This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed as overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0022

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S

Intermediary Use Only:

[ ] Audited	Date Received	_____	[ ]	Initial	[ ] Re-opened
[ ] Desk Reviewed	Intermediary No.	_____	[ ]	Final	

PART I - CERTIFICATION

Check	[ ]	Electronically filed cost report	Date: _____
applicable box	[ ]	Manually submitted cost report	Time: _____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____(Provider name(s) and number(s)) for the cost report beginning _____and ending _____, and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Director

_____
Title

_____
Date

PART II - SETTLEMENT SUMMARY

		TITLE XVIII		
		PART A	PART B	
		1	2	
1	HOME HEALTH AGENCY			1
2	HOME HEALTH-BASED CORF			2
3	HOME HEALTH-BASED CMHC			3
3.5	HOME HEALTH-BASED RHC/FQHC (specify)			3.5
4	TOTAL			4

"According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0022. The time required to complete this information collection is estimated to average 176 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850."

HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-2

Home Health Agency Complex Address:

1	Street:		P.O. Box:	1
1.01	City:	State:	Zip Code:	1.01

Home Health Agency Component Identification

	Component	Component Name	Provider No.	Date Certified	
	0	1	2	3	
2	Home Health Agency				2
3	HHA-based CORF				3
3.50	HHA-based Hopsice				3.50
4	HHA-based CMHC				4
5	HHA- based RHC				5
6	HHA-based FQHC				6

7	Cost Reporting Period (mm/dd/yyyy)	From: _____	To: _____	7

8	Type of control (see instructions)		8
9	If this a low or no Medicare utilization cost report, enter "L" for Low or "N" for No Medicare Utilization.		9

Depreciation: Enter the amount of depreciation reported in this HHA for the methods indicated.

10	Straight Line		10
11	Declining Balance		11
12	Sum of the Years' Digits		12
13	Sum of lines 10, 11 and 12		13

14	Were there any disposals of capital assets during this cost reporting period?		14
15	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period?		15
16	Was accelerated depreciation claimed on assets acquired on or after August l, l970 (See PRM 15-1, Chapter l)?		16
17	If depreciation is funded, enter the balance at end of period.		17
18	Did the provider cease to participate in the Medicare program at the end of the period to which this cost report applies (See PRM 15-1, Chapter 1)?		18
19	Was there substantial decrease in health insurance proportion of allowable costs from prior cost reporting periods (See PRM 15-1, Chapter 1)?		19
20	Does the provider qualify as a small HHA (defined in 42 CFR 413.24(d))?		20
21	Does the home health agency qualify as a nominal charge provider (defined in 42 CFR 409.3)?		21
22	Does the home health agency contract with outside suppliers for physical therapy services?		22
22.01	Does the home health agency contract with outside suppliers for occupational therapy services?		22.01
22.02	Does the home health agency contract with outside suppliers for speech therapy services?		22.02

If this facility contains a non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption.

		Part A	Part B	
		1	2	
23	Home Health Agency			23
24	CORF			24
25	CMHC			25
26	If the home health agency componentized (or fragmented) its administrative and general service costs, indicate whether option one or option two is being utilized. (See PRM-II, Section 3214) (Enter "1" for option one and "2" for option two)			26

27	List amounts of malpractice premiums and paid losses:		27
27.01	Premiums		27.01
27.02	Paid Losses		27.02
27.03	Self Insurance		27.03
28	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? If yes, submit a supporting schedule listing cost centers and amounts contained therein.		28

FORM CMS 1728-94-S-2 (6-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3204)

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-3 PARTS I - III

PART I - STATISTICAL DATA COUNTY _____

	DESCRIPTION	Title XVIII		Other		Total		
		Visits	Patients	Visits	Patients	Visits	Patients	
		1	2	3	4	5	6	
1	Skilled Nursing							1
2	Physical Therapy							2
3	Occupational Therapy							3
4	Speech Pathology							4
5	Medical Social Service							5
6	Home Health Aide							6
7	All Other Services							7
8	Total Visits							8
9	Home Health Aide Hours							9
10	Unduplicated Census Count - Full Cost Reporting Period							10
10.01	Unduplicated Census Count - Pre 10/1/2000							10.01
10.02	Unduplicated Census Count - Post 9/30/2000							10.02

PART II - EMPLOYMENT DATA
(FULL TIME EQUIVALENT)

	Number of hours in your normal work week _____	Staff	Contract	Total	
		1	2	3	
11	Administrator and Assistant Administrator(s)				11
12	Director and Assistant Director(s)				12
13	Other Administrative Personnel				13
14	Direct Nursing Service				14
15	Nursing Supervisor				15
16	Physical Therapy Service				16
17	Physical Therapy Supervisor				17
18	Occupational Therapy Service				18
19	Occupational Therapy Supervisor				19
20	Speech Pathology Service				20
21	Speech Pathology Supervisor				21
22	Medical Social Service				22
23	Medical Social Supervisor				23
24	Home Health Aide				24
25	Home Health Aide Supervisor				25
26					26
27					27

