This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed as overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0037

OUTPATIENT REHABILITATION PROVIDER COST REPORT IDENTIFICATION DATA, CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD: From: _____ To: _____	WORKSHEET S, PARTS I - III

Contractor Use Only:

[ ] Audited Date Received _____ [ ] Initial [ ] Re-opened
[ ] Desk Reviewed *Contractor* No. _____ [ ] Final

PART I - IDENTIFICATION DATA

Outpatient Rehabilitation Facility:

1	Name:		1
1.01	Street:	P.O. Box:	1.01
1.02	City: State:	Zip Code:	1.02
1.03	Cost Reporting Period (mm/dd/yyy) From:	To:	1.03

	Provider No.	Type of Control (see instructions)		Type of Provider (see instructions)	Date Certified	
	1	2	3	4	5	
2						2

3	List malpractice premiums and paid losses:		3
3.01	Premiums		3.01
3.02	Paid Losses		3.02
3.03	Self Insurance		3.03
4	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? If yes, submit a supporting schedule listing cost centers and amounts contained therein.		4

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Outpatient Rehabilitation Provider Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider name(s) and number(s)) for the cost report beginning _____and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Director

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII PART B 1	
6	OUTPATIENT REHABILITATION PROVIDER (specify type)		6

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0037. The time required to complete this information collection is estimated to average 226 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850."

OUTPATIENT REHABILITATION PROVIDER COST REPORT STATISTICAL DATA	PERIOD: FROM _____ TO _____	PROVIDER CCN: _____	WORKSHEET S PART IV

	REIMBURSABLE COST CENTERS	VISITS			PATIENTS			FTE ON PAYROLL				
		Medicare Patients	Other Patients	Total	Medicare	Other	Total	Staff Therapists	Physicians	Social Workers	Others	
		1	2	3	4	5	6	7	8	9	10	
	CORF											
1	Skilled Nursing Care											1
2	Physical Therapy											2
3	Speech Pathology											3
4	Occupational Therapy											4
5	Respiratory Therapy											5
6	Medical Social Services											6
7	Psychological Services											7
8	Prosthetic and Orthotic Devices											8
8	Drugs and Biologicals											8
10	Medical Supplies											10
11	DME-Sold											11
12	DME-Rented											12
13	Other Services											13
	CMHC											
14	Drugs and Biologicals											14
15	Occupational Therapy											15
16	Psychiatric/Psychological Services											16
17	Individual Therapy											17
18	Group Therapy											18
19	Individualized Activity Therapies											19
20	Family Counseling											20
21	Diagnostic Services											21
22	Patient Training & Education											22
23	Other Services											23
	OTHER PROVIDERS											
24	Physical Therapy											24
25	Speech Pathology											25
26	Occupational Therapy											26
27	Other Services											27
28	Total (Sum of lines 1-27)											28
29	Unduplicated Census Count											29

ANALYSIS OF PAYMENTS TO OUTPATIENT REHABILITATION PROVIDERS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	SUPPLEMENTAL WORKSHEET S-1

	DESCRIPTION			PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to Outpatient Rehabilitation Provider					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the *contractor*, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero. (1)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL (Sum of lines 3.01-3.49, minus sum of lines 3.50-3.98)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99) (Transfer to Wkst D, Part I, line 18)					4

TO BE COMPLETED BY *CONTRACTOR*

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (Sum of lines 5.01-5.49, minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (SEE INSTRUCTIONS). (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)					7

Name of *Contractor* *Contractor* Number

Signature of Authorized Person Date: (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 the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES (Omit Cents)

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET A Page 1 of 2

		COST CENTERS	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASS. (from Wkst. A-1)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS (from Wkst. A-3)	NET EXPENSES FOR ALLOCATION (Col 5 +/- Col 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Cap Rel Costs-Bldg & Fixt								1
2	0200	Cap Rel Costs-Mvble Equip								2
3	0300	Employee Benefits								3
4	0400	Administrative & General								4
5	0500	Maintenance & Repairs								5
6	0600	Operation of Plant								6
7	0700	Laundry & Linen Service								7
8	0800	Housekeeping								8
9	0900	Cafeteria								9
10	1000	Central Services & Supply								10
11	1100	Medical Records & Library								11
12	1200	Pro Ed & Training (Apprvd)								12
13		Other (specify)								13
14		Other (specify)								14
		REIMBURSABLE SERVICE COST CENTERS								
		CORF								
15	1500	Skilled Nursing Care								15
16	1600	Physical Therapy								16
17	1700	Speech Pathology								17
18	1800	Occupational Therapy								18
19	1900	Respiratory Therapy								19
20	2000	Medical Social Services								20
21	2100	Psychological Services								21
22	2200	Prosthetic and Orthotic Devices								22
23	2300	Drugs and Biologicals								23
24	2400	Medical Supplies Charged to Patients								24
25	2500	DME-Sold								25
26	2600	DME-Rented								26
27		Other (specify)								27
		CMHC								
29	2900	Drugs & Biologicals								29
30	3000	Occupational Therapy								30
31	3100	Psychiatric/Psychological Services								31
32	3200	Individual Therapy								32
33	3300	Group Therapy								33
34	3400	Individualized Activity Therapies								34
35	3500	Family Counseling								35
36	3600	Diagnostic Services								36
37	3700	Patient Training & Education								37
38		Other (specify)								38

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES (Omit Cents)

