

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER NO.:		PERIOD: FROM _____ TO _____		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
			1	2	3	4	5	6	7
<b>GENERAL SERVICE COST CENTERS</b>									
1	0100	Old Capital Related Costs-Buildings and Fixtures							1
2	0200	Old Capital Related Costs-Movable Equipment							2
3	0300	New Capital Related Costs-Buildings and Fixtures							3
4	0400	New Capital Related Costs-Movable Equipment							4
5	0500	Employee Benefits							5
6	0600	Administrative and General							6
7	0700	Maintenance and Repairs							7
8	0800	Operation of Plant							8
9	0900	Laundry and Linen Service							9
10	1000	Housekeeping							10
11	1100	Dietary							11
12	1200	Cafeteria							12
13	1300	Maintenance of Personnel							13
14	1400	Nursing Administration							14
15	1500	Central Services and Supply							15
16	1600	Pharmacy							16
17	1700	Medical Records & Medical Records Library							17
18	1800	Social Service							18
19		Other General Service (specify)							19
20	2000	Nonphysician Anesthetists							20
21	2100	Nursing School							21
22	2200	Intern & Res. Service-Salary & Fringes (Approved)							22
23	2300	Intern & Res. Other Program Costs (Approved)							23
24	2400	Paramedical Ed. Program (specify)							24
<b>INPATIENT ROUTINE SERVICE COST CENTER</b>									
25	2500	Adults and Pediatrics (General Routine Care)							25
26	2600	Intensive Care Unit							26
27	2700	Coronary Care Unit							27
28	2800	Burn Intensive Care Unit							28
29	2900	Surgical Intensive Care Unit							29
30		Other Special Care (specify)							30
31	3100	Subprovider (specify)							31
33	3300	Nursery							33
34	3400	Skilled Nursing Facility							34
35	3500	Nursing Facility							35
36	3600	Other Long Term Care							36

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3610)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET A			
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
			1	2	3	4	5	6	7
		ANCILLARY SERVICE COST CENTERS							
37	3700	Operating Room							37
38	3800	Recovery Room							38
39	3900	Delivery Room and Labor Room							39
40	4000	Anesthesiology							40
41	4100	Radiology-Diagnostic							41
42	4200	Radiology-Therapeutic							42
43	4300	Radioisotope							43
44	4400	Laboratory							44
45	4500	PBP Clinical Laboratory Services-Program Only							45
46	4600	Whole Blood & Packed Red Blood Cells							46
47	4700	Blood Storing, Processing, & Trans.							47
48	4800	Intravenous Therapy							48
49	4900	Respiratory Therapy							49
50	5000	Physical Therapy							50
51	5100	Occupational Therapy							51
52	5200	Speech Pathology							52
53	5300	Electrocardiology							53
54	5400	Electroencephalography							54
55	5500	Medical Supplies Charged to Patients							55
55.30	5530	<i>Implantable Devices Charged to Patients</i>							<i>55.30</i>
56	5600	Drugs Charged to Patients							56
57	5700	Renal Dialysis							57
58	5800	ASC (Non-Distinct Part)							58
59		Other Ancillary (specify)							59
		OUTPATIENT SERVICE COST CENTERS							
60	6000	Clinic							60
61	6100	Emergency							61
62	6200	Observation Beds							62
63		Other Outpatient Service (specify)							63
		OTHER REIMBURSABLE COST CENTERS							
64	6400	Home Program Dialysis							64
65	6500	Ambulance Services							65
66	6600	Durable Medical Equipment-Rented							66
67	6700	Durable Medical Equipment-Sold							67
68		Other Reimbursable (specify)							68
69		Outpatient Rehabilitation Provider (specify)							69

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36-513

3690 (Cont.)

