Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 18, Form CMS-2088-92

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
1810.1 (Cont.) - 1810.2	18-25 - 18-26 (2 pp.)	18-25 - 18-26 (2 pp.)
1816.6 (Cont.) - 1816.6 (Cont.)	18-42.1 - 18-42.2 (2 pp.)	18-42.1 (1 p.)
1890 (Cont.) - 1890 (Cont.)	18-303 - 18-308 (6 pp.)	18-303 - 18-308 (6 pp.)
1895 (Cont.) - 1895 (Cont.)	18-503 - 18-504 (2 pp.)	18-503 - 18-504 (2 pp.)
	18-507 - 18-512 (6 pp.)	18-507 - 18-512 (6 pp.)
	18-519 - 18-531 (13 pp.)	18-519 - 18-531 (13 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Not Applicable

This transmittal updates Chapter 18, Outpatient Rehabilitation Provider Cost Report for Community Mental Health Centers, (Form CMS-2088-92) to correct the existing instructions. The effective dates vary due to various implementation dates.

Significant Instruction Revisions:

- Worksheet D - Line 17.01 clarifies calculation of the 2 percent Medicare sequestration adjustment, as indicated in the Office of Management and Budget Report to the Congress on the sequestration required by section 251A of the Balanced Budget and Emergency Deficit Control Act, as amended by the Joint Committee. The sequestration adjustment is effective for cost reporting periods that overlap or begin on or after April 1, 2013.

- Worksheet A - Revised to reflect proper coding, usage, and identical cost center description terminology

Significant Electronic Reporting Specifications Revisions:

- Revised a previous specification date to reflect the 3/31/2005.
- Revised Table 1 - Record Specifications to update the medium for transferring cost reports.
- Revised all level I & II edits that reflect a 3/31/2005 effective date.
- Revised the type 2 B-1 record label by deleting the “s” at the end of “Services”
- Removed specifications for Worksheet A-8-5 because it is inapplicable for cost reporting periods after August 2000.
- Revised specifications for Worksheet D, lines 4, 9, and 11 to also include column 1.01.
- Revised specifications for Worksheet D to add lines 17.01 and 19.
- Revised specifications for Worksheet C to reflect the rollup of all subscripted cost centers flowing from Worksheet B.
- Revised edit 1040A by adjusting lines 1, 3, 4, and lines 2, 8-12.
- Revised edit 1045A to reference A-3-1, instead of A-6.
- Revised edit 1005B to reference line 66, instead of 64.
- Revised edit 1000D to reference line 28 [Total], instead of line 27.
- Revised edit 2030 to reflect proper coding, usage, and identical cost center description terminology.
- Revised edit 2005S to reference Part I, instead of Part II.
- Revised edit 2045S to reference Part I, instead of Part II.
- Revised edit 2050S to reference S Part I, and not S-2.

- Revised edit 2050G to reference Worksheet G, instead of Worksheet F.
- Revised the cost center code for Diagnostic Services to read 3600 instead of 2600.
- Modified Table 5; cost center 2000

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

Medicare is not the primary payer under the following situations:

1. If the items of services have been, or can reasonably be expected to be paid under a worker's compensation law of a State or of the United States, including the Federal Black Lung Program;

2. If the items of services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance;

3. If the beneficiary is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an employer group health plan (EGHP), Medicare is the secondary payer for the first 18 months (See §1862(b)(1)(C) of the Act);

4. If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP; and

5. If the beneficiary is under age 65 and disabled and is covered by a large group health plan (LGHP) as a current employee, self-employed individual, or family member of such an employee, or self-employed individual.

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

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

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

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

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

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

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

Line 9.--CORFs and OPTs enter in the applicable column the coinsurance amount billed to Medicare beneficiaries, but this amount may not exceed 20 percent of the customary charges as shown on line 27, Part II. For CMHCs, enter in the applicable the column the gross coinsurance amount billed to Medicare beneficiaries.