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET A Page 2 of 2

		COST CENTERS	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASS. (from Wkst. A-1)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS (from Wkst. A-3)	NET EXPENSES FOR ALLOCATION (Col 5 +/- Col 6)	
			1	2	3	4	5	6	7	
		OTHER PROVIDERS								
40	4000	Physical Therapy								40
41	4100	Speech Therapy								41
42	4200	Occupational Therapy								42
43	4300	Other (specify)								43
		NONREIMBURSABLE COST CENTERS								
45	4500	Sheltered Workshops								45
46	4600	Recreational Programs								46
47	4700	Resident Day Camps								47
48	4800	Pre-school Programs								48
49	4900	Diagnostic Clinics								49
50	5000	Home Employment Programs								50
51	5100	Equipment Loan Service								51
52	5200	Physicians' Private Offices								52
53	5300	Fund Raising								53
54	5400	Coffee Shops & Canteen								54
55	5500	Research								55
56	5600	Investment Property								56
57	5700	Advertising								57
58	5800	Franchise Fees and Other Assessments								58
59	5900	*Pro Ed & Training (Not Apprvd)*								59
60		Other (specify)								60
		CMHC NON-REIMBURSABLE COST CENTERS								
61	6100	Meals and Transportation								61
62	6200	Activity Therapies								62
63	6300	Psychosocial Programs								63
64	6400	Vocational Training								64
65		TOTAL(sum of lines 1- 64)								65

RECLASSIFICATIONS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	AMOUNT(2)	COST CENTER	LINE NO.	AMOUNT(2)	
		1	2	3	4	5	6	7	
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	TOTAL RECLASSIFICATIONS(Sum of Col. 4 must equal Col. 7)								30

(1) A letter (A,B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A. column 4, line as appropriate.

FORM CMS-2088-92 (12-1992) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC. 1805)

ADJUSTMENTS TO EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-3

	DESCRIPTION (1)	BASIS (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	
		1	2	3	4	
1	Payments received from specialists	B				1
2	Investment income (chapter 2)					2
3	Trade, quantity and time discounts (chapter 8)	B				3
4	Refunds and rebates of expenses (chapter 8)	B				4
5	Laundry and linen service			Laundry and Linen Service	7	5
6	Cafeteria--employees, guests, etc.			Cafeteria	9	6
7	Sale of medical and surgical supplies to other than patients			Central Services and Supply	10	7
8	Sale of workshop products or services					8
9	Coffee shops and canteen					9
10	Vending Machines					10
11	Rental of building or office space to others					11
12	Sale of scrap, waste, etc.(Chapter 23)					12
13	Related organization transactions (chapter 10)	Supp. Wks A-3-1				13
14	Provider-based physician adjustment	Supp. Wks. A-8-2				14
15	Respiratory Therapy limit adjustment	Supp. Wks. A-8-4				15
16	Physical therapy limit adjustment	Supp. Wks. A-8-3				16
17	Respiratory Therapy limit adjustment	Supp. Wks. A-8-5				17
17.1	Physical therapy limit adjustment	Supp. Wks. A-8-5				17.1
17.2	Occupational therapy limit adjustment	Supp. Wks. A-8-5				17.2
17.3	Speech pathology limit adjustment	Supp. Wks. A-8-5				17.3
18	Other (Specify) (3)					18
19	Other (Specify) (3)					19
20	Capital Related Costs-Buildings and fixtures	A		Capital Related Costs Buildings & Fixtures	1	20
21	Capital Related Costs- Movable Equipment	A		Capital Related Costs Movable Equipment	2	21
22	TOTAL (Sum of lines 1-21) (Transfer to Worksheet A, col.6, line 65)					22

(1) Include amounts not already applied against expenses included on Worksheet A, column 3

(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 subscripts of this line.

Chapter references are to CMS Pub.15-I

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	SUPPLEMENTAL WORKSHEET A-3-1

A. Are there any costs included in Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10?

[ ] Yes (If "Yes," complete Parts B and C)
[ ] No

B. Costs incurred and adjustments required as a result of transactions with related organizations:

Location and amount included on Worksheet A, Column 5				Amount Allowable In Cost	Net Adjustments (Col 3 minus Col 4)
Line No.		Cost Center	Amount		
1		2	3	4	5
1					
2					
3					
4					
5	TOTALS (Sum of lines 1-4) (Transfer col. 5, line 5 to Worksheet A-3, line 13)				

C. Interrelationship to related organization(s):

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 C of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries 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) Name	Percentage of Ownership	Type of Business
	1	2	3	4	5	6
1						
2						
3						
4						
5						

(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 _____

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET B
Page 1 of 3

	COST CENTERS	Net Expenses (from Wkst.A, Col.7)	Capital Related: Buildings & Fixtures	Capital Related: Movable Equipment	Employee Benefits	Subtotal (cols. 0-4)	Administrative & General	Maintenance & Repairs	
		0	1	2	3	3A	4	5	
	Gen. Service Cost Ctrs.								
1	Cap. Rel. Costs--Bldg.&Fixt.								1
2	Cap. Rel. Costs--Movable Eqp.								2
3	Employee Benefits								3
4	Administrative and General								4
5	Maintenance and Repairs								5
6	Operation of Plant								6
7	Laundry and Linen Service								7
8	Housekeeping								8
9	Cafeteria								9
10	Central Services and Supply								10
11	Medical Records and Library								11
12	Prof. Educ. & Training(1)								12
13									13
14									14
	REIMBURSABLE COST CTRS.								
	CORF								
15	Skilled Nursing Care								15
16	Physical Therapy								16
17	Speech Pathology								17
18	Occupational Therapy								18
19	Respiratory Therapy								19
20	Medical Social Services								20
21	Psychological Services								21
22	Prosthetic and Orthotic Devices								22
23	Drugs and Biologicals								23
24	Supplies Charged to Patients								24
25	DME-Sold								25
26	DME-Rented								26
27									27
	CMHC								
29	Drugs and Biologicals								29
30	Occupational Therapy								30
31	Psychiatric/Psychological Service								31
32	Individual Therapy								32
33	Group Therapy								33
34	Individualized Activity Therapies								34
35	Family Counseling								35
36	Diagnostic Services								36
37	Patient Training & Education								37
38									38
	OTHER PROVIDERS								
40	Physical Therapy								40
41	Speech Pathology								41
42	Occupational Therapy								42
43									43
	NON-REIM. COST CENTERS								
45	Sheltered Workshops								45
46	Recreational Programs								46
47	Resident Day Camps								47
48	Preschool Programs								48
49	Diagnostic Clinics								49
50	Home Employment Programs								50
51	Equipment Loan Service								51
52	Physicians' Private Office								52
53	Fundraising								53
54	Coffee Shops &Canteen								54
55	Research								55
56	Investment Property								56
57	Advertising								57
58	Franchise & Other Ass'mt								58
59	Prof. Ed. & Training(2)								59
60									60
	CMHC NON-REIMBURSABLE								
61	Meals and Transportation								61
62	Activity Therapies								62
63	Psychosocial Programs								63
64	Vocational Training								64
65	Negative Cost Center								65
66	TOTAL								66

