RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER NO.:	PERIOD: FROM ______ TO ______	WORKSHEET A

			COST CENTER (Omit Cents)	SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSIFICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase/Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)	
A	B	C	D	1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS											
1	0100	x	Captial-Related Costs - Building & Fixture								1
2	0200	x	Capital-Related Costs - Moveable Equipment								2
3	0300	x	Employee Benefits								3
4	0400	x	Administrative and General								4
5	0500	x	Plant Operation, Maintenance and Repairs								5
6	0600	x	Laundry and Linen Service								6
7	0700	x	Housekeeping								7
8	0800	x	Dietary								8
9	0900	x	Nursing Administration								9
10	1000		Central Services and Supply								10
11	1100		Pharmacy								11
12	1200		Medical Records and Library								12
13	1300		Social Service								13
14	1400		Intern & Residents (Apprvd Tchng Prog.)								14
15			Other General Service Cost								15
INPATIENT ROUTINE SERVICE COST CENTERS											
16	1600	x	Skilled Nursing Facility								16
17											17
18	1800	x	Nursing Facility								18
18.1	1810	x	Intermediate Care Facility - Mentally Retarded								18.1
19	1900	x	Other Long Term Care								19
20			Other Inpatient Routine Cost								20
ANCILLARY SERVICE COST CENTERS											
21	2100	x	Radiology								21
22	2200	x	Laboratory								22
23	2300	x	Intravenous Therapy								23
24	2400	x	Oxygen (Inhalation) Therapy								24
25	2500	x	Physical Therapy								25
26	2600	x	Occupational Therapy								26
27	2700	x	Speech Pathology								27
28	2800	x	Electrocardiology								28
29	2900	x	Medical Supplies Charged to Patients								29
30	3000	x	Drugs Charged to Patients								30
31	3100	x	Dental Care - Title XIX only								31
32	3200	x	Support Surfaces								32
33		x	Other Ancillary Service Cost Center								33

x Indicates the lines to be used under the Simplified Method

FORM HCFA-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 3516)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER NO.:		PERIOD: FROM ______ TO ______		WORKSHEET A			
COST CENTER (Omit Cents)				SALARIES	OTHER	TOTAL (Col 1 + Col 2)	RECLASSIFICATIONS Increase/Decrease (Fr Wkst A-6)	RECLASSIFIED TRIAL BALANCE (Col 3 +/- Col 4)	ADJUSTMENTS TO EXPENSES Increase /Decrease (Fr Wkst A-8)	NET EXPENSES FOR COST ALLOCATION (Col 5 +/- Col 6)	
A	B	C	D	1	2	3	4	5	6	7	
OUTPATIENT SERVICE COST CENTERS											
34	3400		Clinic								34
35	3500		Rural Health Clinic (RHC)								35
36			Other Outpatient Service Cost								36
OTHER REIMBURSABLE COST CENTERS											
37	3700		Administrative and General - HHA								37
38	3800		Skilled Nursing Care - HHA								38
39	3900		Physical Therapy - HHA								39
40	4000		Occupational Therapy - HHA								40
41	4100		Speech Pathology - HHA								41
42	4200		Medical Social Services - HHA								42
43	4300		Home Health Aide - HHA								43
44	4400		Durable Medical Equipment - Rented - HHA								44
45	4500		Durable Medical Equipment - Sold - HHA								45
46	4600		Home Delivered Meals - HHA								46
47	4700		Other Home Health Services - HHA								47
48	4800		Ambulance								48
49	4900		Intern and Resident (Not Apprvd Tchng Prog)								49
50	5000		Outpatient Rehabilitation Provider								50
51			Other Reimbursable Cost								51
SPECIAL PURPOSE COST CENTERS											
52	5200		Malpractice Premiums & Paid Losses								52
53	5300		Interest Expense							- 0 -	53
54	5400	x	Utilization Review -- SNF							- 0 -	54
55	5500		Hospice							- 0 -	55
56		x	Other Special Purpose Cost								56
57	5700		Subtotals								57
NON REIMBURSABLE COST CENTERS											
58	5800		Gift, Flower, Coffee Shops and Canteen								58
59	5900	x	Barber and Beauty Shop								59
60	6000		Physicians' Private Offices								60
61	6100		Nonpaid Workers								61
62	6200		Patients Laundry								62
63		x	Other Non Reimbursable Cost								63
75		x	TOTAL								75

x Indicates the lines to be used under the Simplified Method

FORM HCFA-2540-96 (01/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 3516)

RECLASSIFICATIONS	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE				DECREASE				
			COST CENTER	LN NO.	SALARY	NON SALARY	COST CENTER	LN NO.	SALARY	NON SALARY	
		1	2	3	4	5	6	7	8	9	
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											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL RECLASSIFICATIONS (Sum of column 4 and 5 must equal sum of column 8 and 9, line 36) (2)										36

