HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO _____	WORKSHEET J-1, PART I

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX [ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

	COMPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	4	4A	5	6	7	8	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

(1) Columns 0 through 25, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO _____	WORKSHEET J-1, PART I (CONT.)
Check Applicable Box:	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT	

	COMPONENT COST CENTER (omit cents)	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	
		9	10	11	12	13	14	15	16	17	18	19	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Respiratory Therapy												7
8	Psychiatric/Psychological Services												8
9	Individual Therapy												9
10	Group Therapy												10
11	Individualized Activity Therapies												11
12	Family Counseling												12
13	Diagnostic Services												13
14	Approved Patient Training & Education												14
15	Prosthetic and Orthotic Devices												15
16	Drugs and Biologicals												16
17	Medical Supplies												17
18	Medical Appliances												18
19	Durable Medical Equipment-Rented												19
20	Durable Medical Equipment-Sold												20
21	All Others												21
22	Totals (sum of lines 1-21)(1)												22
23	Unit Cost Multiplier (see instructions)												23

(1) Columns 0 through 25, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO _____	WORKSHEET J-1, PART I (CONT.)
Check Applicable Box:	[ ] Title V [ ] Title XVIII [ ] Title XIX		[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

	COMPONENT COST CENTER (omit cents)	NURSING SCHOOL	INTERNS & RESIDENTS		PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 4A-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJ.	SUBTOTAL (sum of cols. 24 ± 25)	ALLOCATED COMPONENT A&G (see Part II) (2)	TOTAL (sum of cols. 26 ± 27)	
			SALARY & FRINGES	PROGRAM COSTS							
		20	21	22	23	24	25	26	27	28	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

(1) Columns 0 through 25, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-1, PART II

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX

[ ] CMHC [ ] OOT
[ ] CORF [ ] OSP
[ ] OPT

	CMHC COST CENTER (omit cents)		CAPITAL RELATED COST				ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)
			BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION				
		0	1	2	4	4A	5	6	7	8
1	Administrative and General									
2	Skilled Nursing Care									
3	Physical Therapy									
4	Occupational Therapy									
5	Speech Pathology									
6	Medical Social Services									
7	Respiratory Therapy									
8	Psychiatric/Psychological Services									
9	Individual Therapy									
10	Group Therapy									
11	Individualized Activity Therapies									
12	Family Counseling									
13	Diagnostic Services									
14	Approved Patient Training & Education									
15	Prosthetic and Orthotic Devices									
16	Drugs and Biologicals									
17	Medical Supplies									
18	Medical Appliances									
19	Durable Medical Equipment-Rented									
20	Durable Medical Equipment-Sold									
21	All Others									
22	Totals (sum of lines 1-21)									
23	Total Cost to be Allocated									
24	Unit Cost Multiplier (see instructions)									

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET PART II (CON
[ ] Title V [ ] Title XVIII [ ] Title XIX		[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT	

		CORF COST CENTER (omit cents)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)*	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)
			9	10	11	12	13	14	15	16	17	18
1	1	Administrative and General										
2	2	Skilled Nursing Care										
3	3	Physical Therapy										
4	4	Occupational Therapy										
5	5	Speech Pathology										
6	6	Medical Social Services										
7	7	Respiratory Therapy										
8	8	Psychiatric/Psychological Services										
9	9	Individual Therapy										
10	10	Group Therapy										
11	11	Individualized Activity Therapies										
12	12	Family Counseling										
13	13	Diagnostic Services										
14	14	Approved Patient Training & Education										
15	15	Prosthetic and Orthotic Devices										
16	16	Drugs and Biologicals										
17	17	Medical Supplies										
18	18	Medical Appliances										
19	19	Durable Medical Equipment-Rented										
20	20	Durable Medical Equipment-Sold										
21	21	All Others										
22	22	Totals (sum of lines 1-21)										
23	23	Total Cost to be Allocated										
24	24	Unit Cost Multiplier (see instructions)										

DRAFT DRAFT FORM CMS-2552-10

J-1, T.)	HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-1 PART II (CONT.)
	[ ] Title V	[ ] Title XVIII	[ ] Title XIX	[ ] CMHC [ ] CORF [ ] OPT

NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME)			CORF COST CENTER (omit cents)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)				
19				20	21	22	23	24	25	26	27
	1	1	Administrative and General								
	2	2	Skilled Nursing Care								
	3	3	Physical Therapy								
	4	4	Occupational Therapy								
	5	5	Speech Pathology								
	6	6	Medical Social Services								
	7	7	Respiratory Therapy								
	8	8	Psychiatric/Psychological Services								
	9	9	Individual Therapy								
	10	10	Group Therapy								
	11	11	Individualized Activity Therapies								
	12	12	Family Counseling								
	13	13	Diagnostic Services								
	14	14	Approved Patient Training & Education								
	15	15	Prosthetic and Orthotic Devices								
	16	16	Drugs and Biologicals								
	17	17	Medical Supplies								
	18	18	Medical Appliances								
	19	19	Durable Medical Equipment-Rented								
	20	20	Durable Medical Equipment-Sold								
	21	21	All Others								
	22	22	Totals (sum of lines 1-21)								
	23	23	Total Cost to be Allocated								
	24	24	Unit Cost Multiplier (see instructions)								