PART III - METROPOLITAN STATISTICAL AREA (MSA) CODE DATA

28	Enter the total number of MSAs in which Medicare covered services were provided during the cost reporting period.		28
29	List all MSA codes in which Medicare covered home health services were provided during the cost reporting period (line 29 contains the first code):	MSA Codes	29
			29.01
			29.02
			29.03
			29.04
			29.05
			29.06
			29.07
			29.08
			29.09

FORM CMS-1728-94 (6-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3205)

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-3 PART IV

PART IV - PPS ACTIVITY DATA - Applicable for Services Rendered on or After October 1, 2000

	DESCRIPTION	Full Episodes without Outliers	Full Episodes with Outliers	LUPA Episodes	PEP Only Episodes	SCIC within a PEP	SCIC Only Episodes	Totals	
		1	2	3	4	5	6	7	
30	Skilled Nursing Visits								30
31	Skilled Nursing Visit Charges								31
32	Physical Therapy Visits								32
33	Physical Therapy Visit Charges								33
34	Occupational Therapy Visits								34
35	Occupational Therapy Visit Charges								35
36	Speech Pathology Visits								36
37	Speech Pathology Visit Charges								37
38	Medical Social Service Visits								38
39	Medical Social Service Visit Charges								39
40	Home Health Aide Visits								40
41	Home Health Aide Visit Charges								41
42	Total Visits (Sum of lines 30,32,34,36,38,40)								42
43	Other Charges								43
44	Total Charges (Sum of lines 31,33,35,37,39,41,43)								44
45	Total Number of Episodes								45
46	Total Number of Outlier Episodes								46
47	Total Non-Routine Medical Supply Charges								47

HHA-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-4

Check Applicable Box [ ] RHC [ ] FQHC

Clinic Address and Identification:

1	Street:	1
1.01	City: State: Zip Code: County:	1.01
2	Designation (for FQHCs only) - Enter "R" for rural or "U" for urban	2

Source of Federal Funds:

		Grant Award 1	Date 2	
3	Community Health Center (Section 330(d), PHS Act)			3
4	Migrant Health Center (Section 329(d), PHS Act)			4
5	Health Services for the Homeless (Section 340(d), PHS Act)			5
6	Appalachian Regional Commission			6
7	Look-Alikes			7
8	Other (specify)			8

Physician Information:

		Physician Name	Billing Number	
9	Physician(s) furnishing services at the clinic or under agreement (see instructions)			9

		Physician Name	Hours of Supervision	
10	Supervisory physician(s) and hours of supervision during period (see instructions)			10

11	Does the facility operate as other than an RHC or FQHC? If yes, indicate number of other operations in column 2 and list the other type(s) of operation(s) and hours on subscripts of line 12.			11

Enter the clinic hours on line 12 and list the other type(s) of operation(s) and hours on subscripts of line 12. (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
12	Clinic															12
12.01	Specify:															12.01
12.02	Specify:															12.02
12.03	Specify:															12.03

(1) List hours of operation based on a 24 hour clock. For example, 8:30am is 0830, 5:30pm is 1730 and 12 midnight is 2400.

13	Has the facility been approved for an exception to the productivity standard?		13
14	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List all provider names and numbers below.		14
15	Provider name: _____ Provider number: _____		15
15.01	Provider name: _____ Provider number: _____		15.01
15.02	Provider name: _____ Provider number: _____		15.02
15.03	Provider name: _____ Provider number: _____		15.03
16	Are you claiming allowable and/or non-allowable GME costs as a result of "substantial payment" for interns and residents? If yes, enter the number of Medicare visits in column 2 performed by interns and residents and complete Worksheet RF-1, lines 20 and 27 as applicable.		16

HOSPICE IDENTIFICATION DATA	PROVIDER NO.: _____ HOSPICE NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-5

PART I

	Enrollment Days	Title XVIII Unduplicated Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Other Unduplicated Days	Total Unduplicated Days (sum of cols. 1 & 3)	
		1	2	3	4	
1	Continuous Home Care					1
2	Routine Home Care					2
3	Inpatient Respite Care					3
4	General Inpatient Care					4
5	Total Hospice Days					5

PART II

	Census Data	Title XVIII	Title XVIII Skilled Nursing Facility	Other	Total (sum of cols. 1 & 3)	
		1	2	3	4	
6	Number of Patients Receiving Hospice Care					6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare					7
8	Average Length of Stay (line 5 divided by line 6)					8
9	Unduplicated Census Count					9

NOTE: Parts I & II, column 1 also includes the days reported in column 2.

