage on line 32 and enter the result in the corresponding columns of this line.

Line 34.--Enter in columns 1 through 5 the AHSEA from Part I, line 8, columns 4 through 8, as appropriate.

1815.5 Part V - Computation of Respiratory Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to respiratory therapy service costs in determining the reasonableness of respiratory therapy cost.

Lines 42 and 43.--When the outside supplier provides the equipment and supplies used in furnishing direct services to the provider's patients, the actual costs of the equipment and supplies incurred by the outside supplies, as specified in CMS Pub. 15-I, §1412.1, may be considered as an additional allowance in computing the limitation.

Line 45.--Enter the amounts paid and/or payable to the outside supplies for respiratory therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime or any other expense related to supplying respiratory therapy services for the provider.

Line 46.--Enter the excess of respiratory therapy cost over the limitation, line 45 minus line 44, and transfer this excess cost to Worksheet A-3, line 15. If negative, enter zero.

1816 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 respiratory therapy, physical therapy, occupational therapy and speech pathology services furnished by outside suppliers. (See 42 CFR §413.106.) 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 PRM-I, chapter 14.)

NOTE: CORFs (for ORT, OPT, OOT and OSP services) and OPTs (for OPT, OOT and OSP services) that furnish therapy services under arrangement with outside suppliers, complete this worksheet. CMHCs complete this worksheet only for occupational therapy services furnished by outside suppliers. **CMHCs do not compete this worksheet for services rendered on or after August 1, 2000.** OPTs do not complete this worksheet for respiratory therapy. For services furnished on or after April 10, 1998, prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. (See 42 CFR § 413.106.) Do not complete this form for CORFs and OPTs rendering OPT, OOT, and OSP services on or after January 1, 1999 and CORFs and OPTs rendering ORT services on or after July 1, 2000 as these services are subject to a fee schedule.

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

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o The location where the services are rendered, i.e, at your site or HHA home visit;
- o Add-ons for supervisory functions, aides, overtime, equipment and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the salary equivalency guidelines amounts.

1816.1 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 patients home are only counted once. (See PRM-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 the therapists only 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 offsite visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit. Do not complete these lines.

Line 6.--Enter the number of unduplicated offsite 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 PRM-I, chapter 14.)

Line 8.--Enter the optional travel expense rate applicable. (See PRM-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 PRM-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 PRM-1, 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 PRM-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 PRM-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 PRM-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 PRM-I, §1402.4.)

Lines 12 and 13.--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. Lines 12 and 13 are subscripted into two categories of, provider site and provider offsite. (See CMS Pub. 15-I, §§1402.5 and 1403.1.)

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

1816.2 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 PRM-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. See PRM-I, §2810 for instructions regarding grossing up costs and charges. 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, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others 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.)

Line 21.--Enter 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 22.--Enter the result of line 2 times line 21.

Line 23.--If there are no entries on lines 21 and 22, enter the amount on 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..

1816.3 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. Effective April 10, 1998, one standard travel allowance is recognized per discipline for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends four therapists (2 PTs, 1 OT, and 1 SLP) to you each day, three travel allowance is recognized per day. (See PRM-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 PRM-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 multiplied by line 3 for respiratory therapy or line 7 multiplied by 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.

1816.4 Part IV - Standard Travel Allowance and Standard Travel Expense - Offsite Services.--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 PRM-I, §§1402ff, 1403.1 and

1412.6.) This part is completed for physical therapy, speech pathology, respiratory therapy and occupational therapy only.

Lines 36 through 39.--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Use these lines only 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 through 43.--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with offsite services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 through 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.)

1816.5 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 PRM-I, §1412.4.)

Line 47.--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 4 are either zero or equal to or greater than 2080, 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 **language** pathology and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3 and 4 for **respiratory therapy** 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.

1816.6 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 PRM-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. Transfer this amount to Worksheet A-3, line 17 for respiratory therapy services, line 17.1 for physical therapy services, line 17.2 for occupational therapy services and line 17.3 for speech pathology services.