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

Line 11.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 11. (*3/31/2005*)

Line 11.02.--Enter in column 1, the result of line 11 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 12.--CORFs, OPTs and CMHCs for cost reimbursed services only, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 8 or 10. For cost reporting periods that begin prior to October 1, 2012, for CMHC PPS reimbursed services, enter in the appropriate column the result of line 10 plus line 11. For cost reporting periods that begin on or after October 1, 2012, for CMHC PPS reimbursed services, enter in column 1 the result of line 10 plus line 11.02.

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

Line 16.--Do not use this line for cost reporting periods that begin on or after October 1, 2012.

Line 16.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4)

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

Line 17.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: (2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places) times line 17).

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

Line 19.--Subtract the total amount entered on lines 17.01 and 18 from the amount entered on line 17 and enter the resulting amount. This represents the amount due to or from the provider before any tentative or final settlement. Transfer this amount to Worksheet S, Part III, line 6.

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

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

Line Descriptions

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

Lines 61 and 62.--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in *CMS Pub. 15-1*, §1412.1) is considered an additional allowance in computing the limitation.

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

Line 65.--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero. Transfer this amount to Worksheet A-3, line 17 for respiratory therapy services, line 17.1 for physical therapy services, line 17.2 for occupational therapy services and line 17.3 for speech pathology services.

This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has three types of records. The first group (type one records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type two records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to *contractors* is *either a* 3½" diskette, *a compact diskette (CD), or a flash drive*. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your contractor regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.04-13

3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1         1   1446002004001200436 62A99P00120050312004366
```

Record #1: This is a cost report file submitted by Provider 144600 for the period from January 1, 2004 (2004001) through December 31, 2004 (2004366). It is filed on FORM CMS-2088-92. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the community mental health center on January 31, 2005 (2005031). The electronic cost report specification dated December 31, 2004 (2004366) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:
CMNNNNNN.YYL, where
1. CM (Community Mental Health Center Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare community mental health center provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from community mental health centers with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	CM Provider Number	6	9	17-22	Field must have 6 numeric characters.
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "2" (for FORM CMS-2088-92)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 18-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods beginning on or after 2012275 (10/01/2012). Prior approval(s) *2005090 (03/31/2005)*.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet B-1, columns 1-5, for lines 1-12 are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

LINE	1	2	3	4	5	6
1	CAP REL	BLDGS &	FIXTURES	SQUARE	FEET	1
2	CAP REL	MOVABLE	EQUIPMENT	SQUARE	FEET	1
3	EMPLOYEE	BENEFITS		GROSS	SALARIES	3
4	ADMINIS-	TRATIVE &	GENERAL	ACCUM	COST	3
5	MAIN-	TENANCE &	REPAIRS	SQUARE	FEET	1
6	OPERATION	OF PLANT		SQUARE	FEET	1
7	LAUNDRY	& LINEN	SERVICE	POUNDS OF	LAUNDRY	3
8	HOUSE-	KEEPING		HOURS OF	SERVICE	3
9	CAFETERIA			MEALS	SERVED	3
10	CENTRAL	SERVICES &	SUPPLY	COSTED	REQUSTS	3
11	MEDICAL	RECORDS &	LIBRARY	TIME	SPENT	3
12	PROF.EDUC.	& TRAINING		ASSIGNED	TIME	3

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and subcolumn number fields (positions 11-20). However, spaces are preferred. (See the first two lines of the example for a comparison.)* Refer to Table 5 and 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

```
*  2A000000      1          0100CAP REL COSTS-BLDG & FIXT
*  2A00000000001010000000101CAP REL COSTS-BLDG & FIXT--WEST WING
   2A000000      2          0200CAP REL COSTS-MVBLE EQUIP
   2A000000      8          0800HOUSEKEEPING
   2A000000     30          3000OCCUPATIONAL THERAPY
   2A000000     49          4900DIAGNOSTIC CLINICS
   2A000000     49 1        4901DIAGNOSTIC CLINICS--OTHER
```

Examples of column headings for Worksheets B-1 and B; statistical bases used in cost allocation on Worksheet B-1; and statistical codes used for Worksheet B-1 (line 6) are displayed below.