1,
)

] OOT
] OSP

28	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.:_____ COMPONENT NO.:_____	PERIOD: FROM_____ TO_____	WORKSHEET J-2, PART I

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX [ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

PART I -APPORTIONMENT OF OUTPATIENT REHABILITATION PROVIDER COST CENTERS

		(From Wkst. J-1, Part I, col. 29)	Total Component Charges	Ratio of Costs to Charges (col. 1 ÷ col. 2)	Title V Component Charges	Title V Component Costs (col. 3 x col. 4)	Title XVIII Component Charges	Title XVIII Component Costs (col. 3 x col. 6)	Title XIX Component Charges	Title XIX Component Costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapy										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	All Others (1)										19
20	Totals (sum of lines 1-19)										20

(1) Enter amount in column 1 from Worksheet J-1, Part I, column 29, line 21.

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.:_____ COMPONENT NO.:_____	PERIOD: FROM_____ TO_____	WORKSHEET J-2, PART II

Check Applicable Box: [ ] Title V [ ] Title XVIII [ ] Title XIX [ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

PART II - APPORTIONMENT OF COST OF OUTPATIENT REHABILITATION PROVIDER SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		(From Wkst. J-1, Part I, col. 29)	Total Component Charges	Ratio of Costs to Charges (1)	Title V Component Charges (2)	Title V Component costs (col. 3 x col. 4)	Title XVIII Component Charges (2)	Title XVIII Component costs (col. 3 x col. 6)	Title XIX Component Charges (2)	Title XIX Component costs (col. 3 x col. 8)	
		1	2	3	4	5	6	7	8	9	
21	Respiratory Therapy										21
22	Physical Therapy										22
23	Occupational Therapy										23
24	Speech Pathology										24
25	Medical Supplies Charged to Patients										25
26	Implantable Devices Charged to Patients										26
27	Drugs Charged to Patients										27
28	Total (sum of lines 21-28)										28
29	Total component costs. Add the amount from Part I, line 20 and the amounts from line 29, columns 5, 7, and 9. (3)										29

(1) From Worksheet C, Part I, column 9, lines as appropriate

(2) Charges for columns 4, 6, and 8 are obtained from your records.

(3) Transfer the amounts on line 29, columns 5, 7, and 9, as appropriate, to Worksheet J-3, line 1.

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-3

Check Applicable Box:	[ ] Title V	[ ] CMHC	[ ] OOT
	[ ] Title XVIII	[ ] CORF	[ ] OSP
	[ ] Title XIX	[ ] OPT	

		PROGRAM COST 1	
1	Cost of component services (from Worksheet J-2, Part II, line 30)		1
2	PPS payments received excluding outliers		2
3	Outlier Payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
6	Total charges for program services		6
	CUSTOMARY CHARGES		
7	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
10	Total customary charges (see instructions)		10
11	Excess of customary charges over reasonable cost (see instructions)		11
12	Excess of reasonable cost over customary charges (see instructions)		12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
13	Total reasonable cost (from line 5)		13
14	Part B deductible billed to program patients		14
15	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Reimbursable bad debts (from provider records) (see instructions)		21
22			22
23	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
26	Total cost (line 24 plus or minus line 25)		26
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 27 and 28)		29
30	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)		30

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA BENEFICIARIES	PROVIDER NO.: / COMPONENT NO.:	PERIOD FROM_____ TO_____	WORKSHEET J-4

Check Applicable Box:	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] CMHC [ ] OOT [ ] CORF [ ] OSP [ ] OPT

	DESCRIPTION			Part B 1 mm/dd/yyyy	Part B 2 Amount
1	Total interim payments paid to providers				
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.				
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1).	Program to Provider	.01		
			.02		
			.03		
			.04		
			.05		
		Provider to Program	.50		
			.51		
			.52		
			.53		
			.54		
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet J-3, line 35)				

TO BE COMPLETED BY INTERMEDIARY

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider	.01		
			.02		
			.03		
		Provider to Program	.50		
			.51		
			.52		
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider	.01		
		Provider to Program	.02		
7	Total Medicare liability (see instructions)				

8	Name of Contractor	Contractor Number	(Month, Day, Year)

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

ont.)

1
2

3.01
3.02
3.03
3.04
3.05
3.50
3.51
3.52
3.53
3.54

3.99
4

5.01
5.02
5.03
5.50
5.51
5.52

5.99

6.01

6.02

7
8