(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-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3517)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES	PROVIDER NO:	PERIOD: FROM ____ TO ____	WORKSHEET A - 7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donation	Total			
		1	2	3	4	5	6	
1	Land					( )		1
2	Land Improvements					( )		2
3	Buildings and Fixtures					( )		3
4	Building Improvements					( )		4
5	Fixed Equipment					( )		5
6	Movable Equipment					( )		6
7	TOTAL					( )		7

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3518)

ADJUSTMENTS TO EXPENSES	PROVIDER NO. ________________	PERIOD: FROM ____________ TO ______________	WORKSHEET A-8

	(1) DESCRIPTION	(2) BASIS FOR ADJUST- MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A - TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	LINE NO.	
		1	2	3	4	
1	Investment income on restricted funds (ch.2) funds (chapter 2)					1
2	Trade, quantity and time discounts on purchases (chapter 8)					2
3	Refunds and rebates of expenses (Chapter 8)					3
4	Rental of provider space by suppliers (Chapter 8)					4
5	Telephone services (pay stations excluded) (chapter 21)					5
6	Television and radio service (Chapter 21)					6
7	Parking lot (chapter 21)					7
8	Remuneration applicable to provider-based physician adjustment	**Worksheet A-8-2**				8
9	Home office costs (chapter 21)					9
10	Sale of scrap, waste, etc. (chapter 23)					10
11	Nonallowable costs related to certain Capital expenditures (chapter 24)					11
12	Adjustment resulting from transactions with related organizations (chapter 10)	**Worksheet A-8-1**				12
13	Laundry and Linen service					13
14	Revenue - Employee meals					14
15	Cost of meals - Guests					15
16	Sale of medical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Vending machines					19
20	Income from imposition of interest, finance or penalty charges (chapter 21)					20
21	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					21
22	Other Adjustment	**(3)**				22
23	Other Adjustment	**(3)**				23
24	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	**(3)**		**Oxygen (Inhalation) Therapy**	**24**	24
25	Adjustment for physical therapy costs in excess of limitation	**(3)**		**Physical Therapy**	**25**	25
26	Adjustment for HHA physical therapy costs in excess of limitation	**See Instructions**		**Physical Therapy--HHA**	**39**	26
27	SUBTOTAL (Sum of lines 1-26)					27
28	Utilization review--physicians' compensation (chapter 21)			**Utilization Review- SNF**	**54**	28
29	Depreciation--buildings and fixtures			**Capital Related Cost- Building**	**1**	29
30	Depreciation--movable equipment			**Capital Related Cost-Movable Equipment**	**2**	30
31	Other Adjustment					31
32	TOTAL (line 27 plus the sum of lines 28 - 31) (Transfer to Worksheet A, col. 6, line 75)					32

(1) Description--all chapter references in this column pertain to CMS Pub. 15

(2) Basis for adjustmen A. Costs--if costs, including applicable overhead, can be determine
B. Amount Received--if cost cannot be determine

(3) See Instructions to report therapy services provided on and after April 10, 199

FORM CMS-2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3519)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER NO:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount	Amount Allowable In Cost	Adjustments (Col 4 minus Col 5)	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10	TOTALS (Sum of lines 1-9) (Transfer column 6, lines as applicable, to Worksheet A, column 6, lines as appropriate) Transfer column. 6, line 5 to Worksheet A-8, column 2, line 12)						10

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 y furnish the information requested under Part C of this workshee

This information is used by the Health Care Financing Administration and its intermediaries in determining that the cc applicable to services, facilities and supplies furnished by organizations related to you by common ownership or cont represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or a part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claim reimbursement under title XVIII

				Related Organization(s)			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate interrelationship to related organizatior

A. Individual has financial interest (stockholder, partner, etc in both related organization and in provider

B. Corporation, partnership or other organization has financia interest in provider

C. Provider has financial interest in corporation, partnershi or other organization

D. Director, officer, administrator or key person of provider relative of such person has financial interest in relate organization.

E. Individual is director, officer, administrator or key person of provid and related organization

F. Director, officer, administrator or key person of related organizatic or relative of such person has financial interest in provide

G. Other (financial or non-financial) specify ____________________

FORM CMS - 2540-96 (10/98) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTION 3520)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS	PROVIDER NO:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-2

	Wkst A Line No.	Cost Center / Physician Identifier	Total Remuneration	Professional Component	Provider Component	R C E Amount	Physician / Provider omponent Hou	Unadjusted R C E Limit	5 Percent of Unadjusted R C E Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
75		TOTAL								75

	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 Column 14	Adjusted R C E Limit	R C E Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
75		TOTAL								75

FORM CMS-2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3521)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO: ____________	PERIOD: FROM ____________ TO ____________	WORKSHEET A-8-3 PARTS I & II