HHA-BASED CORF STATISTICAL DATA	PROVIDER NO.: _____ CORF NO.: _____	PERIOD: From: _____ To: _____	SUPPLEMENTAL WORKSHEET S-6

	CORF TREATMENTS	Title XVIII		Other		Total		
		Treatments	Patients	Treatments	Patients	Treatments	Patients	
		1	2	3	4	5	6	
1	Skilled Nursing Care							1
2	Physical Therapy							2
3	Occupational Therapy							3
4	Speech Pathology							4
5	Medical Social Services							5
6	Respiratory Therapy							6
7	Psychological Services							7
8	All Other Service							8
9	Total Treatments (Sum of lines 1-8)							9

CORF - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Enter the number of hours in your normal workweek _____

		Staff	Contract	Total	
		1	2	3	
10	Administrators and Assistant Administrators				10
11	Directors and Assistant Directors				11
12	Other Administrative Personnel				12
13	Direct Nursing Service				13
14	Nursing Supervisor				14
15	Physical Therapy Service				15
16	Physical Therapy Supervisor				16
17	Occupational Therapy Service				17
18	Occupational Therapy Supervisor				18
19	Speech Pathology Service				19
20	Speech Pathology Supervisor				20
21	Medical Social Service				21
22	Medical Social Supervisor				22
23	Respiratory Therapy Service				23
24	Respiratory Therapy Supervisor				24
25	Psychological Service				25
26	Psychological Service Supervisor				26
27					27
28					28

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO.: _____ | PERIOD: From: _____ To: _____ | WORKSHEET A

			SALARIES (Fr Wks A-1)	EMPLOYEE BENEFITS (Fr Wks A-2)	TRANSPOR-TATION (See Instructions)	CONTRACTED PURCHASED SERVICES (Fr Wks A-3)	OTHER COSTS	TOTAL	RECLASSI-FICATION (Fr Wks A-4)	RECLASSI-FIED TRIAL BALANCE (Cols 6 + 7)	ADJUST-MENTS	EXPENSES FOR COST ALLOCATION (Col 8 + 9)	
			1	2	3	4	5	6	7	8	9	10	
		GENERAL SERVICE COST CENTER											
1	0100	Capital Related - Bldg. & Fix.											1
2	0200	Capital Related - Movable Equip											2
3	0300	Plant Operation & Maintenance											3
4	0400	Transportation (See Instructions)											4
5	0500	Administrative and General											5
		HHA REIMBURSABLE SERVICES											
6	0600	Skilled Nursing Care											6
7	0700	Physical Therapy											7
8	0800	Occupational Therapy											8
9	0900	Speech Pathology											9
10	1000	Medical Social Services											10
11	1100	Home Health Aide											11
12	1200	Supplies (See Instructions)											12
13	1300	Drugs											13
14	1400	DME											14
		HHA NONREIMBURSABLE SERVICES											
15	1500	Home Dialysis Aide Services											15
16	1600	Respiratory Therapy											16
17	1700	Private Duty Nursing											17
18	1800	Clinic											18
19	1900	Health Promotion Activities											19
20	2000	Day Care Program											20
21	2100	Home Delivered Meals Program											21
22	2200	Homemaker											22
23		Other											23
		SPECIAL PURPOSE COST CENTERS											
24	2400	CORF											24
25	2500	Hospice											25
26	2600	CMHC											26
27	2700	RHC											27
28	2800	FQHC											28
29		Total											29

FORM CMS-1728-94 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3206)

COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER NO.: _____

PERIOD:
From: _____
To: _____

WORKSHEET A-1

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

(1) Transfer the amounts in column 9 to Wkst. A, column 1

COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO.: _____

PERIOD:
From: _____
To: _____

WORKSHEET A-2

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SRVS										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Services										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

(1) Transfer the amounts in column 9 to Wkst. A, column 2

FORM CMS-1728-94-A-2 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3208)

COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER NO.: _____

PERIOD:
From: _____
To: _____

WORKSHEET A-3

		ADMINIS-TRATORS 1	DIRECTORS 2	CONSULTANTS 3	SUPERVISORS 4	NURSES 5	THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL (1) 9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Services										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

(1) Transfer the amounts in column 9 to Wkst. A, column 4

RECLASSIFICATIONS | PROVIDER NO. _____ | PERIOD: From: _____ To: _____ | WORKSHEET A-4

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	AMOUNT(2)	COST CENTER	LINE NO.	AMOUNT(2)	
		1	2	3	4	5	6	7	
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	TOTAL RECLASSIFICATIONS (Sum of col. 4 must equal sum of col. 7)								30

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

(2) Transfer to Worksheet A, column 7, line as appropriate.