```
2B10000*     1   1   CAP REL
2B10000*     2   1   BLDGS &
2B10000*     3   1   FIXTURES
2B10000*     4   1   SQUARE
2B10000*     5   1   FEET
2B10000*     6   1   1
2B10000*     1   3   EMPLOYEE
2B10000*     2   3   BENEFITS
2B10000*     4   3   GROSS
2B10000*     5   3   SALARIES
2B10000*     6   3   3
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 3 Records for Nonlabel Data

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "3"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Subcolumn Number	2	9	19-20	Numeric
8.	Field Data				
	a. Alpha Data	36	X	21-56	Left justified. (Y or N for yes/no answers; dates must use MM/DD/YYYY format - slashes, no hyphens.) Refer to Table 6 for additional requirements for alpha data.
		4	X	57-60	Spaces (optional).
	b. Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeros are suppressed; trailing zeros to the right of the decimal point are not. Positive values are presumed; no "+" signs are allowed. Use leading minus to specify negative values. Express percentages as decimal equivalents, i.e., 8.75% is expressed as .087500. All records with zero values are dropped. Refer to Table 6 for additional requirements regarding numeric data.

A sample of type 3 records are below.

```
3A000000    33   1          36393
3A000000    33 1 1           5599
3A000000     3   1          47750
3A000000     4   1         167922
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 1 - RECORD SPECIFICATIONS

The line numbers are numeric. In several places throughout the cost report (see list below), the line numbers themselves are data. The placement of the line and subline numbers as data must be uniform.

Worksheet A-1, columns 3 and 6
Worksheet A-3, column 4
Worksheet A-3-1, Part B, column 1

Examples of records (*) with a Worksheet A line number as data are below.

	3A100010	13		0	TO SPREAD INTEREST EXPENSE
	3A100010	13		1	G
*	3A100010	13		3	1.00
	3A100010	13		4	221409
*	3A100010	13		6	51.00
	3A100010	13		7	225321
	3A100010	14		0	BETWEEN CAPITAL-RELATED COST
	3A100010	14		1	G
*	3A100010	14		3	4.00
	3A100010	14		4	3912
	3A100010	15		0	BUILDING & FIXTURES AND
	3A100010	16		0	ADMINISTRATIVE AND GENERAL
	3A300010	18		0	IRS PENALTY
	3A300010	18		1	B
	3A300010	18		2	-935
*	3A300010	18		4	4.00
	3A300010	19	1	0	MISC INCOME
	3A300010	19	1	1	A
	3A300010	19	1	2	-114525
*	3A300010	19	1	4	4.00
*	3A31000A	1		1	9.00
	3A31000A	3		1	KITCHEN
	3A31000A	4		1	3352
	3A31000A	5		1	1122

RECORD NAME: Type 4 Records - File Encryption

This type 4 record consists of 3 records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to disk and insures the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided for only those worksheets for which data are to be provided.

The worksheet indicator consists of seven digits in positions 2-8 of the record identifier. The first two digits of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third digit of the worksheet indicator (position 4 of the record identifier) is as part of the worksheet, e.g., A*31*. For Worksheets A-1 and A-8-2, if there is a need for extra lines on multiple worksheets, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify the page number. The seventh digit of the worksheet indicator (position 8 of the record identifier) represents the worksheet or worksheet part.

Worksheets That Apply to the CMHC Complex

Worksheet	Worksheet Indicator	
S, Part I	S000001	
S, Part III	S000003	
S, Part IV	S000004	
S-1	S100000	
A	A000000	
A-1	A100010	(b)
A-3	A300000	
A-3-1, Part A	A31000A	
A-3-1, Part B	A31000B	
A-3-1, Part C	A31000C	
A-8-2	A820010	
B-1 (For use in column headings)	B10000*	
B	B000000	
B-1	B100000	
C	C000000	
D	D000000	(a)
G	G000000	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Worksheets With Multiple Parts Using Identical Worksheet Indicator
Although some worksheets have multiple parts, the lines are numbered sequentially. In these instances, the same worksheet identifier is used with all lines from this worksheet regardless of the worksheet part. This differs from the Table 3 presentation, which still identifies each worksheet and part as they appear on the printed cost report. This affects Worksheet A-8-5.

(b) Multiple Worksheets for Reclassifications and Adjustments Before Stepdown
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheet A-1. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

