PROVIDER NAME: _____

PROVIDER NUMBER: _____

FISCAL YEAR ENDED:_____

PLEASE INDICATE APPLICABLE TYPE OF PROVIDER:

☐ REHABILITATION AGENCY

☐ COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)

☐ COMMUNITY MENTAL HEALTH CENTER (CMHC)

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OR PROVIDER

I hereby certify that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost, the Balance Sheet and Statement of Revenue and Expenses for the cost report period beginning _____ and ending _____, and that to the best of my knowledge and belief, it is true, correct and complete statement, prepared from the books and records of

_____

Name of Facility Address

in accordance with applicable instructions, except as may be noted. The above referenced information was prepared by:

_____

Name Address

Signed:_____

Officer or Administrator of Provider

_____

Date

PROVIDER NAME: PROV NO: _____

_____ FYE: _____

ANALYSIS OF INTERIM PAYMENTS FOR TITLE XIX SERVICES

		TOTAL PROGRAM VISITS	TOTAL PROGRAM CHARGES
1	SKILLED NURSING CARE		
2	PHYSICAL THERAPY		
3	SPEECH THERAPY		
4	OCCUPATIONAL THERAPY		
5	RESPIRATORY THERAPY		
6	MEDICAL SOCIAL SERVICES		
7	PSYCHOLOGICAL SERVICES		
8	PROSTHETIC & ORTHOTIC DEVICES		
9	DRUGS & BIOLOGICALS		
10	SUPPLIES CHARGED TO PATIENT		
11	DME - SOLD		
12	DME - RENTED		
13			
14			
15			
	ENTER ON CURRENT FISCAL REPORT		
16	TOTAL PROGRAM VISITS (Sum of Lines 1 thru 15)		
17	TOTAL PROGRAM CHARGES (Sum of Lines 1 thru 15)		
18	AMOUNT RECEIVED FROM PRIMARY CARRIER AND PATIENT PAYMENT		
19	AMOUNT RECEIVED FROM INTERMEDIARY		
20	CASH ADVANCES RELATIVE TO THE COST REPORTING PERIOD		
21	TOTAL INTERIM PAYMENTS RECEIVED (Lines 18, 19, & 20)		

PROVIDER NAME: PROV NO:

FYE:

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES - TITLE XIX

[ ] CORF [ ] OPT [ ] CMHC

PART I -- COMPUTATION OF REIMBURSEMENT SETTLEMENT

	DESCRIPTION	
1	Reasonable Cost of Provider Services (From Exhibit C, Col 3,Totals, line a)	
2	Excess of Reasonable Cost Over Customary Charges (From Part II, Line 4)	
3	Subtotal (Line 1 minus Line 2)	
4	Recovery of Unreimbursed Cost Under the Lesser of Cost or Charges (From Part II, Line 6) **	
5	TOTAL COST (Lines 3 + 4)	
6	Interim Payments (From Intermediary & Primary Carrier - Exhibit A)	
7	Balance Due Provider/(Program) - (Line 5 less Line 6) (Indicate overpayment with bracket)	

PART II -- COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

1	Cost of Services (From Part I, Line 1)	
2	Total Charges for Medicaid Services (Exhibit A)	
3	Excess of Customary Charges Over Reasonable Cost (Complete only if Line 2 exceeds Line 1)	
4	Excess of Reasonable Cost over Customary Charges (Complete only if Line 1 exceeds Line 2)	
5	Carryover of Unreimbursed Cost from Prior Year Ended ___	
6	Recovery of Unreimbursed Cost from Prior Year (Lesser of Line 3 or Line 5)	

**** NEW PROVIDERS ONLY - Computation of Recovery and Carryover of Unreimbursed Costs are Subject to the Definitions Set Forth in 42 CFR 413.13**

PROVIDER NAME: _____ PROV NO: _____

FYE: _____

Apportionment of Patient Service Costs

		Totals	Ratio of Cost to Statistical Basis (Col 1, Line a divided by Col 2, Line b)	Title XIX (See Exh A)
		1	2	3
Reimbursable Service Cost Centers **CORF**				
15 Skilled Nursing Care	a			
	b			
16 Physical Therapy	a			
	b			
17 Speech Pathology	a			
	b			
18 Occupational Therapy	a			
	b			
19 Respiratory Therapy	a			
	b			
20 Medical Social Services	a			
	b			
21 Psychological Services	a			
	b			
22 Prosthetic & Orthotic Devices	a			
	b			
23 Drugs & Biologicals	a			
	b			
24 Supplies Charged to Patients	a			
	b			
25 DME - Sold	a			
	b			
26 DME - Rented	a			
	b			
27 OTHER VISITS (Specify Type)	a			
	b			
28 TOTAL (Lines 15 through 27)	a			
	b			

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a = Cost Data from HCFA 2088-92, Worksheet B, Col 17

b = Charges from Your Records

Note: (Col 2) Charges Line B Times Ratio (Col 2) = Cost Line a (Col 3)

PROVIDER NAME: _____ PROV NO: _____

FYE: _____

Apportionment of Patient Service Costs

		Totals	Ratio of Cost to Statistical Basis (Col 1, Line a divided by Col 2, Line b)	Title XIX (See Exh A)
		1	2	3
Reimbursable Service Cost Centers **CMHC**				
29 Skilled Nursing Care	a			
	b			
30 Physical Therapy	a			
	b			
31 Speech Pathology	a			
	b			
32 Occupational Therapy	a			
	b			
33 Respiratory Therapy	a			
	b			
34 Medical Social Services	a			
	b			
35 Psychological Services	a			
	b			
36 Prosthetic & Orthotic Devices	a			
	b			
37 Drugs & Biologicals	a			
	b			
38 OTHER VISITS (Specify Type)	a			
	b			
39 TOTAL (Lines 29 through 38)	a			
	b			
OTHER PROVIDERS OUTPATIENT REHAB AGENCY				
40 Physical Therapy	a			
	b			
41 Speech Pathology	a			
	b			
42 Occupational Therapy	a			
	b			
43 OTHER VISITS (Specify Type)	a			
	b			
44 OTHER VISITS (Specify Type)	a			
	b			
45 **TOTAL FOR OUTPATIENT REHAB** (Lines 40 thru 44)	a			
	b			

CMHC - Transfer Col 3, Ln 39a to WKS B, ln 1

OTHERS - Col 3, Ln 28a OR Ln 45a to WKS B, Ln 1