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

COST ALLOCATION
GENERAL SERVICE COSTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET B
Page 2 of 3

	COST CENTERS	Operation of Plant	Laundry and Linen Services	House-keeping	Cafeteria	Medical Supplies	Medical Records Library	
		6	7	8	9	10	11	
	Gen. Service Cost Ctrs.							
1	Cap. Rel. Costs--Bldg.&Fixt.							1
2	Cap. Rel. Costs--Movable Eqp.							2
3	Employee Benefits							3
4	Administrative and General							4
5	Maintenance and Repairs							5
6	Operation of Plant							6
7	Laundry and Linen Service							7
8	Housekeeping							8
9	Cafeteria							9
10	Central Services and Supply							10
11	Medical Records and Library							11
12	Prof. Educ. & Training(1)							12
13								13
14								14
	REIMBURSABLE COST CTRS.							
	CORF							
15	Skilled Nursing Care							15
16	Physical Therapy							16
17	Speech Pathology							17
18	Occupational Therapy							18
19	Respiratory Therapy							19
20	Medical Social Services							20
21	Psychological Services							21
22	Prosthetic and Orthotic Devices							22
23	Drugs and Biologicals							23
24	Supplies Charged to Patients							24
25	DME-Sold							25
26	DME-Rented							26
27								27
	CMHC							
29	Drugs and Biologicals							29
30	Occupational Therapy							30
31	Psychiatric/Psychological Service							31
32	Individual Therapy							32
33	Group Therapy							33
34	Individualized Activity Therapies							34
35	Family Counseling							35
36	Diagnostic Services							36
37	Patient Training & Education							37
38								38
	OTHER PROVIDERS							
40	Physical Therapy							40
41	Speech Pathology							41
42	Occupational Therapy							42
43								43
	NON-REIM. COST CENTERS							
45	Sheltered Workshops							45
46	Recreational Programs							46
47	Resident Day Camps							47
48	Preschool Programs							48
49	Diagnostic Clinics							49
50	Home Employment Programs							50
51	Equipment Loan Service							51
52	Physicians' Private Office							52
53	Fundraising							53
54	Coffee Shops &Canteen							54
55	Research							55
56	Investment Property							56
57	Advertising							57
58	Franchise & Other Ass'mt							58
59	Prof. Ed. & Training(2)							59
60								60
	CMHC NON-REIMBURSABLE							
61	Meals and Transportation							61
62	Activity Therapies							62
63	Psychosocial Programs							63
64	Vocational Training							64
65	Negative Cost Center							65
66	TOTAL							66

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

FORM CMS-2088-92 (12-1992) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC.1808)

COST ALLOCATION GENERAL SERVICE COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET B Page 3 of 3

	COST CENTERS	Prof. Education and Training					Total	
		12	13	14	15	16	17	
	Gen. Service Cost Ctrs.							
1	Cap. Rel. Costs--Bldg.&Fixt.							1
2	Cap. Rel. Costs--Movable Eqp.							2
3	Employee Benefits							3
4	Administrative and General							4
5	Maintenance and Repairs							5
6	Operation of Plant							6
7	Laundry and Linen Service							7
8	Housekeeping							8
9	Cafeteria							9
10	Central Services and Supply							10
11	Medical Records and Library							11
12	Prof. Educ. & Training(1)							12
13								13
14								14
	REIMBURSABLE COST CTRS.							
	CORF							
15	Skilled Nursing Care							15
16	Physical Therapy							16
17	Speech Pathology							17
18	Occupational Therapy							18
19	Respiratory Therapy							19
20	Medical Social Services							20
21	Psychological Services							21
22	Prosthetic and Orthotic Devices							22
23	Drugs and Biologicals							23
24	Supplies Charged to Patients							24
25	DME-Sold							25
26	DME-Rented							26
27								27
	CMHC							
29	Drugs and Biologicals							29
30	Occupational Therapy							30
31	Psychiatric/Psychological Service							31
32	Individual Therapy							32
33	Group Therapy							33
34	Individualized Activity Therapies							34
35	Family Counseling							35
36	Diagnostic Services							36
37	Patient Training & Education							37
38								38
	OTHER PROVIDERS							
40	Physical Therapy							40
41	Speech Pathology							41
42	Occupational Therapy							42
43								43
	NON-REIM. COST CENTERS							
45	Sheltered Workshops							45
46	Recreational Programs							46
47	Resident Day Camps							47
48	Preschool Programs							48
49	Diagnostic Clinics							49
50	Home Employment Programs							50
51	Equipment Loan Service							51
52	Physicians' Private Office							52
53	Fundraising							53
54	Coffee Shops &Canteen							54
55	Research							55
56	Investment Property							56
57	Advertising							57
58	Franchise & Other Ass'mt							58
59	Prof. Ed. & Training(2)							59
60								60
	CMHC NON-REIMBURSABLE							
61	Meals and Transportation							61
62	Activity Therapies							62
63	Psychosocial Programs							63
64	Vocational Training							64
65	Negative Cost Center							65
66	TOTAL							66

(1) Approved Educational Activity
(2) Not an Approved Educational Activity

FORM CMS-2088-92 (12-1992) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC.1808)

COST ALLOCATION
(STATISTICAL BASIS)