This table identifies those data elements necessary to calculate a *CMHC* cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 6) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the *CMHC* and the report produced by the contractor. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or " 1" (with a space preceding the 1) in field locations 14-15. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For Other (specify) lines, i.e., Worksheet settlement series, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Automated systems should reorder these numbers where providers skip or delete a line in the series.

Drop all records with zero values from the file. Any record absent from a file is treated as if it were zero.

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero that are specified in Table 3 with a usage of "-9". Amounts that are within preprinted parentheses on the worksheets, indicating the reduction of another number, are reported as positive values.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET B-1 (Continued)				
* In each column using accumulated costs as the statistical basis for allocating costs, identify each cost center that is to receive no allocation with a negative 1 (-1) placed in the accumulated cost column. Providers may elect to indicate total accumulated cost as a negative amount in the reconciliation column. However, there should never be entries in both the reconciliation column and accumulated column simultaneously. For those cost centers that are to receive partial allocation of costs, provide only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. If line 4 is fragmented, line 4 must be deleted and subscripts of line 4 must be used.				
WORKSHEET C				
Patient charges	29-38 (all on subline .02)	1	9	9
Total patient costs	39.01	1	9	9
Total patient charges	39.02	1	9	9
Medicare program charges	29-38 (all on subline .02)	3	9	9
Total Medicare patient costs	39.01	3	9	9
Total Medicare patient charges	39.02	3	9	9
Non-Medicare program charges	29-38 (all on subline .02)	4	9	9
Total Non-Medicare program costs	39.01	4	9	9
Total Non-Medicare program charges	39.02	4	9	9
Medicare charges for services rendered on or after 8/1/2000, 1/1/2002, 1/1/2003 or 1/1/2004	29-38	5	9	9
Total Medicare program charges after transition date	39	5	9	9
Medicare cost for services rendered on or after 8/1/2000, 1/1/2002, 1/1/2003 or 1/1/2004	29-38	6	9	9
Total Medicare program costs after transition date	39	6	9	9
WORKSHEET D				
Part I:				
Total PPS payments for CMHC – Part A and B	1.01	1 & 1.01	9	9
1996 CMHC specific payment to cost ratio	1.02	1 & 1.01	5	9.9(3)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET D (Continued)				
Amounts paid by primary payers when Medicare liability is secondary to the primary payer	2	1 & 1.01	9	9
Deductibles billed to Medicare patients	4	1 *& 1.01*	9	9
Coinsurance billed to Medicare patients	9	1 *& 1.01*	9	9
Reimbursable bad debts	11	1 *& 1.01*	9	*-9*
Reimbursable bad debts for dual eligible beneficiaries	11.01	1	9	*-9*
Adjusted reimbursable bad debts	11.02	1	9	-9
Sequestration adjustment (see instructions)	16	1	9	9
Text as needed for blank line (specify)	16.5	0	36	X
Other adjustments (see instructions)	16.5	1	9	-9
Sequestration adjustment amount	*17.01*	*1*	*9*	*-9*
Balance due Provider/Program	*19*	*1*	*9*	*-9*
WORKSHEET G				
Total patient revenues	1	2	9	9
Contractual allowances and discounts on patients' accounts	2	2	9	-9
Other income	6-22	1	9	9
Other expenses	25-30	1	9	9
Net income	32	2	9	-9
Text as needed for blank lines	20-22, 28-30	0	36	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet S, Part II

TABLE 3B - TABLES TO WORKSHEET S, Part I

Type of Control

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Sole Proprietor
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, State
8 = Governmental, Hospital District
9 = Governmental, County
10 = Governmental, City
11 = Governmental, City-County
12 = Governmental, Other

Type of Provider

5 = Community Mental Health Center (CMHC)

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED
(BEYOND THOSE PREPRINTED)

Worksheet	Lines
S, Parts I – III	All
S, Part IV	28, 29
Supplemental S-1	1, 2, 3.01-3.04, 3.50-3.53
A	65 (Lines 28, 39, 44 may not be used)
A-1	All
A-3	1-12, 13-17, 17.1, 17.2, 17.3, 22
Supplemental A-3-1, Part B	1-3
Supplemental A-3-1, Part C	1-4
B	65, 66 (Lines 28, 39, 44 may not be used)