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 HHA visits - supervisors or therapists (See Instructions)					5
6	Number of unduplicated HHA 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 (HHA only)					12
13	Number of miles driven (HHA only)					13

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

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522 THROUGH 3522.07)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-3 PARTS III & IV

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

PART IV - STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION - HHA 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 times column 2, line 10)		32
33	Assistants (Column 3, line 12 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)		35
	Total Travel Allowance and Travel Expense - HHA 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

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522 THROUGH 3522.7)

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO: ________	PERIOD: FROM ________ TO ________	WORKSHEET A-8-3 PARTS V, VI, & VII

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 - HHA 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)		57

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

58	Cost of outside supplier services - SNF (from your records)		58
59	Cost of outside supplier services - HHA (from your records)		59
60	Total cost (Sum of lines 58-59) (This line must agree with line 56)		60
61	Ratio of SNF cost of outside supplier services to total cost (Line 58 divided by line 60)		61
62	Ratio of HHA cost of outside supplier services to total cost (Line 59 divided by line 60)		62
63	SNF excess of cost over limitation (Line 57 times line 61) (Transfer to Wkst A-8, line 25)		63
64	HHA excess of cost over limitation (Line 57 times line 62) (Transfer to Wkst A-8, line 26)		64

FORM CMS-2540-96 (07/99) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3522.6 - 3522.7)

REASONABLE COST DETERMINATION FOR RESPIRATORY THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO: ________________	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			Aides	Trainees	
		Registered	Certified	Nonregistered Noncertified	Registered	Certified	Nonregistered Noncertified			
		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									9
	(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.)									

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	PROVIDER NO:	PERIOD: FROM ______ TO ______	WORKSHEET A-8-4 PARTS III, IV AND V

PART III - STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION

Line	Description	Amount	Line
23	Regeistered 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

Line	Description	Therapists			Aides	Trainees	Total	Line
		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

Line	Description	Amount	Line
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 Wkst. A-8 line 24)		46

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3523.3 - 3523.5)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-5 PARTS I & II

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] 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 HHA visits - supervisors or therapists (see instructions)		5
6	Number of unduplicated HHA 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
12	Number of travel hours - Provider off site - (see instructions)						12.01
13	Number of miles driven - Provider on site - (see instructions)						13
13	Number of miles driven - Provider off site - (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, 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 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 NO.:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-5 PARTS III & IV

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

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

	Standard Travel Allowance		
24	Supervisor and 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	Supervisor and Therapists (sum of columns 1 and 2, line 12, times column 2 line 10)		29
30	Assistants (column 3, line 12 times column 3 line 10)		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 31)		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 - PROVIDER OFF 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 times column 2, line 10)		40
41	Assistants (column 3, line 12 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)		43
	Total Travel Allowance and Travel Expense - 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 NO.:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-5 PARTS V & VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [ ] 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) (Enter in column 5, the sum of columns 1, 3 and 4 for respiratory therapy; and columns 1 through 3 for all others.)						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 - HHA services (from Part IV, lines 44, 45, or 46)		59
60	Overtime allowance (from Part V, column 4, 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)		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.:	PERIOD: FROM ____ TO ____	WORKSHEET A-8-5 PARTS VII

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

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	Cost of outside supplier services - SNF (from your records)		66
67	Cost of outside supplier services - CORF (from your records)		67
68	Cost of outside supplier services - CMHC (from your records)		68
69	Cost of outside supplier services - OPT (from your records)		69
70	Cost of outside supplier services - HHA (from your records)		70
71	Total cost (Sum of lines 66 - 70)		71
72	Ratio of SNF cost of outside supplier services to total cost (line 66 divided by line 71)		72
73	Ratio of CORF cost of outside supplier services to total cost (line 67 divided by line 71)		73
74	Ratio of CMHC cost of outside supplier services to total cost (line 68 divided by line 71)		74
75	Ratio of OPT cost of outside supplier services to total cost (line 69 divided by line 71)		75
76	Ratio of HHA cost of outside supplier services to total cost (Line 70 divided by line 71)		76
77	SNF excess of cost over limitation (line 65 times line 72) (Transfer to Worksheet A-8, - see instructions)		77
78	CORF excess of cost over limitation (line 65 times line 73) (Transfer to Worksheet A-8, see instructions)		78
79	CMHC excess of cost over limitation (line 65 times line 74) (Transfer to Worksheet A-8, see instructions)		79
80	OPT excess of cost over limitation (line 65 times line 75) (Transfer to Worksheet A-8, see instructions)		80
81	HHA excess of cost over limitation (line 65 times line 76) (Transfer to Worksheet A-8, see instructions)		81
82	Total excess of cost over limitation (sum of lines 77 through 81 and subscripts) (This line must agree with line 65)		82