

3656. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

Use this worksheet only if you operate as part of your complex a certified hospital-based community mental health center (CMHC), comprehensive outpatient rehabilitation facility (CORF), outpatient rehabilitation facility (ORF) which generally furnishes outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). Only those cost centers that represent services for which the facility is certified are used. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. If all services are paid under established fee schedules do not complete these worksheets for cost reporting periods beginning on or after April 1, 2001 for CORFs and cost reporting periods beginning on or after July 1, 2003 for ORFs.

3656.1 Part I - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers.--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, lines as appropriate:

<u>Component</u>	<u>From Worksheet A, Column 7</u>
CMHC	line 69 and subscripts
OPT/OOT/OSP	line 69 and subscripts
CORF	line 69 and subscripts

Obtain the cost center allocation (column 0, lines 1 through 21) from your records. The amounts on line 22, columns 0 through 24 and column 26 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 24 and column 26, lines as appropriate:

<u>Component</u>	<u>Worksheet B, Part I, Columns 0 through 24 and 26</u>
CMHC	line 69 and subscripts
OPT/OOT/OSP	line 69 and subscripts
CORF	line 69 and subscripts

Complete the amounts entered on lines 1 through 21, columns 1 through 24 and column 26 in accordance with the instructions contained in §3656.2.

**NOTE:** Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 26, excluded the costs of interns and residents, column 26 on this worksheet must also exclude these costs.

Line 23--To calculate the unit cost multiplier for component administrative and general costs divide line 1 by the result of line 22 minus line 1 and round to six decimal places.

3656.2 Part II - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers - Statistical Basis.--Worksheet J-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §3617 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, is identical. The statistical basis shown at the top of each column on Worksheet J-1, Part II, is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See HCFA Pub. 15-I, §2313.)

Except for non-PPS providers, unless there is a change in ownership, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302(d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 21--On Worksheet J-1, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, lines as appropriate:

<u>Component</u>	<u>Worksheet B-1, Corresponding Column</u>
CMHC	line 69
OPT/OOT/OSP	line 69
CORF	line 69

Line 23--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, lines as appropriate (see §3656.1), from the same column used to enter the statistical base on Worksheet J-1, Part II (e.g., for a CORF provider, in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 72).

Line 24--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

In column 25, Part I, enter the total of columns 5A through 24.

In column 28, Part I, for lines 2 through 21, multiply the amount in column 27 by the unit cost multiplier on line 23, Part I, and enter the result. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount in column 27, line 1.

In column 29, Part I, enter on lines 2 through 21 the sum of columns 27 and 28. The total on line 22 equals the total in column 28, line 22.

**3657. WORKSHEET J-2 - COMPUTATION OF OUTPATIENT REHABILITATION PROVIDER COSTS**

Use this worksheet only if you operate a hospital-based outpatient rehabilitation provider. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

**3657.1 Part I - Apportionment of Outpatient Rehabilitation Provider Cost Centers.--**

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 29. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for the component's title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs. For title XVIII, subscript column 6 to report services rendered prior to January 1, 1998, and services rendered on or after January 1, 1998, to allow for capital and operating reduction required by the BBA. For 1998 calendar year end cost reporting periods and after, no subscripting is required; simply report the charges for the whole year in column 6. No subscripting is required for CMHCs. For services rendered on and after January 1, 1999, therapy services, excluding respiratory therapy, are paid under a fee schedule. For services rendered on or after July 1, 2000 respiratory therapy is paid under a fee schedule. Only report charges prior to these dates for these services. However, for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, you must subscript columns 6 and 7 to report CMHC charges before and after the transition date, in columns 6 and 6.01 to accommodate the implementation of prospective payment. For cost reporting periods beginning on or after January 1, 2004, no subscripting is required.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3. Subscript column 7 to agree with column 6. Enter 90 percent of the result in the subscript of column 7 for services through December 31, 1998. For proper subscripting and reporting of costs in column 7, see the discussion for columns 4, 6, and 8 above.

Line 20--Enter the totals of lines 1 through 19 in columns 1, 2, and 4 through 9.

**3657.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Provider Services Furnished by Shared Hospital Departments.--**Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's outpatient rehabilitation provider.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9 from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX CORF patients, respectively. For proper reporting of charges required to be subscripted see the discussion for columns 4, 6, and 8 in Part I above.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3. Subscript column 7 to agree with column 6. Enter 90 percent of the result in the subscript of column 7 for services rendered from January 1, 1998 through December 31, 1998. CMHCs are not subject to the 10 percent reduction. For proper subscripting and reporting of costs in column 7 and subscripts, see the discussion for columns 4, 6, Rev. 12

and 8 in Part I above. Report charges prior to the effective dates identified in Part I above for the various therapy services.

Line 27--Enter the totals for columns 4 through 9.

Line 28--Enter the total costs from Part I, columns 5, 7 and subscripts, and 9, line 20 plus columns 5, 7 and subscripts, and 9, line 27, respectively and transfer to Worksheet J-3, line 1, or 1.01.

3658. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT -  
OUTPATIENT REHABILITATION PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. For all outpatient rehabilitation providers, subscript column 1 to provide for the reporting of cost and charges before and on or after January 1, 1998, to agree with the subscripting occurring on Worksheet J-2, Parts I and II, columns 4 through 9. No subscripting is required for cost reporting periods beginning on or after January 1, 1998. For CMHCs, for title XVIII, subscript the column for lines 1.01 through 1.06 to report the services before and on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. No subscripting of the column is required for cost reporting periods beginning on or after January 1, 2003.