FORM CMS-1728-94-A-4 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3210)

ADJUSTMENTS TO EXPENSES	PROVIDER NO.: _____		PERIOD: From: _____ To: _____	WORKSHEET A-5	
Description (1)	(2) BASIS/CODE	Amount	Expense Classification on Worksheet A To/From Which The Amount is to be Adjusted		
			Cost Center	Line No.	
	1	2	3	4	
1 Excess funds generated from operations, other than net income	B				1
2 Trade, quantity, time and other discounts on purchases (Chap. 8)	B				2
3 Rebates and refunds of expenses (Chap. 8)	B				3
4 Home office costs (Chap. 21)	A				4
5 Adjustments resulting from transaction with related organization (Chap. 10)	From Wks A-6		#REF!	#REF!	5
6 Sale of medical records and abstracts	B				6
7 Income from imposition of interest, finance or penalty charges (Chap. 21)	B				7
8 Sale of medical and surgical supplies to other than patients	A				8
9 Sale of Drugs to other than patients	A				9
10 Physical therapy adjustment (Chap. 14)	From Supp Wks A-8-3		Physical Therapy	7	10
10.1 Occupational therapy adjustment (Chap. 14)	From Supp Wks A-8-3		Occupational Therapy	8	10.1
10.2 Speech pathology adjustment (Chap. 14)	From Supp Wks A-8-3		Speech Pathology	9	10.2
11 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	A				11
12 Lobbying Activities	A				12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21 TOTAL (Sum of lines 1-20)					21

(1) Description - All line references in this column pertain to the Provider Reimbursement Manual, Part 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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed as overpayments (42 USC 1395g).

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET A-6

A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10?

[ ] Yes [ ] No (If "Yes," complete Parts B and C)

B. Costs incurred and adjustment required as result of transactions with related organizations

	LOCATION AND AMOUNT INCLUDED ON WKST A, COL. 8				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (col 4 -5)
	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT		
	1	2	3	4	5	6
1						
2						0
3						0
4	TOTALS (Sum of lines 1-3)(Transfer col. 6, lines 1-3 to Wkst A, Col. 9, lines as appropriate)(Transfer col. 6, line 4 to Wkst A-5, col. 2, line 5)					

C. Interrelationship of provider to related organization(s):

The Secretary, by virtue of authority granted under section 1814(b)(1) of the Health Insurance for the Aged and Disabled Act, requires the provider to furnish the information requested on Part C of this worksheet.

The information will be used by the CMS and its intermediaries in determining that the costs applicable to services, facilities and supplies furnished by organizations related to the provider by common ownership or control, represent reasonable costs as determined under section 1861 of the Health Insurance for the Aged and Disabled Act. If the provider does not provide all or any part of the requested information, the cost report will be considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	SYMBOL (1)	Name	Address	Percent Owned by Provider	Percent Ownership of Provider	Type of Business
	1	2	3	4	5	6
1						
2						
3						
4						
5						

(1) Use the following symbols to indicate the interrelationship of the provider 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 nonfinancial) specify.

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET A-7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donations	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: From: To:	WORKSHEET A-8-3 PARTS I - III

Check applicable box: [ ] Physical Therapy services rendered before 4/10/98 [ ] Occupational Therapy [ ] Speech Pathology
[ ] Physical Therapy services rendered on or after 4/10/98

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 HHA visits - supervisors or therapists (See Instructions)		3
4	Number of unduplicated HHA visits - therapy assistants (Include only visits made by therapy assistants and on which supervisor and/or therapist was not present during the visit) (See Instructions)		4
5	Standard travel expense rate		5
6	Optional travel expense rate per mile		6

		Supervisors	Therapists	Assistants	Aides	
		1	2	3	4	
7	Total hours worked					7
8	AHSEA (See Instructions)					8
9	Standard Travel Allowance (Cols 1 and 2, one-half of col 2, line 8; col 3, one-half of col 3, line 8)					9
10	Number of travel hours (HHA only)					10
11	Number of miles driven (HHA only)					11

PART II - SALARY EQUIVALENCY COMPUTATIONS

12	Supervisors (Col 1, line 7 times col 1, line 8)		12
13	Therapists (Col 2, line 7 times col 2, line 8)		13
14	Assistants (Col 3, line 7 times col 3, line 8)		14
15	Subtotal Allowance Amount (Sum of lines 12-14)		15
16	Aides (Col 4, line 7 times col 4, line 8)		16
17	Total Allowance Amount (Sum of lines 15 and 16)		17
	If the sum of cols 1-3, line 7, is greater than line 2, make no entries on lines 18 and 19 and enter on line 20 the amount from line 17. Otherwise, complete lines 18-20.		
18	Weighted average rate excluding aides (Line 15 divided by the sum of cols 1-3, line 7)		18
19	Weighted allowance excluding aides (Line 2 times line 18)		19
20	Total Salary Equivalency (Line 17 or sum of lines 16 plus 19)		20

