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

**Department of Health and Human Services (DHHS)**
**HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

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| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
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| 1803 - 1803 | 18-8.1 (1p.) | 18-8.1 (1p.) |
| 1809 - 1813 (Cont.) | 18-21 - 18-28 (9 pp.) | 18-21 - 18-28 (8 pp.) |
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**REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Changes effective for services rendered on or after August 1, 2000.**

This transmittal revises Chapter 18, Outpatient Rehabilitation Provider Cost Reporting Form HCFA-2088-92 for implementation of an Outpatient Prospective Payment System (OPPS) in accordance with §1833 of the Social Security Act as amended by §4523 of the Balanced Budget Act of 1997, effective for such services rendered on or after August 1, 2000.

The following is a list of the revised cost reporting forms:

| Form HCFA 2088-92 Wkst.: | Summary of Changes: |
|---|---|
| S, Part I-III | Revised disclosure statement. |
| C | Opened columns 5 and 6, lines 29 thru 39 for data entry and revised the column heading for columns 5, 6 and 8. |
| D | Subscripted line 1 (currently 1 thru 1.05) and column 1 (added column 1.01) from lines 1 thru 12 to facilitate the calculation of the OPPS for CMHC services rendered on or after August 1, 2000. |

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

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

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

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the outpatient rehabilitation provider. Also include all Prospective Payment System (PPS) payments for CMHC services rendered on or after August 1, 2000. Do not include payments received for services reimbursed on a fee schedule basis. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the outpatient rehabilitation provider's interim payments due to an offset against overpayments to the outpatient rehabilitation provider applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the outpatient rehabilitation provider is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet D, line 18.

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

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

**NOTE**: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet D, line 17.

## 1809. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Partial hospitalization services provided by CMHCs reimbursed based on a Prospective Payment System (PPS).--For CMHC services (lines 29-38) rendered on or after August 1, 2000, reimbursement is based on PPS subject to a transitional corridor payment. Vaccines furnished by CMHCs are reimbursed based on outpatient PPS.

Column 5, lines 29-38.--For each cost center, enter the title XVIII charges (from your records) for services rendered on or after August 1, 2000.

Column 6, lines 29-38.--Determine the title XVIII cost for services rendered on or after August 1, 2000 by multiplying the charges in column 5 by the ratio in column 2, and enter the result.

Column 8, lines 29-38.--Determine the title XVIII pre 8/1/2000 cost by subtracting the amount in column 6 from the amount in column 3, subline .01, and enter the result.

Line 39.--Enter the total of lines 29 through 38, and transfer the amount on line 39, column 8 to Worksheet D, line 1.

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

Line 44.--Enter the total of lines 40 through 43, columns 5 through 8 and transfer the amount on line 44, column 8 to Worksheet D, line 1.

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

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

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

Worksheet D consists of two parts:

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

### 1810.1 Part I - Computation of Reimbursement Settlement.--

Line Descriptions

Line 1.--Enter the total expenses applicable to the health insurance program obtained from Worksheet C, column 8, line as appropriate (other providers from line 44). CORFs & OPTs use column 1 only. CMHCs enter in column 1 the cost of services provided prior to August 1, 2000 from Worksheet C, column 8, line 39. CMHCs enter in column 1.01 the cost of services provided on or after August 1, 2000 from Worksheet C, column 6, line 39. CORFs enter cost of services provided on or after January 1, 1998 by subtracting the amount in column 7, line 28 from the amount in column 6, line 28.

**NOTE**: For CMHCs only column 1 is subscripted for lines 1 through 12 for cost reporting periods which overlap August 1, 2000. Column 1 must also be subscripted for all cost reporting periods which overlap December 31, 2001, 2002 and 2003 to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. Enter in column 1 any data applicable to CMHC services rendered prior to August 1, 2000. Enter in column 1.01 data applicable to CMHC services rendered on or after August 1, 2000.

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

Line 1.01.--Enter the PPS payments received including outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio provided by your intermediary.

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

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

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

For services rendered on or after August 1, 2000 through December 31, 2001:
a. If line 1.04 is => 90% but < 100% enter 80% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered on or after January 1, 2002 through December 31, 2002:
a. If line 1.04 is => 90% but < 100% enter 70% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
c. If line 1.04 is < 80% enter 13% of line 1.03.