B-1	65-67 (Lines 28, 39, 44 may not be used)
C	*All*
D	All (except line 16.5)*
G	All (except lines 22 and 30)

*** NOTE**: Line 16.5 may be subscripted 4 times from line 16.6 through 16.9.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are peculiar to the reporting provider and give no hint as to the actual function being reported. Using codes to standardize meanings makes practical data analysis possible. The method to accomplish this must be rigidly controlled to assure accuracy.

For any added cost center names (the preprinted cost center labels must be precoded), preparers must be presented with the allowable choices for that line or range of lines from the lists of standard and nonstandard descriptions. They then select a description that best matches their added label. The code associated with the matching description, including increments due to choosing the same description more than once, will then be appended to the user's label by the software.

Additional guidelines are:

X Do not allow any pre-existing codes for the line to be carried over.
X Do not precode all Other lines.
X For cost centers, the order of choice must be standard first, then specific nonstandard, and finally the nonstandard A Other . . ."
X or the nonstandard "Other . . .", prompt the preparers with, "Is this the most appropriate choice?," and then offer the chance to answer yes or to select another description.
X Allow the preparers to invoke the cost center coding process again to make corrections.
X For the preparers' review, provide a separate printed list showing their added cost center names on the left with the chosen standard or nonstandard descriptions and codes on the right.
X On the screen next to the description, display the number of times the description can be selected on a given report, decreasing this number with each usage to show how many remain. The numbers are shown on the cost center tables.
X Do not change standard cost center lines, descriptions and codes. The acceptable formats for these items are listed on page 18-535 of the Standard Cost Center Descriptions and Codes. The proper line number is the first two digits of the cost center code.

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding standardized the meaning of cost center labels used by health care providers on the Medicare cost reporting forms. The use of this coding methodology allows providers to continue to use their labels for cost centers that have meaning within the individual institution.

The four digit codes that are required to be associated with each label provide standardized meaning for data analysis. Normally, it is necessary to code only added labels because the preprinted standard labels are automatically coded by CMS approved cost report software.

Additional cost center descriptions have been identified. These additional descriptions are hereafter referred to as the nonstandard labels. Included with the nonstandard descriptions is an "Other . . ." designation to provide for situations where no match in meaning can be found. Refer to Worksheet A, line 38.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 5 - COST CENTER CODING

Both the standard and nonstandard cost center descriptions along with their cost center codes are shown on Table 5. The "use" column on that table indicates the number of times that a given code can be used on one cost report. You are required to compare your added label to the descriptions shown on the standard and nonstandard tables for purposes of selecting a code. Most CMS approved software provides an automated process to present you with the allowable choices for the line/column being coded and automatically associates the code for the selected matching description with your label.

Additional Guidelines

Categories

Make a selection from the proper category such as general service description for general service lines, special purpose cost center descriptions for special purpose cost center lines, etc.

Use of a Cost Center Coding Description More Than Once

Often a description from the "standard" or "nonstandard" tables applies to more than one of the labels being added or changed by the preparer. In the past, it was necessary to determine which code was to be used and then increment the code number upwards by one for each subsequent use. This was done to provide a unique code for each cost center label. Now, most approved software associate the proper code, including increments as required, once a matching description is selected. Remember to use your label. You are matching to CMS's description only for coding purposes.

