ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

PROVIDER NO.: _____ COMPONENT NO.: _____

PERIOD: FROM_____ TO _____

WORKSHEET J-1, PART I

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

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

(1) Columns 0 through 27, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO _____	WORKSHEET J-1, PART I (CONT.)

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

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

(1) Columns 0 through 27, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO _____	WORKSHEET J-1, PART I (CONT.)

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

	COMPONENT COST CENTER (omit cents)	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 5a-24)	INTERN & RESIDENT COST & POST STEPDOWN ADJ.	SUBTOTAL (sum of cols. 25 ± 26)	ALLOCATED COMPONENT A&G (see Part II) (2)	TOTAL (sum of cols. 27 ± 28)	
		21	22	23	24	25	26	27	28	29	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)(1)										22
23	Unit Cost Multiplier (see instructions)										23

(1) Columns 0 through 27, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

(2) The sum of lines 2-21 must equal the amount in column 27, line 1.

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS STATISTICAL BASIS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-1, PART II

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

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

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3656.2)

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS STATISTICAL BASIS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-1, PART II (CONT.)

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

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

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3656.2)

ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS STATISTICAL BASIS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-1, PART II (CONT.)

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

	CORF COST CENTER (omit cents)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS: SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS: PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)						
		21	22	23	24	25	26	27	28	29	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Respiratory Therapy										7
8	Psychiatric/Psychological Services										8
9	Individual Therapy										9
10	Group Therapy										10
11	Individualized Activity Therapies										11
12	Family Counseling										12
13	Diagnostic Services										13
14	Approved Patient Training & Education										14
15	Prosthetic and Orthotic Devices										15
16	Drugs and Biologicals										16
17	Medical Supplies										17
18	Medical Appliances										18
19	Durable Medical Equipment-Rented										19
20	Durable Medical Equipment-Sold										20
21	All Others										21
22	Totals (sum of lines 1-21)										22
23	Total Cost to be Allocated										23
24	Unit Cost Multiplier (see instructions)										24

FORM CMS-2552-96 (9/97) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3656.2)

COMPUTATION OF OUTPATIENT REHABILITATION PROVIDER COSTS	PROVIDER NO.:_____ COMPONENT NO.:_____	PERIOD: FROM_____ TO_____	WORKSHEET J-2, PART I

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

PART I -APPORTIONMENT OF OUTPATIENT REHABILITATION PROVIDER COST CENTERS

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

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

APPORTIONMENT OF COST OF OUTPATIENT REHABILITATION PROVIDER SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS	PROVIDER NO.:_____ COMPONENT NO.:_____	PERIOD: FROM_____ TO_____	WORKSHEET J-2, PART II

Check Applicable Box: [ ] CMHC [ ] OPT [ ] OSP [ ] CORF [ ] OOT

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

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

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

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

(3) Transfer the amounts on line 28, columns 5, 7, and 9, as appropriate, to Worksheet J-3, line 1.

CALCULATION OF REIMBURSEMENT SETTLEMENT OUTPATIENT REHABILITATION PROVIDER SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET J-3

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

		PROGRAM COST	
		1	
1	Cost of component services (from Worksheet J-2, Part II, line 28)		1
1.01	Cost of health services for services rendered on or after August 1, 2000 (see instructions)		1.01
1.02	PPS payments received including outliers		1.02
1.03	1996 hospital specific payment to cost ratio (see instructions)		1.03
1.04	Line 1.01 times line 1.03.		1.04
1.05	Line 1.02 divided by line 1.01.		1.05
1.06	Transitional corridor payment (see instructions)		1.06
2	Primary payer payments		2
3	Total reasonable cost (line 1 minus line 2) (see instructions)		3
	COMPUTATION OF LESSER OF COST OR CHARGES		
4	Total charges for program services		4
	CUSTOMARY CHARGES		
5	Aggregate amount actually collected from patients liable for services on a charge basis		5
6	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		6
7	Ratio of line 5 to line 6 (not to exceed 1.000000) (see instructions)		7
8	Total customary charges (see instructions)		8
9	Excess of customary charges over reasonable cost (see instructions) (1)		9
10	Excess of reasonable cost over customary charges (see instructions) (1)		10
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
11	Total reasonable cost (from line 3)		11
12	Part B deductible billed to program patients		12
13	Net cost (line 11 minus line 12)		13
14	Excess of reasonable cost over customary charges (from line 10)		14
15	Subtotal (line 13 minus line 14)		15
16	80 percent of costs (80% of line 15 for title XVIII only)		16
17	Actual coinsurance billed to program patients (from provider records)		17
18	Net cost less actual billed coinsurance (line 15 minus line 17)		18
19	Reimbursable bad debts (from provider records) (see instructions)		19
19.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		19.01
20	Net reimbursable amount (see instructions)		20
21	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		21
22	Recovery of excess depreciation resulting from facility's termination or a decrease in program utilization		22
23	Other adjustments (see instructions) (specify)		23
24	Total cost (line 20 plus lines 22 and 23 minus line 21)		24
25	Sequestration adjustment - title XVIII only (see instructions)		25
26	Adjusted amount payable to provider (line 24 minus line 25)		26
27	Interim payments (see instructions)		27
27.01	Tentative settlement (for fiscal intermediary use only)		27.01
28	Balance due component/program (line 26 minus lines 27and 27.01)		28
29	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)		29

Lines 1.01 through 1.06 are to be completed by CMHC components only.

(1) CORF components do not complete lines 9 and 10 for services rendered prior to 1/1/1998.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED OUTPATIENT REHABILITATION PROVIDERS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.:	PERIOD FROM_____	WORKSHEET J-4
	COMPONENT NO.:	TO_____	

Check Applicable Box:	[ ] CMHC	[ ] OOT
	[ ] CORF	[ ] OSP
	[ ] OPT	

	DESCRIPTION			Part B 1 mm/dd/yyyy	Part B 2 Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.					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 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 Worksheet J-3, line 27)					4
	TO BE COMPLETED BY INTERMEDIARY					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider	.01			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 liability (see instructions)					7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	(Month, Day, Year)

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