				FROM _____		TO _____				
		COST CENTER DESCRIPTIONS (omit cents)		SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
				1	2	3	4	5	6	7
70	7000	Intern-Resident Service (not appvd. tchnng. prgm.)								70
71	7100	Home Health Agency								71
		SPECIAL PURPOSE COST CENTERS								
82	8200	Lung Acquisition								82
83	8300	Kidney Acquisition								83
84	8400	Liver Acquisition								84
85	8500	Heart Acquisition								85
86		Other Organ Acquisition (specify)								86
88	8800	Interest Expense								- 0 -
89	8900	Utilization Review-SNF								- 0 -
90	9000	Other Capital-Related Costs (see instructions)								- 0 -
92	9200	Ambulatory Surgical Center (Distinct Part)								92
93	9300	Hospice								93
94		Other Special Purpose (specify)								94
95		SUBTOTALS (sum of lines 1-94)								95
		NONREIMBURSABLE COST CENTERS								
96	9600	Gift, Flower, Coffee Shop, & Canteen								96
97	9700	Research								97
98	9800	Physicians' Private Offices								98
99	9900	Nonpaid Workers								99
100		Other Nonreimbursable (specify)								100
101		TOTAL (sum of lines 95-100)					- 0 -			101

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3610)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS	PROVIDER NO: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-7, PARTS I & II
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**PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES**

Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Purchases	Donation	Total				
		1	2	3				
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 Subtotal (sum of lines 1-6)								7
8 Reconciling Items								8
9 Total (line 7 minus line 8)								9

**PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES**

Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Purchases	Donation	Total				
		1	2	3				
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 Subtotal (sum of lines 1-6)								7
8 Reconciling Items								8
9 Total (line 7 minus line 8)								9

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3612-3612.1)

RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-7, PARTS III & IV
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**PART III - RECONCILIATION OF CAPITAL COSTS CENTERS**

Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instru.)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5-7)	
*	1	2	3	4	5	6	7	8	
1 Old Capital Related Costs-Buildings and Fixtures									1
2 Old Capital Related Costs-Movable Equipment									2
3 New Capital Related Costs-Buildings and Fixtures									3
4 New Capital Related Costs-Movable Equipment									4
5 Total (sum of lines 1-4)				1.000000					5

Description	SUMMARY OF OLD AND NEW CAPITAL								
	Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)		
*	9	10	11	12	13	14	15		
1 Old Capital Related Costs-Buildings and Fixtures									1
2 Old Capital Related Costs-Movable Equipment									2
3 New Capital Related Costs-Buildings and Fixtures									3
4 New Capital Related Costs-Movable Equipment									4
5 Total (sum of lines 1-4)									5

(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

**PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4**

Description	SUMMARY OF OLD AND NEW CAPITAL								
	Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)		
*	9	10	11	12	13	14	15		
1 Old Capital Related Costs-Buildings and Fixtures									1
2 Old Capital Related Costs-Movable Equipment									2
3 New Capital Related Costs-Buildings and Fixtures									3
4 New Capital Related Costs-Movable Equipment									4
5 Total (sum of lines 1-4)									5

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 thru 4. Enter in each column the appropriate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 thru 4.

\* All line numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers.