For services rendered on or after January 1, 2003 through December 31, 2003:
a. If line 1.04 is => 90% but < 100% enter 60% of the result of line 1.03 minus line 1.01.
b. If line 1.04 is < 90% enter 6% of line 1.03.

Line 1.1.--Enter the CORF total expenses for services provided prior to January 1, 1998 by subtracting the amount in column 6, line 28 from the amount in column 3, line 28.01.

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

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--Enter the total expenses for CMHC services furnished prior to August 1, 2000 in column 1 by adding lines 1 and 1.1 minus line 2. Enter the total PPS payment for CMHC services furnished on or after August 1, 2000 in column 1.01 by adding lines 1.01 and 1.05 minus line 2.

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

Line 6.--CMHCs, CORFs, and other providers enter in column 1 the amount from line 29 of Part II.

Line 8.--Enter in column 1 80 percent of the amount shown on line 7.

Line 9.--Enter in column 1 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. Enter in column 2 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 in column 2 must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 12.--In column 1 enter the result of line 11 plus the lesser of the amounts on line 8 or 10. In column 2 enter the result of line 11 plus the lesser of the amounts on line 7 or 10.

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

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

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

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

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

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

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

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

Line Descriptions

Line 21.--This line is the reasonable cost of title XVIII services from Part I, line 1, column 1 for CMHCs rendered prior to August 1, 2000 (from line 1, column 1) and OPTs. For CORFs this line represents the reasonable cost of title XVIII services rendered on or after January 1, 1998.

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

Line 22.--This line provides for the charges which relate to the reasonable cost on line 21. For CMHCs, enter the result of Worksheet C, column 3, line 39.02 minus column 5, line 39. For OPTs, enter the amount from Worksheet C, column 3, line 44.02. Do not include the charges for any

services that are reimbursed under any method other than cost reimbursement. For CORFs, enter the total charges for Medicare services provided on or after January 1, 1998 from Worksheet C, column 5, line 28.

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

Lines 23 through 27.--These lines provide for the reduction of Medicare charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge

1812. WORKSHEET G - STATEMENT OF REVENUE AND EXPENSES

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

Worksheet G is completed by all providers.

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

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

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

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

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

Column Descriptions

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

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

When RCE limits are applied on an individual basis to each physician in a department, each physician must be listed on successive lines below the cost center. Each physician must be listed using an individual identifier which is not necessarily either the name or social security number of

the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to the fiscal intermediary upon audit.

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

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

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

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

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

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

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

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the Federal Register before any allowable adjustments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

## 1816 WORKSHEET A-8-5 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

This worksheet provides for the computation of any needed adjustments to costs applicable to respiratory therapy, physical therapy, occupational therapy and speech pathology services furnished by outside suppliers. (See 42 CFR §413.106.) The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See PRM-I, chapter 14.)

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

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

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

1816.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1.--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patients home are only counted once. (See PRM-I, chapter 14.)

Line 2.--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3.--Enter the number of days in which the supervisor or therapist (report the therapists only for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4.--Enter the number of days in which the therapy assistant (PT, OT, SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

**NOTE**: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist, and assistant on one day,

count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5.--Enter the number of unduplicated offsite visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit. Do not complete these lines.

Line 6--Enter the number of unduplicated offsite visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7.--Enter the standard travel expense rate applicable. (See PRM-I, chapter 14.)

Line 8.--Enter the optional travel expense rate applicable. (See PRM-I, chapter 14.) Use this rate only for services for which time records are available.

Line 9.--Enter in the appropriate columns the total number of hours worked for each category..

Line 10.--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in PRM-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of PRM-1, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of PRM-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, aides, and trainees respectively) the AHSEA from either the appropriate exhibit found in PRM-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See PRM-I, §1412.2.)

Line 11.--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 10. Enter in column 3 one half of the amount in column 3, line 10. (See PRM-I, §1402.4.)

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

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

1816.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of PRM-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. See PRM-I, §2810 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20.--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only.)