PART III - TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - HHA SERVICES

	Standard Travel Allowance and Standard Travel Expense		
21	Therapists (Line 3 times col 2, line 9)		21
22	Assistants (Line 4 times col 3, line 9)		22
23	Subtotal (Sum of lines 21 and 22)		23
24	Standard Travel Expense (Line 5 times sum of lines 3 and 4)		24
	Optional Travel Allowance and Optional Travel Expense		
25	Therapists (Sum of cols 1 and 2, line 10 times col 2, line 8)		25
26	Assistants (Col 3, line 10 times col 3, line 8)		26
27	Subtotal (Sum of lines 25 and 26)		27
28	Optional Travel Expense (Line 6 times sum of cols 1-3, line 11)		28
	Total Travel Allowance and Travel Expenses - HHA Services; Complete one of the following three lines 29, 30 or 31, as appropriate		
29	Standard Travel Allowance and Standard Travel Expenses (Sum of lines 23 and 24 - See Instructions)		29
30	Optional Travel Allowance and Standard Travel Expenses (Sum of lines 27 and 24 - See Instructions)		30
31	Optional Travel Allowance and Optional Travel Expenses (Sum of lines 27 and 28 - See Instructions)		31

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET A-8-3 PART IV & V

Check applicable box: [ ] Physical Therapy services rendered before 4/10/98 [ ] Occupational Therapy [ ] Speech Pathology
[ ] Physical Therapy services rendered on or after 4/10/98

PART IV - OVERTIME COMPUTATION

	Description	Therapists 1	Assistants 2	Aides 3	TOTAL 4	
32	Overtime hours worked during cost reporting period (If col 4, line 32, is zero or equal to or greater than 2,080, do not complete lines 33-40 and enter zero in each column of line 41)					32
33	Overtime rate (Multiply the amounts in cols 2-4, line 8 (AHSEA) times 1.5)					33
34	Total overtime (Including base and overtime allowance) (Multiply line 32 times line 33)					34
	CALCULATION OF LIMIT					
35	Percentage of overtime hours by category (Divide the hours in each column on line 32 by the total overtime worked - col. 4, line 32)					35
36	Allocation of provider's standard workyear for one full-time employee times the percentage on line 35) (See Instructions)					36
	DETERMINATION OF OVERTIME ALLOWANCE					
37	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols 2-4, line 8)					37
38	Overtime cost limitation (Line 36 times line 37)					38
39	Maximum overtime cost (Enter the lesser of line 34 or line 38)					39
40	Portion of overtime already included in hourly computation at the AHSEA (Multiply line 32 times line 37)					40
41	Overtime allowance (Line 39 minus line 40 - if negative enter zero) (Col 4, sum of cols 1-3)					41

PART V - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

42	Salary equivalency amount (from Part II, line 20)		42
43	Travel allowance and expense - HHA services (from Part III, lines 29, 30 or 31)		43
44	Overtime allowance (from Part IV, col. 4, line 41)		44
45	Equipment cost (See Instructions)		45
46	Supplies (See Instructions)		46
47	Total allowance (Sum of lines 42-46)		47
48	Total cost of outside supplier services (from provider records)		48
49	Excess over limitation (line 48 minus line 47 - transfer amount to A-5, line 10, 10.1, or 10.2 as applicable - if negative, enter zero -- See Instructions)		49

COST ALLOCATION - GENERAL SERVICE COST | PROVIDER NO.: _____ | PERIOD: From: _____ To: _____

		NET EXPENSES FOR COST ALLOCATION (FR.WKST A, COL10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)
			BLDGS & & FIXTURES	MOVABLE EQUIPMENT			
		0	1	2	3	4	4A
	GENERAL SERVICE COST CENTERS						
1	Capital Related - Bldg. and Fixtures		0				
2	Capital Related - Movable Equipment		0	0			
3	Plant Operation & Maintenance		0	0	0		
4	Transportation (See Instructions)		0	0	0		
5	Administrative and General						
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care		0	0	0		
7	Physical Therapy		0	0	0		
8	Occupational Therapy		0	0	0		
9	Speech Pathology		0	0	0		
10	Medical Social Services		0	0	0		
11	Home Health Aide		0	0	0		
12	Supplies (See Instructions)		0	0	0		
13	Drugs		0	0	0		
14	DME		0	0	0		
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						
16	Respiratory Therapy						
17	Private Duty Nursing						
18	Clinic						
19	Health Promotion Activities						
20	Day Care Program						
21	Home Delivered Meals Program						
22	Homemaker Services						
23	Other						
	SPECIAL PURPOSE COST CENTER						
24	CORF						
25	Hospice						
26	CMHC						
27	RHC						
28	FQHC						
29	Total		0	0	0		

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COST ALLOCATION - STATISTICAL BASIS			PROVIDER NO.: _____	PERIOD: From: _____ To: _____	
		CAPITAL RELATED COSTS			
	COST CENTER	BLDGS & & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION
		1	2	3	4	5A
	GENERAL SERVICE COST CENTER					
1	Capital Related - Bldg. and Fixtures					
2	Capital Related - Movable Equipment					
3	Plant Operation & Maintenance					
4	Transportation (See Instructions)					
5	Administrative and General					
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care					
7	Physical Therapy					
8	Occupational Therapy					
9	Speech Pathology					
10	Medical Social Services					
11	Home Health Aide					
12	Supplies (See Instructions)					
13	Drugs					
14	DME					
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					
16	Respiratory Therapy					
17	Private Duty Nursing					
18	Clinic					
19	Health Promotion Activities					
20	Day Care Program					
21	Home Delivered Meals Program					
22	Homemaker Services					
23	Other					
	SPECIAL PURPOSE COST CENTER					
24	CORF					
25	Hospice					
26	CMHC					
27	RHC					
28	FQHC					
29	Total					
30	Cost To Be Allocated (Per Wkst B)					
31	Unit Cost Multiplier					