Cost Center Coding and Line Restrictions

Use cost center codes only in designated lines in accordance with the classification of cost center(s), e.g., lines 29 through 37 may only contain cost center codes within the CMHC services cost center category of both standard and nonstandard coding.

Administrative and General Cost Centers

A&G can either be shown as one cost center with a code of 0400 or subscripted If A&G is subscripted, do not use line 4 or cost center code 0400.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Cap Rel Costs-Bldg & Fixt	0100	(20)
Cap Rel Costs-Mvble Equip	0200	(20)
Employee Benefits	0300	(20)
Administrative & General	0400	(20)
Maintenance & Repairs	0500	(20)
Operation of Plant	0600	(20)
Laundry & Linen Service	0700	(20)
Housekeeping	0800	(20)
Cafeteria	0900	(20)
Central Services & Supply	1000	(20)
Medical Records & Library	1100	(20)
Pro Ed & Training (Apprvd)	1200	(20)
CMHC		
Drugs & Biologicals	2900	(10)
Occupational Therapy	3000	(10)
Psychiatric / Psychological Services	3100	(10)
Individual Therapy	3200	(10)
Group Therapy	3300	(10)
Individualized Activities Therap*ies*	3400	(10)
Family Counseling	3500	(10)
Diagnostic Services	3600	(10)
Patient Training & Education	3700	(10)
NONREIMBURSABLE COST SERVICES		
Sheltered Workshops	4500	(10)
Recreational Programs	4600	(10)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

	CODE	USE
NONREIMBURSABLE SERVICES (Continued)		
Resident Day Camps	4700	(10)
Pre-school Programs	4800	(10)
Diagnostic Clinics	4900	(10)
Home Employment Programs	5000	(10)
Equipment Loan Service	5100	(10)
Physician's Private Offices	5200	(10)
Fund Raising	5300	(10)
Coffee Shops & Canteen	5400	(10)
Research	5500	(10)
Investment Property	5600	(10)
Advertising	5700	(10)
Franchise Fees and Other Assessments	5800	(10)
Pro Ed & Training (Not Apprvd)	5900	(10)

	CODE	USE
CMHC NONREIMBURSABLE SERVICES		
Meals and Transportation	6100	(10)
Activity Therapies	6200	(10)
Psychosocial Programs	6300	(10)
Vocational Training	6400	(10)

NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

SPECIAL PURPOSE COST CENTER		
Other General Services Cost Centers	1300	(10)
Other General Services Cost Centers	1400	(10)
Other CMHC Services	3800	(10)
Other Nonreimbursable Cost Centers	6000	(10)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 - EDITS

Medicare cost reports submitted electronically must be subjected to various edits, which are divided into two categories: Level I and level II edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare *CMHCs* must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the *CMHC* of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file containing a level I edit will be rejected by your contractor without exception.

Level I edits (1000 series reject codes) test that the file conforms to processing specifications, identifying error conditions that would result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items that may have exceptions and should not automatically cause a cost report rejection. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both contractor processing time and unnecessary rejections. Vendors should develop their programs to prevent their client community mental health centers from generating either a hard copy substitute cost report or electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated.

NOTE: Dates in brackets [ ] at the end of an edit indicate the effective date of that edit for cost reporting periods ending on or after that date. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted. [10/31/2000]

I. Level I Edits (Minimum File Requirements)

Reject Code	Condition
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [*03/31/2005*]
1005	No record may exceed 60 characters. [*03/31/2005*]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [*03/31/2005*]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [*03/31/2005*]