Line 17.--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

EXHIBIT 1 - Form HCFA-2088-92

The following is a listing of the Form HCFA-2088-92 worksheets and the page number location.

| Worksheets | Page(s) |
|---|---|
| Wkst. S, Parts I-III | 18-303 |
| Wkst. S, Part IV | 18-304 |
| Wkst. S-1 | 18-305 |
| Wkst. A | 18-306 - 18-307 |
| Wkst. A-1 | 18-308 |
| Wkst. A-3 | 18-309 |
| Wkst. A-3-1 | 18-310 |
| Wkst. B | 18-311 - 18-313 |
| Wkst. B-1 | 18-314 - 18-316 |
| Wkst. C | 18-317 - 18-318 |
| Wkst. D | 18-319 |
| Wkst. G | 18-320 |
| Wkst. A-8-2 | 18-321 |
| Wkst. A-8-3, Parts I-III | 18-322 |
| Wkst. A-8-3, Parts IV-VI | 18-323 |
| Wkst. A-8-4, Parts I & II | 18-324 |
| Wkst. A-8-4, Parts III-V | 18-325 |
| Wkst. A-8-5, Parts I & II | 18-326 |
| Wkst. A-8-5, Parts III & IV | 18-327 |
| Wkst. A-8-5, Parts V & VI | 18-328 |

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 NO.: _____ | PERIOD: From: _____ To: _____ | WORKSHEET S, PARTS I - III |
|---|---|---|---|

Intermediary Use Only:

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

**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 |

| | 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 0938-0022. 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: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850."

| OUTPATIENT REHABILITATION PROVIDER COST REPORT STATISTICAL DATA | PERIOD: FROM _____ TO _____ | PROVIDER NO: _____ | 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 |

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO: _____ | 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 OR 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 | | | | | | | | |
| | | .02 | | | | | | | | |
| 16 | Physical Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 17 | Speech Pathology | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 18 | Occupational Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 19 | Respiratory Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 20 | Medical Social Services | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 21 | Psychological Services | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 22 | Prosthetic and Orthotic Devices | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 23 | Drugs and Biologicals | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 24 | Supplies Charged to Patients | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 25 | DME-Sold | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 26 | DME-Rented | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 27 | | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 28 | TOTAL(Line 15 through 27) | .01 | | | | | | | | |
| | | .02 | | | | | | | | |

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

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APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C Page 2 of 2

| | CMHC 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 AFTER 8/1/2000 | TITLE XVIII COSTS ON OR AFTER 8/1/2000 | REASONABLE COST REDUCTION AMOUNT | TITLE XVIII COSTS PRIOR TO 8/1/2000 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 29 | Drugs and Biologicals | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 30 | Occupational Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 31 | Psychiatric/Psychological Services | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 32 | Individual Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 33 | Group Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 34 | Individualized Activity Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 35 | Family Counseling | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 36 | Diagnostic Services | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 37 | Patient Training & Education | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 38 | | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 39 | TOTAL (Lines 29 through 38) | .01 | | | | | | | | |
| | | .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 | | | | | | | | |
| | | .02 | | | | | | | | |
| 41 | Speech Pathology | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 42 | Occupational Therapy | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 43 | | .01 | | | | | | | | |
| | | .02 | | | | | | | | |
| 44 | TOTAL (Lines 40 through 43) | .01 | | | | | | | | |
| | | .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.

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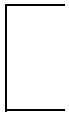

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| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES-TITLE XVIII | PROVIDER NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D |
|---|---|---|---|

CORF | OPT | CMHC

PART I - COMPUTATION OF REIMBURSEMENT SETTLEMENT

| | DESCRIPTION | 1 | 1.01 | |
|---|---|---|---|---|
| 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 intermediary) | | | 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) | | | 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 |
| 12 | TOTAL COST-- (line 11 plus the lesser of line 8 or line 10 ) | | | 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 (line 12 plus line 14 ) (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 |
| 18 | Interim Payments | | | 18 |
| 18.5 | Tentative settlement (For intermediary use only) | | | 18.5 |
| 19 | Balance due Provider/Program (line 17 minus line 18) (Indicate overpayment in brackets) | | | 19 |

NOTE: FOR CORF SERVICES RENDERED PRIOR TO 1/1/1998 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 HCFA-2088-92 (3-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15 - II, SEC. 1810, 1810.1 AND 1810.2)

| STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: _____ | 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 |