RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures								1
2	00200	Capital Related Costs-Movable Equipment								2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits								4
5	00500	Administrative and General								5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service								8
9	00900	Housekeeping								9
10	01000	Dietary								10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library								16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)								30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO.: _____			PERIOD: FROM _____ TO _____		WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electro cardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

							FROM _____ TO _____			
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)								118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118-199)				- 0 -				200

RECLASSIFICATIONS | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1												1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
30												30
31												31
32												32
33												33
34												34
35												35
###	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)											###

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	HIT designated Assets								7
8	Subtotal (sum of lines 1-7)								8
9	Reconciling Items								9
10	Total (line 7 minus line 9)								10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Total (sum of lines 1-2)								3

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instru.)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5-7)	
*		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
3	Total (sum of lines 1-2)				1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
*		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Total (sum of lines 1-2)								3

(1) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE # 4	Wkst. A-7 Ref. 5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	62		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	63		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		26
27	Depreciation - movable equipment			Movable Equipment	2		27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	64		30
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	65		31
32	CAH HIT Adjustment for Depreciation and Interest						32
33	Other adjustments (specify) (3)						33
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)						50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 32 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER NO: _____	PERIOD: FROM_____ TO_____	WORKSHEET A-8-1

A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.							5

* The amounts on lines 1-4 and subscripts as appropriate are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. Interrelationship to related organization(s) and/or home office:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial or non-financial) specify _____

PROVIDER-BASED PHYSICIANS ADJUSTMENTS | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-2

	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									101

	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL									200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS I & II

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)		1
2	Line 1 multiplied by 15 hours per week		2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		6
7	Standard travel expense rate		7
8	Optional travel expense rate per mile		8

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked						9
10	AHSEA (see instructions)						10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)						11
12	Number of travel hours (see instructions)						12
13	Number of miles driven (see instructions)						13

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)		15
16	Assistants (column 3, line 9 times column 3, line10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 9, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		20

If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.

21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)		23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A-8-3, PARTS III & IV

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	Standard Travel Allowance		
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
	Optional Travel Allowance and Optional Travel Expense		
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	Standard Travel Expense		
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
	Optional Travel Allowance and Optional Travel Expense		
40	Therapists (sum of columns 1 and 2, line 12 .01 times column 2, line 10)		40
41	Assistants (column 3, line 12.01 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		43
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: FROM _____	WORKSHEET A-8-3, PARTS V-VII

				_____	TO _____		
Check applicable box:	[ ] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology						

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
	CALCULATION OF LIMIT						
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 4, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35))		58
59	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)		63
64	Total cost of outside supplier services (from your records)		64
65	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		65