FORM CMS-1728-94-B-1 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC 3214)

	WORKSHEET B	
ADMINISTRA- TIVE & GENERAL	TOTAL	
5	6	
		1
		2
		3
		4
		5
0		6
0		7
0		8
0		9
0		10
0		11
0		12
0		13
0		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26
		27
		28
0		29

	WORKSHEET B-1	
ADMINISTRA- TIVE & GENERAL (ACCUMU- LATED COST)	TOTAL	
5	6	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
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		25
		26
		27
		28
		29
		30
		31

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO.: _____ | PERIOD: From: _____ To: _____

PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATION

	Cost Per Visit Computation Patient Services	From Wkst B, Col. 6, Line:	To Cost
		1	2
1	Skilled Nursing	6	
2	Physical Therapy	7	
3	Occupational Therapy	8	
4	Speech Pathology	9	
5	Medical Social Services	10	
6	Home Health Aide Services	11	
7	Total (Sum of lines 1-6)		

PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)

MSA CODE:

	Total Medicare Patient Service Cost Computation	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Medicare Program Visits			Cost of Medicare Serv	
					Part B			Par
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance
			4	5	6	7	8	9
1	Skilled Nursing	1						
2	Physical Therapy	2						
3	Occupational Therapy	3						
4	Speech Pathology	4						
5	Medical Social Services	5						
6	Home Health Aide Services	6						
7	Total (Sum of lines 1-6)							

	Total Medicare Patient Service Cost Limitation Computation	Program Cost Limits	Medicare Program Visits			Cost of Medicare Serv	
				Part B			Par
			Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance
		4	5	6	7	8	9
8	Skilled Nursing						
9	Physical Therapy						
10	Occupational Therapy						
11	Speech Pathology						
12	Medical Social Services						
13	Home Health Aide Services						
14	Total (Sum of lines 8-13 plus the subscripts of lines 1-6, respectively)						

(1) Compute the average cost per visit one time for each discipline (column 4, lines 1 through 6) for the entire home health agency.
(2) Complete Worksheet C, Part II once for each MSA where Medicare covered services were furnished during the cost reporting period.

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APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO.: _____ | PERIOD: From: _____ To: _____

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	Other Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Charges from HHA Record)	Ratio (Col 2 ÷ 3)	Medicare Covered Charges Part A	Medicare Covered Charges Part B Not Subject to Deductibles & Coinsurance	Medicare Covered Charges Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Not Subject to Deductibles & Coinsurance
		1	2	3	4	5	6	6.01	7	8	9
15	Cost of Medical Supplies	12									
16	Cost of Drugs	13									

PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION

		Medicare Program Unduplicated Census Count For Each MSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From Your Intermediary)	Cost of Medicare Serv Par Part A	Cost of Medicare Serv Par Not Subject to Deductibles & Coinsurance
		1	2	3	4
17	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, lines 1-6 (exculsive of subscripts))				
18	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))				
19	Total (Sum of lines 17 and 18)				
20	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &11, respectively, line 14)				
21	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))				
22	Total (Sum of lines 20 and 21)				

		MSA Code (3)				
		0	1	2	3	4
23	Per Beneficiary Cost Limitation for MSA:					
23.01	Per Beneficiary Cost Limitation for MSA:					
23.02	Per Beneficiary Cost Limitation for MSA:					
23.03	Per Beneficiary Cost Limitation for MSA:					
23.04	Per Beneficiary Cost Limitation for MSA:					
23.05	Per Beneficiary Cost Limitation for MSA:					
23.06	Per Beneficiary Cost Limitation for MSA:					
23.07	Per Beneficiary Cost Limitation for MSA:					
23.08	Per Beneficiary Cost Limitation for MSA:					
23.09	Per Beneficiary Cost Limitation for MSA:					
24	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)					

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION

	Patient Services	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Part B Subject to Deductibles and Coinsurance: Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services 1/1/98-12/31/98	Medicare Program Visits for Services 1/1/99-9/30/00	Medicare Program Visits for Services on or after 10/1/00	Medicare Program Costs for Services 1/1/98-12/31/98
		1	2	3	4	5	5.01	5.02	6
25	Physical Therapy	2							
26	Occupational Therapy	3							
27	Speech Pathology	4							
28	Total (Sum of lines 25-27)								

(3) The MSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.
(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01.