ADJUSTMENTS TO EXPENSES		PROVIDER NO.	PERIOD: FROM _____ TO _____	WORKSHEET A-8		
DESCRIPTION (1)	(2)		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7	Ref.
	BASIS/CODE	AMOUNT	COST CENTER	LINE #	5	
	1	2	3	4		
1	Investment income - old buildings and fixtures (chapter 2)		Old Buildings and Fixtures	1		1
2	Investment income - old movable equipment (chapter 2)		Old Movable Equipment	2		2
3	Investment income - new buildings and fixtures (chapter 2)		New Buildings and Fixtures	3		3
4	Investment income - new movable equipment (chapter 2)		New Movable Equipment	4		4
5	Investment income - other (chapter 2)					5
6	Trade, quantity, and time discounts (chapter 8)					6
7	Refunds and rebates of expenses (chapter 8)					7
8	Rental of provider space by suppliers (chapter 8)					8
9	Telephone services (pay stations excluded) (chapter 21)					9
10	Television and radio service (chapter 21)					10
11	Parking lot (chapter 21)					11
12	Provider-based physician adjustment	Wkst A-8-2				12
13	Sale of scrap, waste, etc. (chapter 23)					13
14	Related organization transactions (chapter 10)	Wkst A-8-1				14
15	Laundry and linen service					15
16	Cafeteria-employees and guests					16
17	Rental of quarters to employee and others					17
18	Sale of medical and surgical supplies to other than patients					18
19	Sale of drugs to other than patients					19
20	Sale of medical records and abstracts					20
21	Nursing school (tuition, fees, books, etc.)					21
22	Vending machines					22
23	Income from imposition of interest, finance or penalty charges (chapter 21)					23
24	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					24
25	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3/ Wkst A-8-4	Respiratory Therapy	49		25
26	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3/ Wkst A-8-4	Physical Therapy	50		26
27	Adjustment for HHA physical therapy costs in excess of limitation	Wkst A-8-3	HHA	71		27
28	Utilization review - physicians' compensation (chapter 21)		Utilization Review - SNF	89		28
29	Depreciation - old buildings and fixtures		Old Buildings and Fixtures	1		29
30	Depreciation - old movable equipment		Old Movable Equipment	2		30
31	Depreciation - new buildings and fixtures		New Buildings and Fixtures	3		31
32	Depreciation - new movable equipment		New Movable Equipment	4		32
33	Non-physician Anesthetist		Nonphysician Anesthetist	20		33
34	Physicians' assistant					34
35	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-4	Occupational Therapy	51		35
36	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-4	Speech Pathology	52		36
37	Other adjustments (specify) (3)					37
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)					50

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER NO: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-1
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**A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:**

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 14.					5

\* The amounts on lines 1-4 and subscripts as appropriate are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

**B. Interrelationship to related organization(s) and/or home office:**

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
			Name	Percentage of Ownership	Type of Business	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify \_\_\_\_\_

PROVIDER-BASED PHYSICIANS ADJUSTMENTS				PROVIDER NO.:		PERIOD: FROM _____ TO _____		WORKSHEET A-8-2	
	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE 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
101	TOTAL								101
	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE 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
101	TOTAL								101

FORM CMS-2552-96 (9/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3615)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS I & II
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Check applicable box:  Occupational  Physical  Respiratory  Speech Pathology

**PART I - GENERAL INFORMATION**

1	Total number of weeks worked (excluding aides) (see instructions)					1
2	Line 1 multiplied by 15 hours per week					2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					5
6	Number of unduplicated offsite 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 (see instructions)					12
13	Number of miles driven (see instructions)					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, line 9 times column 3, line 10)					16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					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 (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					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 line 2, 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 (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)					22
23	Total salary equivalency (see instructions)					23

FORM CMS-2552-96 (5/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8-3616.10)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS III & IV
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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	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		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	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12 )		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		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 - SERVICES OUTSIDE PROVIDER 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 .01 times column 2, line 10)		40
41	Assistants (column 3, line 12.01 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 13.01)		43
Total Travel Allowance and Travel Expense - Offsite Services; 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

FORM CMS-2552-96 (12/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8, 3616.11-3616.12)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-4, PARTS V-VII
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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
<b>CALCULATION OF LIMIT</b>							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 4, line 47)						50
51	Allocation of provider's standard workyear for one full-time employee times the percentages on line 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
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 line 2)						57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)						58
59	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						59
60	Overtime allowance (from column 5, 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)						65

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

66	Cost of outside supplier services - (see instructions) (from your records)						66
67	Total cost (sum of line 66 and subscripts) (this line must agree with line 64)						67
68	Ratio of cost of outside supplier services to total cost (line 66 and subscripts divided by line 67)						68
69	Excess of cost over limitation (see instructions) (transfer to Wkst. A-8, lines as indicated in instructions)						69
70	Total excess of cost over limitation (sum of line 69 and subscripts of line 69) (this line must agree with line 65)						70

FORM CMS-2552-96 (5/1999) (INSTRUCTIONS FOR THIS FORM ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3616.8 and 3616.13-3616.15)