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET B-1
Page 1 of 3

	COST CENTERS		Capital Related: Buildings & Fixtures (Square Feet)	Capital Related: Movable Equipment (Square Feet)	Employee Benefits (Gross Salaries)	Reconcil-iation	Administrative & General (Accum. Cost)	Maintenance & Repairs (Square Feet)	
		0	1	2	3	4A	4	5	
	Gen. Service Cost Ctrs.								
1	Cap. Rel. Costs--Bldg.&Fixt.								1
2	Cap. Rel. Costs--Movable Eqp.								2
3	Employee Benefits								3
4	Administrative and General								4
5	Maintenance and Repairs								5
6	Operation of Plant								6
7	Laundry and Linen Service								7
8	Housekeeping								8
9	Cafeteria								9
10	Central Services and Supply								10
11	Medical Records and Library								11
12	Prof. Educ. & Training(1)								12
13									13
14									14
	REIMBURSABLE COST CTRS.								
	CORF								
15	Skilled Nursing Care								15
16	Physical Therapy								16
17	Speech Pathology								17
18	Occupational Therapy								18
19	Respiratory Therapy								19
20	Medical Social Services								20
21	Psychological Services								21
22	Prosthetic and Orthotic Devices								22
23	Drugs and Biologicals								23
24	Supplies Charged to Patients								24
25	DME-Sold								25
26	DME-Rented								26
27									27
	CMHC								
29	Drugs and Biologicals								29
30	Occupational Therapy								30
31	Psychiatric/Psychological Service								31
32	Individual Therapy								32
33	Group Therapy								33
34	Individualized Activity Therapies								34
35	Family Counseling								35
36	Diagnostic Services								36
37	Patient Training & Education								37
38									38
	OTHER PROVIDERS								
40	Physical Therapy								40
41	Speech Pathology								41
42	Occupational Therapy								42
43									43
	NON-REIM. COST CENTERS								
45	Sheltered Workshops								45
46	Recreational Programs								46
47	Resident Day Camps								47
48	Preschool Programs								48
49	Diagnostic Clinics								49
50	Home Employment Programs								50
51	Equipment Loan Service								51
52	Physicians' Private Office								52
53	Fundraising								53
54	Coffee Shops &Canteen								54
55	Research								55
56	Investment Property								56
57	Advertising								57
58	Franchise & Other Ass'mt								58
59	Prof. Ed. & Training(2)								59
60									60
	CMHC NON-REIMBURSABLE								
61	Meals and Transportation								61
62	Activity Therapies								62
63	Psychosocial Programs								63
64	Vocational Training								64
65	Negative Cost Center								65
66	Cost to be Allocated								66
67	Unit Cost Multiplier								67

(1) Approved Educational Activity (2) Not an Approved Educational Activity

FORM CMS-2088-92 (12-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC.1808)

COST ALLOCATION (STATISTICAL BASIS) | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B-1 Page 2 of 3

	COST CENTERS	Operation of Plant (Square Feet)	Laundry and Linen Services (Pounds of Laundry)	House-keeping (Hrs. of Service)	Cafeteria Meals Served)	Medical Supplies (Costed Requisitions)	Medical Records Library (Time Spent)	
		6	7	8	9	10	11	
	Gen. Service Cost Ctrs.							
1	Cap. Rel. Costs--Bldg.&Fixt.							1
2	Cap. Rel. Costs--Movable Eqp.							2
3	Employee Benefits							3
4	Administrative and General							4
5	Maintenance and Repairs							5
6	Operation of Plant							6
7	Laundry and Linen Service							7
8	Housekeeping							8
9	Cafeteria							9
10	Central Services and Supply							10
11	Medical Records and Library							11
12	Prof. Educ. & Training(1)							12
13								13
14								14
	REIMBURSABLE COST CTRS.							
	CORF							
15	Skilled Nursing Care							15
16	Physical Therapy							16
17	Speech Pathology							17
18	Occupational Therapy							18
19	Respiratory Therapy							19
20	Medical Social Services							20
21	Psychological Services							21
22	Prosthetic and Orthotic Devices							22
23	Drugs and Biologicals							23
24	Supplies Charged to Patients							24
25	DME-Sold							25
26	DME-Rented							26
27								27
	CMHC							
29	Drugs and Biologicals							29
30	Occupational Therapy							30
31	Psychiatric/Psychological Service							31
32	Individual Therapy							32
33	Group Therapy							33
34	Individualized Activity Therapies							34
35	Family Counseling							35
36	Diagnostic Services							36
37	Patient Training & Education							37
38								38
	OTHER PROVIDERS							
40	Physical Therapy							40
41	Speech Pathology							41
42	Occupational Therapy							42
43								43
	NON-REIM. COST CENTERS							
45	Sheltered Workshops							45
46	Recreational Programs							46
47	Resident Day Camps							47
48	Preschool Programs							48
49	Diagnostic Clinics							49
50	Home Employment Programs							50
51	Equipment Loan Service							51
52	Physicians' Private Office							52
53	Fundraising							53
54	Coffee Shops &Canteen							54
55	Research							55
56	Investment Property							56
57	Advertising							57
58	Franchise & Other Ass'mt							58
59	Prof. Ed. & Training(2)							59
60								60
	CMHC NON-REIMBURSABLE							
61	Meals and Transportation							61
62	Activity Therapies							62
63	Psychosocial Programs							63
64	Vocational Training							64
65	Negative Cost Center							65
66	Cost to be Allocated							66
67	Unit Cost Multiplier							67