FORM CMS-1728-94-C (3-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3215 - 3215.5)

Rev. 12

WORKSHEET C
PARTS I & II

tal Visits 3	Average Cost Per Visit (Cols 2 ÷ 3) (1) 4	
		1
		2
		3
		4
		5
		6
		7

ices t B Subject to Deductibles & Coinsurance 10	Total (Sum of Cols 8 & 9) 11	
		1
		2
		3
		4
		5
		6
		7

ices t B Subject to Deductibles & Coinsurance 10	Total (Sum of Cols 8 & 9 11	
		8
		9
		10
		11
		12
		13
		14

WORKSHEET C
PARTS III, IV & V

Part B		
Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
9.01	10	
		15
		16

ices t B		
Subject to Deductibles & Coinsurance	Total (Sum of Cols 3 & 4	
5	6	
		17
		18
		19
		20
		21
		22

	(Col 1 x 2)	
5	6	
		23
		23.01
		23.02
		23.03
		23.04
		23.05
		23.06
		23.07
		23.08
		23.09
		24

Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
7	8	
		25
		26
		27
		28

CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET D

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

	Description	PART A	PART B Not Subject to Deductibles & Coinsurance	PART B Subject to Deductibles & Coinsurance	
		1	2	3	
Reasonable Cost of Title XVIII - Part A & Part B Services					
1	Reasonable Cost of Services (See Instructions)				1
2	Cost of Services, RHC & FQHC				2
3	Sum of Lines 1 and 2				3
4	Total charges for title XVIII - Part A and Part B Services - Pre 10/1/2000				4
4.01	Total charges for title XVIII - Part A and Part B Services - Post 9/30/2000				4.01
	Customary Charges				
5	Amount actually collected from patients liable for payment for services on a charge basis (From your records)				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(b)				6
7	Ratio of line 5 to 6 (Not to exceed 1.000000)				7
8	Total customary charges - title XVIII (Multiply line 7 by line 4 for column 1) (Multiply line 7 by the sum of lines 4 & 4.01 for columns 2 & 3, respectively) (See Instructions)				8
9	Excess of total customary charges over total reasonable cost (Complete only if line 8 exceeds line 3)				9
10	Excess of reasonable cost over customary charges (Complete only if line 3 exceeds line 8)				10
11	Primary Payer Amounts				11

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

	Description	PART A Services	PART B Services	
		1	2	
12	Total reasonable cost (See Instructions)			12
12.01	Total PPS Payment - Full Episodes without Outliers			12.01
12.02	Total PPS Payment - Full Episodes with Outliers			12.02
12.03	Total PPS Payment - LUPA Episodes			12.03
12.04	Total PPS Payment - PEP Only Episodes			12.04
12.05	Total PPS Payment - SCIC within a PEP Episodes			12.05
12.06	Total PPS Payment - SCIC Only Episodes			12.06
12.07	Total PPS Outlier Payment - Full Episodes with Outliers			12.07
12.08	Total PPS Outlier Payment - PEP Only Episodes			12.08
12.09	Total PPS Outlier Payment - SCIC within a PEP Episodes			12.09
12.10	Total PPS Outlier Payment - SCIC Only Episodes			12.10
12.11	Total Other Payments			12.11
12.12	DME Payment			12.12
12.13	Oxygen Payment			12.13
12.14	Prosthetics and Orthotics Payment			12.14
13	Part B deductibles billed to Medicare patients (exclude coinsurance)			13
14	Subtotal (Sum of lines 12-12.14 minus line 13)			14
15	Excess reasonable cost (from line 10)			15
16	Subtotal (Line 14 minus line 15)			16
17	Coinsurance billed to Medicare patients (From your records)			17
18	Net cost (Line 16 minus line 17)			18
19	Reimbursable bad debts (From your records)			19
20	Pneumococcal Vaccine			20
21	Total Costs - Current cost reporting period (See Instructions)			21
22	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			22
23	Recovery of excess depreciation resulting from agencies' termination or decrease in Medicare utilization			23
24	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit			24
25	Total cost before sequestration and other adjustments- (line 21 plus/minus line 22 minus sum of lines 23 and 24)			25
25.5	Other Adjustments (see instructions) (specify)			25.5
26	Sequestration Adjustment (See Instructions)			26
27	Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.5 minus line 26)			27
28	Total interim payments (From Worksheet D-1, line 4)			28
28.5	Tentative settlement (For intermediary use only)			28.5
29	Balance due HHA/Medicare program (Line 27 minus line 28) (Indicate overpayments in brackets)			29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			30
31	Balance due HHA/Medicare program (Line 29 minus line 30) (Indicate overpayments in brackets)			31

FORM CMS-1728-94-D (3-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3216 - 3216.2)

ANALYSIS OF PAYMENTS TO HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET D-1

	Description			PART A		PART B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim pymts payable on individual bills either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a 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 a 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 Wkst D, Part II, column as appropriate, line 28)							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 a zero. (1) "NONE" or enter a 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)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)							7