1020	The CMHC provider number (record #1, positions 17-22) must be valid (issued by the applicable certifying agency and falls within the specified range) and numeric. [*03/31/2005*]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate (the date must be possible and correspond to the current cost reporting period). [*03/31/2005*]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than or equal to the fiscal year ending date (record #1, positions 30-36). [*03/31/2005*]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 - EDITS

Reject Code	Condition
1035	The vendor code (record #1, positions 38-40) must be a valid code. [*03/31/2005*]
1050	The type 1 record #1 must be correct and the first record in the file. [*03/31/2005*]
1055	All record identifiers (positions 1-20) must be unique. [*03/31/2005*]
1060	Only a Y or N is valid for fields which require a Yes/No response. [*03/31/2005*]
1065	Variable column (Worksheet B and Worksheet B-1) must have a corresponding type 2 record (Worksheet A label) with a matching line number. [*03/31/2005*]
1070	All line, subline, column, and subcolumn numbers (positions 11-13, 14-15, 16-18, and 19-20, respectively) must be numeric, except for any cost center with accumulated cost as its statistic, which must have its Worksheet B-1 reconciliation column numbered the same as its Worksheet A line number followed by an "A" as part of the line number followed by the subline number. [*03/31/2005*]
1075	Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [*03/31/2005*]
1080	For every line used on Worksheets A, B, and C, there must be a corresponding type 2 record. [*03/31/2005*]
1090	Fields requiring numeric data (charges, visits, costs, FTEs, etc.) may not contain any alpha character. [*03/31/2005*]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [*03/31/2005*]
1005S	The cost report ending date must be on or after *March 31, 2005*. [*03/31/2005*]
1010S	The provider number displayed on Worksheet S, Part I, column 1, line 2, must contain six (6) alphanumeric characters. [*03/31/2005*]
1015S	The cost report period beginning date (Worksheet S, line 1.03, column 1) must precede the cost report ending date (Worksheet S, line 1.03, column 2). [*03/31/2005*]
1020S	The CMHC name, street address, city, state, and zip code (Worksheet S, Part I, column 1, line 1; columns 1 and 2, line 1.01; columns 1 through 3, line 1.02) must be present and valid. [*03/31/2005*]
1025S	The CMHC provider number, type of control, type of provider, and certification date (Worksheet S, Part I, columns 1, 2, 4, and 5, line 2) must be present and valid. [*03/31/2005*]
1030S	All amounts reported on Worksheet S, Part IV must not be less than zero. [*03/31/2005*]
1000A	All amounts reported on Worksheet A, columns 1-3, line 65, must be greater than or equal to zero. [*03/31/2005*]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 - EDITS

Reject Code	Condition
1020A	For reclassifications reported on Worksheet A-1, the sum of all increases (column 4) must equal the sum of all decreases (column 7). [*03/31/2005*]
1025A	For each line on Worksheet A-1, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [*03/31/2005*]
1040A	For Worksheet A-3 adjustments on lines *1 through 12* and 20-21, if column 2 has an entry, then columns *1,* 2 and 4 must have entries, and if *lines 18 or 19* and subscripts thereof ha*ve* an entry *in column 2,* then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [*03/31/2005*]
1045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-*1*, chapter 10 (Worksheet A-*3-1*, Part A, column 1, line 1 is "Y"), Worksheet A-*3-1*, Part B, columns 4 or 5, sum of lines 1-4 must be greater than zero; and Part C, column 1, any one of lines 1-5 must contain any one of alpha characters A through G. Conversely, if Worksheet A-*3-1*, Part A, column 1, line 1 is "N", Worksheet A-*3-1*, Parts B and C must not be completed. [*03/31/2005*]
1050A	Worksheet A-8-2, column 3 must be equal to or greater than the sum of columns 4 and 5 and columns 6 and 7 must each be greater than zero if column 5 is greater than zero. [*03/31/2005*]
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [*03/31/2005*]
1005B	Worksheet B, column 17, line 6*6* must be greater than zero. [*03/31/2005*]
1010B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet A, column 7, lines 1-14), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any column that uses accumulated cost as its basis for allocation and any reconciliation column. [*03/31/2005*]
1000C	The sum of columns 3 and 4, lines 29 through 39 (and subscripts), must equal column 1 of the corresponding line on Worksheet C. [*03/31/2005*]