(1) Approved Educational Activity (2) Not an Approved Educational Activity

COST ALLOCATION (STATISTICAL BASIS)		PROVIDER CCN: _____		PERIOD: FROM _____ TO _____		WORKSHEET B-1 Page 3 of 3	
	COST CENTERS	Prof.Educ. & Training (Assigned Time)					
		12	13	14	15	16	17	
	Gen. Service Cost Ctrs.							
1	Cap. Rel. Costs--Bldg.&Fixt.							1
2	Cap. Rel. Costs--Movable Eqp.							2
3	Employee Benefits							3
4	Administrative and General							4
5	Maintenance and Repairs							5
6	Operation of Plant							6
7	Laundry and Linen Service							7
8	Housekeeping							8
9	Cafeteria							9
10	Central Services and Supply							10
11	Medical Records and Library							11
12	Prof. Educ. & Training(1)							12
13								13
14								14
	REIMBURSABLE COST CTRS.							
	CORF							
15	Skilled Nursing Care							15
16	Physical Therapy							16
17	Speech Pathology							17
18	Occupational Therapy							18
19	Respiratory Therapy							19
20	Medical Social Services							20
21	Psychological Services							21
22	Prosthetic and Orthotic Devices							22
23	Drugs and Biologicals							23
24	Supplies Charged to Patients							24
25	DME-Sold							25
26	DME-Rented							26
27								27
	CMHC							
29	Drugs and Biologicals							29
30	Occupational Therapy							30
31	Psychiatric/Psychological Service							31
32	Individual Therapy							32
33	Group Therapy							33
34	Individualized Activity Therapies							34
35	Family Counseling							35
36	Diagnostic Services							36
37	Patient Training & Education							37
38								38
	OTHER PROVIDERS							
40	Physical Therapy							40
41	Speech Pathology							41
42	Occupational Therapy							42
43								43
	NON-REIM. COST CENTERS							
45	Sheltered Workshops							45
46	Recreational Programs							46
47	Resident Day Camps							47
48	Preschool Programs							48
49	Diagnostic Clinics							49
50	Home Employment Programs							50
51	Equipment Loan Service							51
52	Physicians' Private Office							52
53	Fundraising							53
54	Coffee Shops &Canteen							54
55	Research							55
56	Investment Property							56
57	Advertising							57
58	Franchise & Other Ass'mt							58
59	Prof. Ed. & Training(2)							59
60								60
	CMHC NON-REIMBURSABLE							
61	Meals and Transportation							61
62	Activity Therapies							62
63	Psychosocial Programs							63
64	Vocational Training							64
65	Negative Cost Center							65
66	Cost to be Allocated							66
67	Unit Cost Multiplier							67

(1) Approved Educational Activity (2) Not an Approved Educational Activity

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C Page 1 of 2

	CORF REIMBURSABLE SERVICE COST CENTERS		TOTALS	RATIO OF COST TO CHARGES (Col. 1 line .01, divided by Col. 1, line .02)	TITLE XVIII (See Instructions)	ALL OTHER (See Instructions)	TITLE XVIII CHARGES ON OR AFTER 1/1/98	TITLE XVIII COSTS ON AFTER 1/1/98	REASONABLE COST REDUCTION AMOUNT	TITLE XVIII COST NET OF APPLICABLE REASONABLE COST REDUCTION	
			1	2	3	4	5	6	7	8	
15	Skilled Nursing Care	.01									15
		.02									
16	Physical Therapy	.01									16
		.02									
17	Speech Pathology	.01									17
		.02									
18	Occupational Therapy	.01									18
		.02									
19	Respiratory Therapy	.01									19
		.02									
20	Medical Social Services	.01									20
		.02									
21	Psychological Services	.01									21
		.02									
22	Prosthetic and Orthotic Devices	.01									22
		.02									
23	Drugs and Biologicals	.01									23
		.02									
24	Supplies Charged to Patients	.01									24
		.02									
25	DME-Sold	.01									25
		.02									
26	DME-Rented	.01									26
		.02									
27		.01									27
		.02									
28	TOTAL(Line 15 through 27)	.01									28
		.02									

CORF Providers--See instructions for amounts to transfer to Worksheet D, Part I.

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C Page 2 of 2

	CMHC REIMBURSABLE SERVICE COST CENTERS		TOTALS	RATIO OF COST TO CHARGES (Col. 1 line a, divided by Col. 1, line b.	TITLE XVIII (See Instructions)	ALL OTHER (See Instructions)	TITLE XVIII CHARGES ON OR AFTER 8/1/00, 1/1/02, 1/1/03, or 1/1/04 (See Instructions)	TITLE XVIII COSTS ON OR AFTER 8/1/00, 1/1/02, 1/1/03, or 1/1/04 (See Instructions)	REASONABLE COST REDUCTION AMOUNT	TITLE XVIII COSTS PRIOR TO 8/1/00, 1/1/02, 1/1/03, or 1/1/04 (See Instructions)	
			1	2	3	4	5	6	7	8	
29	Drugs and Biologicals	.01									29
		.02									
30	Occupational Therapy	.01									30
		.02									
31	Psychiatric/Psychological Services	.01									31
		.02									
32	Individual Therapy	.01									32
		.02									
33	Group Therapy	.01									33
		.02									
34	Individualized Activity Therapy	.01									34
		.02									
35	Family Counseling	.01									35
		.02									
36	Diagnostic Services	.01									36
		.02									
37	Patient Training & Education	.01									37
		.02									
38		.01									38
		.02									
39	TOTAL (Lines 29 through 38)	.01									39
		.02									

	OTHER OUTPATIENT THERAPY PROVIDERS		TOTALS	RATIO OF COST TO CHARGES (Col. 1 line .01, divided by Col. 1, line .02)	TITLE XVIII (See Instructions)	ALL OTHER (See Instructions)	TITLE XVIII CHARGES ON OR AFTER 1/1/1998	TITLE XVIII COSTS ON OR AFTER 1/1/1998	REASONABLE COST REDUCTION AMOUNT	TITLE XVIII COSTS NET OF APPLICABLE REASONABLE COST REDUCTION	
			1	2	3	4	5	6	7	8	
40	Physical Therapy	.01									40
		.02									
41	Speech Pathology	.01									41
		.02									
42	Occupational Therapy	.01									42
		.02									
43		.01									43
		.02									
44	TOTAL (Lines 40 through 43)	.01									44
		.02									