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 28 from columns 5, 7 and subscripts (1/1/98), or 9, as applicable (column 5 for title V, column 7 for title XVIII, and column 9 for title XIX). Line 1 is not completed by CMHCs for cost reporting periods beginning on or after August 1, 2000.

Lines 1.01 through 1.06 are to be completed by CMHCs for title XVIII, for services on or after August 1, 2000.

Line 1.01--Enter the cost of the health services for services rendered on or after August 1, 2000, from worksheet J-2, Part II, column 7.01, line 28 (column 7 for cost reporting periods beginning after August 1, 2000).

Line 1.02--Enter the sum of gross PPS payments received, including outliers.

Line 1.03—Do not complete this line.

Line 1.04—Do not complete this line.

Line 1.05--Line 1.02 divided by line 1.01.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following:

For services rendered from August 1, 2000 through December 31, 2001:

- a. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 80 percent of (line 1.01 minus line 1.02).
- b. If line 1.05 is  $\geq 80$  percent but  $< 90$  percent, enter the result of 71 percent of (line 1.01) minus 70 percent of (line 1.02).
- c. If line 1.05 is  $\geq 70$  percent but  $< 80$  percent, enter the result of 63 percent of (line 1.01) minus 60 percent of (line 1.02).
- d. If line 1.05 is  $< 70$  percent, enter 21 percent of line 1.01.

For services rendered from January 1, 2002 through December 31, 2002:

- a. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 70 percent of the result of line 1.01 minus line 1.02.
- b. If line 1.05 is  $\geq 80$  percent but  $< 90$  percent, enter the result of 61 percent of (line 1.01) minus 60 percent of (line 1.02).
- c. If line 1.05 is  $< 80$  percent, enter 13 percent of 1.01.

For services rendered from January 1, 2003 through December 31, 2003:

- a. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 60 percent of the result of line 1.01 minus line 1.02.
- b. If line 1.05 is  $< 90$  percent, enter 6 percent of 1.01.

If the cost reporting periods overlap any of these effective dates you must subscript the column and make a separate transitional corridor payment for the appropriate periods.

Line 2—Enter the amounts paid and payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 3--Enter the amount obtained by subtracting line 2 from line 1 in column 1. For CMHCs subtract line 2 from the sum of lines 1, 1.02 and 1.06 in column 1.01 for cost reports that overlap August 1, 2000. For cost reporting periods beginning on or after August 1, 2000 enter the sum of lines 1.02 and 1.06.

Line 4--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, Columns 4, 6, 6.01, and 8 as appropriate, lines 20 and 27.

Lines 5 through 8--These lines provide for the reduction of program charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 7 is greater than zero, enter on line 8 the product of multiplying the ratio on line 7 by line 4.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 5, 6, and 7, but enter on line 8 the amount from line 4. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Lines 9 and 10--Lines 9 and 10 provide for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e).

Enter on line 9 the excess of total customary charges (line 8) over the total reasonable cost (line 3). In situations when in any column the total charges on line 8 are less than the total cost on line 3, enter zero (0) on line 9.

Enter on line 10 the excess of total reasonable cost (line 3) over total customary charges (line 8). In situations when in any column the total cost on line 3 is less than the customary charges on line 8,

enter zero (0) on line 10.

**NOTE:** Payment to CORFs is based on the reasonable cost of services prior to January 1, 1998. (See 42 CFR 413.13(c).) CORF providers do not complete lines 9 and 10 for services rendered prior January 1, 1998.

Line 12--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 14--If there is an excess of reasonable cost over customary charges, enter the excess on this line. CORF providers are to complete this line for services rendered on or after January 1, 1998.

Line 16--Enter in column 1, 80 percent of line 15 for title XVIII. Make no entry for titles V and XIX. Make no entry in column 1.01 for CMHC.

Line 17--Enter the actual coinsurance billed to program patients (from your records).

Line 19--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 19 will be negative.

Line 19.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 19. (4/1/2004b)

Line 20--For title XVIII, in column 1, enter the lesser of line 16 plus line 19 or line 18 plus line 19. In column 1.01 enter the result of line 18 plus line 19. For titles V and XIX, enter the sum of lines 18 and 19.

Line 21--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-§§132ff.) Enter the amount of any excess depreciation taken as a negative number.

Line 22--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§128ff.)

Line 23--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-I §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 24--Enter the result of line 20 plus or minus lines 22 and 23, minus line 21. Add columns 1 and 1.01 if applicable.

Line 25--Enter the sequestration adjustment, if applicable.

Line 26--Enter the result of line 24 minus line 25.

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4. For intermediary final settlement, report on line 27.01 the amount from line 5.99.

Line 28--Enter the balance due provider/program, and transfer this amount to Worksheet S, Part II, columns as appropriate, lines as appropriate.

Line 29--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

3659. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED  
OUTPATIENT REHABILITATION PROVIDER FOR SERVICES RENDERED TO  
PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

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 program interim payments paid to the outpatient rehabilitation provider. 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 includes amounts withheld from the component's interim payments due to an offset against overpayments to the component 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.

Line 2--Enter the total program 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. It 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--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.**

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 from the provider to the 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, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.