1000D	If Medicare CMHC visits (Worksheet S, Part IV, column 1, line *28 [Total]*) are greater than zero, then Medicare CMHC costs (Worksheet D, Part I, sum of columns 1 and subscripts, line 12) must be greater than zero. [*03/31/2005*]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 - EDITS

II. Level II Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, provide additional information in schedules, note form, or any other manner as may be required by your contractor. Failure to clear these errors in a timely fashion, as determined by your contractor, may be grounds for withholding payments.

Edit	Condition
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [*03/31/2005*]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [*03/31/2005*]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [*03/31/2005*]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [*03/31/2005*]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [*03/31/2005*]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [*03/31/2005*]
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [*03/31/2005*]

Cost Center	Line	Code
Cap Rel Costs-Bldg & Fixt	1	0100-0119
Cap Rel Costs-Mvble Equip	2	0200-0219
Employee Benefits	3	0300-0319
Administrative & General	4	0400-0419
Maintenance & Repairs	5	0500-0519
Operation of Plant	6	0600-0619
Laundry & Linen	7	0700-0719
Housekeeping	8	0800-0819
Cafeteria	9	0900-0919
Central Services & Supply	10	1000-1019
Medical Records & Library	11	1100-1119

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 – EDITS

Cost Center	Line	Code
Pro Ed & Training (Apprvd)	12	1200-*1219*
Drugs *&* Biologicals	29	2900-*2909*
Occupational Therapy	30	3000-*3009*
Psychiatric / Psychological Services	31	3100-*3109*
Individual Therapy	32	3200-*3209*
Group Therapy	33	3300-*3309*
Individualized Activity Therap*ies*	34	3400-*3409*
Family Counseling	35	3500-*3509*
Diagnostic Services	36	*3*600-*3609*
Patient Training *&* Education	37	3700-*3709*
Sheltered Workshops	45	4500-*4509*
Recreational Programs	46	4600-*4609*
Resident Day Camps	47	4700-*4709*
Pre-School Programs	48	4800-*4809*
Diagnostic Clinics	49	4900-*4909*
Home Employment Programs	50	5000-*5009*
Equipment Loan Service	51	5100-*5109*
Physician’s Private Office	52	5200-*5209*
Fund Raising	53	5300-*5309*
Coffee Shop*s &* Canteen	54	5400-*5409*
Research	55	5500-*5509*
Investment Property	56	5600-*5609*
Advertising	57	5700-*5709*
Franchise Fees and Other Assessments	58	5800-*5809*
Pro Ed & Training (Not Apprvd)	59	5900-*5909*
Meals & Transportation	61	6100-*6109*
Activity Therap*ies*	62	6200-*6209*
Psychosocial Programs	63	6300-*6309*
Vocational Training	64	6400-*6409*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
TABLE 6 – EDITS

Edit	Condition
2035	The administrative and general standard cost center code (0400) may appear only on line 4. [*03/31/2005*]
2040	All calendar format dates must be edited for 10 character format, e.g., 01/01/1996 (MM/DD/YYYY). [*03/31/2005*]
2045	All dates must be possible, e.g., no "00", no "30", or "31" of February. [*03/31/2005*]
2005S	The amount due the provider or program (Worksheet S, Part *I*, line 6, column 1) should not equal zero. [*03/31/2005*]
2020S	The length of the cost reporting period should be greater than 27 days and less than 459 days. [*03/31/2005*]
2045S	Worksheet S, Part *I*, column 2, line 2 (type of control) must have a value of 1 through 12. (See Table 3B.) [*03/31/2005*]
2050S	On Worksheet *S, Part I*, a response is required for at least one of the questions on lines 3.01or 3.03. [*03/31/2005*]
2000A	Worksheet A-1, column 1 (reclassification code) must be alpha characters. [*03/31/2005*]
2000B	a. At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center. This edit applies to all general service cost centers required and/or listed. Exclude any reconciliation columns from this edit. [*03/31/2005*]
2005B	b. The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [*03/31/2005*]
2005G	Net income or loss (Worksheet G, column 2, line 32) should not equal zero. [*03/31/2005*]
2050G	Total patient revenue (Worksheet *G*, column *2*, line 1) should be equal to or greater than *total* CMHC charges (Worksheet C, column 1, sum of lines 29.02 through 38.02, respectively. [*03/31/2005*]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.

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