CMHC Providers--Transfer the amount entered in column 8, line 39 to Worksheet D, line 1.
Other Outpatient Therapy Providers--Transfer the amount entered in column 8, line 44 to Worksheet D, line 1.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES-TITLE XVIII	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D

	CORF		OPT		CMHC

PART I - COMPUTATION OF REIMBURSEMENT SETTLEMENT

	DESCRIPTION	1	
1	Cost of provider services (see instructions)		1
1.01	CMHC PPS payments including outlier payments		1.01
1.02	1996 CMHC specific payment to cost ratio (obtain this ratio from your contractor)		1.02
1.03	Line 1, column 1.01 times 1.02		1.03
1.04	Line 1.01 divided by line 1.03		1.04
1.05	CMHC transitional corridor payment		1.05
1.1	Cost of CORF services prior to 1/1/1998 (see instructions)		1.1
2	Adjustment for the cost of services covered by Workers' Compensation, and other primary payers (see instructions)		2
3	Subtotal (line 1 plus line 1.1 minus line 2) (For CMHCs see instructions)		3
4	Deductibles billed to program patients. (Do not include coinsurance)		4
5	Total amount reimbursable to provider prior to application of Lesser of reasonable cost or customary charges (line 3 minus line 4)		5
6	Excess of reasonable cost over customary charges (see instructions)		6
7	Subtotal (line 5 minus line 6)		7
8	80 percent of costs (line 7 x 80 percent)		8
9	Coinsurance billed to program patients (see instructions)		9
10	Net cost for comparison (line 7 minus line 9)		10
11	Reimbursable bad debts (see instructions)		11
11.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		11.01
11.02	Adjusted reimbursable bad debts		11.02
12	TOTAL COST-- (see instructions)		12
13	Recovery of unreimbursed cost under the lesser of cost or charges (from Worksheet D-1, Part I, line 3)		13
14	80% of recovery of unreimbursed cost under the lesser of cost or charges (line 13 X 80 percent)		14
15	Total cost (see instructions)		15
16	Sequestration adjustment (see instructions)		16
16.5	Other Adjustments (see instructions) (specify)		16.5
17	Adjusted total cost (line 15 minus the sum of lines 16 and 16.5) (see instructions)		17
17.01	Sequestration adjustment (see instructions)		17.01
18	Interim Payments		18
18.5	Tentative settlement (For intermediary use only)		18.5
19	Balance due Provider/Program (line 17 minus lines 17.01 and 18) (Indicate overpayment in brackets)		19

NOTE: FOR CORF SERVICES RENDERED PRIOR TO JANUARY 1, 1998 CORFS COMPLETE LINE 22.1 ONLY AS THESE SERVICES ARE NOT SUBJECT TO THE LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES, BUT ARE REIMBURSED BASED ON REASONABLE COSTS. FOR CORF RENDERED ON OR AFTER JANUARY 1, 1998, COMPLETE LINE 21 THROUGH 29 AS THESE SERVICES AS SUBJECT TO LCC.

PART II -COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES		1	
20	Reasonable cost of services		20
21	Cost of services (from Part I, line 1) (from Part I, line 1, column 1 for CMHCs) (see instructions)		21
21.1	Cost of services (from Part I, line 1.1 for CORFs) (see instructions)		21.1
22	TOTAL charges for medicare services		22
22.1	TOTAL CORF charges for medicare services prior to 1/1/1998		22.1
23	Customary Charges		23
24	Aggregate amount actually collected from patients liable for payment for services on a charge basis.		24
25	Amounts 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)		25
26	Ratio of line 24 to line 25 (not to exceed 1.000000)		26
27	Total customary charges (line 22 x line 26)		27
27.1	Total customary CORF charges prior to 1/1/1998 (line 22.1 x line 26)		27.1
28	Excess of customary charges over reasonable cost (Complete only if line 27 exceeds line 21) (see instructions)		28
29	Excess of reasonable cost over customary charges (Complete only if line 21 exceeds line 27) (see instructions)		29

FORM CMS-2088-92 (04-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15 - 2, SEC. 1810, 1810.1 AND 1810.2)

STATEMENT OF REVENUES AND EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET G

1	Total patient revenues			1
2	Less: Allowances and discounts on patients' accounts			2
3	Net patient revenues (Line 1 minus line 2)			3
4	Less: total operating expenses			4
5	Net income from service to patients (Line 3 minus line 4)			5
	Other income:			
6	Grants , gifts, and income designated by donor for specific expenses			6
7	Payments received from specialists			7
8	Investment income on unrestricted funds			8
9	Trade , quantity ,time and other discounts on purchases			9
10	Rebates and refunds of expenses			10
11	Income from laundry and linen service			11
12	Income from cafeteria - employees , guests, etc.			12
13	Sale of medical supplies to other than patients			13
14	Sale of workshop products or services			14
15	Coffee shops and canteen			15
16	Vending machines			16
17	Rental of building or office space to others			17
18	Sale of scrap, waste, etc.			18
19	Sale of medical records and abstracts			19
20	Other(Specify)			20
21	Other(Specify)			21
22	Other(Specify)			22
23	Total other income (Sum of lines 6-22)			23
24	Total (Line 5 plus line 23)			24
	Other expenses :			
25	Fund raising			25
26	Gift, coffee shops, and canteen			26
27	Investment property			27
28	Other(Specify)			28
29	Other(Specify)			29
30	Other(Specify)			30
31	Total other expenses (Sum of lines 25 - 30)			31
32	Net income (or loss) for the period (line 24 minus line 31)			32

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0037

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

SUPPLEMENTAL WORKSHEET A-8-2

Wkst A Line No.	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
TOTAL								

Wkst A Line No.	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
TOTAL								

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	(COMPLETE THIS WORKSHEET FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998)	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-3 PARTS I, II & III

PART I - GENERAL INFORMATION

1	Total number of weeks worked (During which outside suppliers (excluding aides) worked)		1
2	Line 1 multiplied by 15 hours per week		2
3	Number of unduplicated days on which supervisor or therapist was on provider site (See Instructions)		3
4	Number of unduplicated days on 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	
		1	2	3	4	
9	Total hours worked					9
10	A H S E A (See Instructions)					10
11	Standard Travel Allowance (Cols. 1 and 2, one-half of col. 2, line 10; col. 3, one-half of col 3, line 10)					11
12	Number of travel hours - Provider site - (see instructions)					12
12.01	Number of travel hours - Provider offsite - (see instructions)					12.01
13	Number of miles driven - Provider site - (see instructions)					13
13.01	Number of miles driven - Provider offsite - (see instructions)					13.01

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, line9 times column 3, line10)		16
17	Subtotal Allowance Amount (Sum of lines 14-16)		17
18	Aides (Column 4, line 9 times column 4, line 10)		18
19	Total Allowance Amount (Sum of lines 17 and 18)		19
	If the sum of columns 1-3, line 9, is greater than line 2, make no entries on lines 20 and 21 and enter on line 22 the amount from line 19. Otherwise complete lines 20 - 22.		
20	Weighted average rate excluding aides (Line 17 divided by the sum of columns 1-3, line 9)		20
21	Weighted allowance excluding aides (Line 2 times line 20)		21
22	Total Salary Equivalency (Line 19 or sum of lines 18 plus 21)		22

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

Standard Travel Allowance

23	Therapists (Line 3 times column 2, line 11)		23
24	Assistants (Line 4 times column3, line 11)		24
25	Subtotal (Sum of lines 23 and 24)		25
26	Standard Travel Expense (Line 7 times sum of lines 3 and 4)		26
27	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site (Sum of lines 25 and 26)		27

FORM CMS-2088-92-A-8-3 (11-1998) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 1814 - 1814.3)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	(COMPLETE THIS WORKSHEET FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998)	PROVIDER CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-3 PARTS IV, V & VI

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

	Standard Travel Expense		
28	Therapists (Line 5 times column 2, line 11)		28
29	Assistants (Line 6 times column 3, line 11)		29
30	Subtotal (Sum of lines 28 and 29)		30
31	Standard Travel Expense (Line 7 times the sum of lines 5 and 6)		31
	Optional Travel Allowance and Optional Travel Expense		
32	Therapists (Sum of columns 1 and 2, line 12.01 times column 2, line 10)		32
33	Assistants (Column 3, line 12.01 times column 3, line 10)		33
34	Subtotal (Sum of lines 32 and 33)		34
35	Optional Travel Expense (Line 8 times the sum of columns 1-3, line 13.01)		35
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 36, 37, or 38, as appropriate.		
36	Standard Travel Allowance and Standard Travel Expense (Sum of lines 30 and 31 - See Instructions)		36
37	Optional Travel Allowance and Standard Travel Expense (Sum of lines 34 and 31 - See Instructions)		37
38	Optional Travel Allowance and Optional Travel Expense (Sum of lines 34 and 35 - See Instructions)		38

PART V - OVERTIME COMPUTATION

	Description	Therapists	Assistants	Aides	Total	
		1	2	3	4	
39	Overtime hours worked during cost reporting period (If column 4, line 39, is zero or equal to or greater than 2,080, do not complete lines 40-47 and enter zero in each column of line 48)					39
40	Overtime rate (Multiply the amounts in columns 2-4, line 10 (A H S E A) times 1.5)					40
41	Total overtime (Including base and overtime allowance) (Multiply line 39 times line 40)					41
	Calculation of Limit					
42	Percentage of overtime hours by category (Divide the hours in each column on line 39 by the total overtime worked - column 4, line 39)					42
43	Allocation of provider's standard workyear for one full-time employee times the percentages on line 42. (See Instructions)					43
	Determination of Overtime Allowance					
44	Adjusted hourly salary equivalency amount (A H S E A) (From Part I, Columns 2-4, line 10)					44
45	Overtime cost limitation (Line 43 times line 44)					45
46	Maximum overtime cost (Enter the lessor of line 41 or line 45)					46
47	Portion of overtime already included in hourly computation at the A H S E A (Multiply line 39 times line 44)					47
48	Overtime allowance (Line 46 minus 47 - if negative enter zero)(Column 4, sum of cols 1-3)					48

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

49	Salary equivalency amount (from Part II, line 22)		49
50	Travel allowance and expense - provider site (from Part III, line 27)		50
51	Travel allowance and expense - offsite services (from Part IV, lines 36, 37 or 38)		51
52	Overtime allowance (from Part V, col. 4, line 48)		52
53	Equipment cost (See Instructions)		53
54	Supplies (See Instructions)		54
55	Total allowance (Sum of lines 49-54)		55
56	Total cost of outside supplier services (from your records)		56
57	Excess over limitation (line 56 minus line 55 - if negative, enter zero -- See Instructions) (Transfer amount to Wkst. A-3, line 16)		57

FORM CMS-2088-92-A-8-3 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 1814.4 - 1814.6)

REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	**(COMPLETE THIS WORKSHEET FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998)**	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-4 PARTS I & II

PART I - GENERAL INFORMATION

1	Total number of weeks worked (During which outside suppliers (excluding aides and trainees) worked)		1
2	Line 1 multiplied by 15 hours per week		2
	Number of unduplicated days on which the following category, as appropriate, has the highest A H S E A on the provider site (See Instructions):		
3	Registered Therapist		3
4	Certified Therapist		4
5	Nonregistered, Noncertified Therapist		5
6	Standard travel expense rate		6

	Description	Supervisors			Therapists					
		Registered	Certified	Nonregistered Noncertified	Registered	Certified	Nonregistered Noncertified	Aides	Trainees	
		1	2	3	4	5	6	7	8	
7	Total Hours Worked									7
8	A H S E A (See Instructions)									8
9	Standard Travel Allowance (Enter in cols 1, 2, or 3, one-half of the amounts on line 8, columns 4, 5 or 6 respectively. Enter in cols. 4, 5 or 6 one-half of the amounts on line 8, columns 4, 5 or 6 respectively.)									9

PART II - SALARY EQUIVALENCY COMPUTATION

10	Supervisory Registered Therapist (Col 1, line 7 times col 1, line 8)		10
11	Supervisory Certified Therapist (Col 2, line 7 times col 2, Line 8)		11
12	Supervisory Non-Registered, Non-Certified Therapist (Col 3, line 7 times col 3, line 8)		12
13	Registered Therapists (Col 4, line 7 times col 4, line 8)		13
14	Certified Therapists (Col 5, line 7 times col 5, line 8)		14
15	Non-Registered, Non-Certified Therapists (Col 6, line 7 times col 6, line 8)		15
16	Subtotal Allowance Amount (Sum of lines 10-15)		16
17	Aides (Col 7, line 7 times col 7, line 8)		17
18	Trainees (Col 8, line 7 times col 8, line 8)		18
19	Total Allowance Amount (Sum of lines 16-18)		19
	If the sum of cols 1-6, line 7, is greater than line 2, make no entries on lines 20 and 21 and enter on line 22 the amount from line 19. Otherwise, complete lines 20-22.		
20	Weighted average rate excluding aides and trainees (Line 16 divided by the sum of cols 1-6, line 7)		20
21	Weighted allowance excluding aides and trainees (Line 2 times line 20)		21
22	Total Salary Equivalency (Line 19 or sum of lines 17, 18 and 21)		22

REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	**(COMPLETE THIS WORKSHEET FOR SERVICES PROVIDED PRIOR TO APRIL 10, 1998)**	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-4 PARTS III, IV & V

PART III - STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION

23	Registered Therapists (Line 3 times col 4, line 9)		23
24	Certified Therapists (Line 4 times col 5, line 9)		24
25	Non-Registered, Non-Certified Therapists (Line 5 times col 6, line 9)		25
26	Subtotal (Sum of lines 23-25)		26
27	Standard Travel Expense (Line 6 times sum of lines 3-5)		27
28	Total Standard Travel Allowance and Standard Travel Expense (Sum of lines 26 and 27)		28

PART IV - OVERTIME COMPUTATION

	Description	Therapists			Aides	Trainees	Total	
		Registered	Certified	Nonregistered Noncertified				
		1	2	3	4	5	6	
29	Overtime hours worked during cost reporting period (If col 6, line 29, is zero, or equal to or greater than 2,080, do not complete lines 30 through 37 and enter zero in each column of line 38)							29
30	Overtime rate (Multiply the amounts in cols 4-8, line 8 (the AHSEA) times 1.5)							30
31	Total overtime (Including base and overtime allowance) (Multiply line 29 times line 30)							31
	Calculation of Limitation							
32	Percentage of overtime hours by category (Divide the hours in each column on line 29 by the total overtime worked - column 6, line 29)						100%	32
33	Allocation of provider's standard workyear for one full-time employee times the percentage on line 32. (See Instructions)							33
	Determination of Overtime Allowance							
34	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols. 4-8, line 8)							34
35	Overtime cost limitation (Line 33 times line 34)							35
36	Maximum overtime cost (Enter the lessor of line 31 or 35)							36
37	Portion of overtime already included in hourly computation at the A H S E A. (Multiply line 29 times line 34)							37
38	Overtime allowance (Line 36 minus line 37 - if negative enter zero) (Col. 6, sum of cols. 1 - 5)							38

PART V - COMPUTATION OF RESPIRATORY THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

39	Salary equivalency amount (from Part II, line 22)		39
40	Travel allowance and expense (from Part III, line 28)		40
41	Overtime allowance (from Part IV, col 6, line 38)		41
42	Equipment cost (See Instructions)		42
43	Supplies (See Instructions)		43
44	Total allowance (Sum of lines 39 - 43)		44
45	Total cost of outside supplier services (from your records)		45
46	Excess over limitation (line 45 minus line 44, - if negative, enter zero - See Instructions) (Transfer to amount Wkst. A-3, line 15)		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-5 PARTS I & II

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

PART I - GENERAL INFORMATION

1	Total number of weeks worked (during which outside (excluding aides worked)		1
2	Line 1 multiplied by 15 hours per week		2
3	Number of unduplicated days on which supervisor or therapist was on provider site (see instructions)		3
4	Number of unduplicated days on 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 - Provider on site - (see instructions)						12
####	Number of travel hours - Provider offsite - (see instructions)						####
13	Number of miles driven - Provider on site - (see instructions)						13
####	Number of miles driven - Provider offsite - (see instructions)						####

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 14-16)		17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total Allowance Amount (see instructions)		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 (see instructions)		21
22	Weighted allowance excluding aides and trainees (see instructions)		22
23	Total salary equivalency (see instructions)		23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-5 PARTS III & IV

Check applicable box: [ ] Respiratory [ ] Physical [ ] Occupational [ ] 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 (sum of lines 24 and 25)		26
27	Standard Travel Expense (line 7 times sum of lines 3 and 4)		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 (sum of columns 1 and 2, line 12 times column 2, line 10)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (sum of lines 29 and 30)		31
32	Optional travel expense (line 8 times the sum of columns 1-3, line 13)		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 30)		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 ON OR AFTER APRIL 10, 1998	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-5 PARTS V & VI

Check applicable box: [ ] Respiratory [ ] Physical [ ] Occupational [ ] 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 5, line 47)						50
51	Allocation of provider's standard workyear 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 lessor 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) (column 5, sum of columns 1-4)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from Part II, line 23)		57
58	Travel allowance and expense - provider site (from Part III, lines 33, 34, or 35))		58
59	Travel allowance and expense - provider offsite services (from Part IV, lines 44, 45, or 46)		59
60	Overtime allowance (from Part V, 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 -- See Instructions) (Transfer amount to Wkst. A-3, line 17, 17.1, 17.2 or 17.3 as applicable)		65