Name of Intermediary	Intermediary Number	
Signature of Authorized Person	Date: 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 the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

FORM CMS-1728-94-D-1 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3217)

BALANCE SHEET (To be completed by all providers maintaining fund type accounting records. Nonproprietary providers not maintaining fund type accounting records, should complete the "General Fund" column only.)	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET F

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts Receivable					4
5	Other Receivables					5
6	Less: Allowance for uncollectible notes and accounts receivable	( )				6
7	Inventory					7
8	Prepaid Expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (Sum of lines 1-10)					11
	FIXED ASSETS					
12	Land					12
13	Land Improvements					13
14	Less: Accumulated Depreciation	( )				14
15	Buildings					15
16	Less: Accumulated Depreciation	( )				16
17	Leasehold improvements					17
18	Less: Accumulated Depreciation	( )				18
19	Fixed equipment					19
20	Less: Accumulated Depreciation	( )				20
21	Automobiles and trucks					21
22	Less: Accumulated Depreciation	( )				22
23	Major movable equipment					23
24	Less: Accumulated Depreciation	( )				24
25	Minor equipment nondepreciable					25
26	Other fixed assets					26
27	TOTAL FIXED ASSETS (Sum of lines 12-26)					27
	OTHER ASSETS					
28	Investments					28
29	Deposits on leases					29
30	Due from owners/officers					30
31						31
32	TOTAL OTHER ASSETS (Sum of lines 28-31)					32
33	TOTAL ASSETS (Sum of lines 11, 27 and 32)					33
	LIABILITIES AND FUND BALANCE (Omit Cents)					
	CURRENT LIABILITIES					
34	Accounts payable					34
35	Salaries, wages & fees payable					35
36	Payroll taxes payable					36
37	Notes & loans payable (short term)					37
38	Deferred income					38
39	Accelerated payments					39
40	Due to other funds					40
41	Other (Specify)					41
42	TOTAL CURRENT LIABILITIES (Sum of lines 34-41)					42
	LONG TERM LIABILITIES					
43	Mortgage payable					43
44	Notes payable					44
45	Unsecured Loans					45
46	Loans from owners - prior to 7/1/66					46
47	Loans from owners - on or after 7/1/66					47
48	Other (Specify)					48
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43-48)					49
50	TOTAL LIABILITIES (Sum of lines 42 and 49)					50
	CAPITAL ACCOUNTS					
51	General fund balance					51
52	Specific purpose fund balance					52
53	Donor created--Endowment fund balance--restricted					53
54	Donor created--Endowment fund balance--unrestricted					54
55	Governing body created--Endowment fund balance					55
56	Plant fund balance--Invested in plant					56
57	Plant fund balance-- Reserve for plant improvement, replacement and expansion					57
58	TOTAL FUND BALANCES (Sum of lines 51 thru 57)					58
59	TOTAL LIABILITIES AND FUND BALANCE (Sum of lines 50 and 58)					59

( ) = contra amount

FORM CMS-1728-94-F (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3218)

STATEMENT OF REVENUE AND EXPENSES	PROVIDER NO.: _____	PERIOD From: _____ To: _____	WORKSHEET F-1

1	Total patient revenues			1
2	Less: Allowances and discounts on patients' accounts			2
3	Net patient revenues (Line 1 minus line 2)			3
4	Operating expenses (From Worksheet A, column 6, line 29)			4
5	Additions to operating expenses (Specify)			5
6				6
7				7
8				8
9				9
10				10
11	Subtractions from operating expenses (Specify)			11
12				12
13				13
14				14
15				15
16				16
17	Less total operating expenses (net of lines 4 thru 16)			17
18	Net income from service to patients (Line 3 minus line 17)			18
	Other income:			
19	Contributions, donations, bequests, etc.			19
20	Income from investments			20
21	Purchase discounts			21
22	Rebates and refunds of expenses			22
23	Sale of Medical and Nursing Supplies to other than patients			23
24	Sale of durable medical equipment to other than patients			24
25	Sale of drugs to other than patients			25
26	Sale of medical records and abstracts			26
27	Other revenues (Specify)			27
28				28
29				29
30				30
31				31
32	Total Other Income (Sum of lines 19 thru 31)			32
33	Net Income or Loss for the period (Line 18 plus line 32)			33

FORM CMS-1728-94 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SEC. 3218)

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER NO.: _____ | PERIOD: From: _____ To: _____ | WORKSHEET F-2

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net Income (loss) (From Worksheet F-1, line 33)									2
3	Total (Sum of line 1 and line 2)									3
4	Additions (Credit adjustments) (Specify)									4
5										5
6										6
7										7
8										8
9	Total Additions (Sum of lines 4-8)									9
10	Subtotal (line 3 plus line 9)									10
11	Deductions (Debit adjustments) (Specify)									11
12										12
13										13
14										14
15										15
16	Total Deductions (Sum of lines 11-15)									16
17	Fund balance at end of period per balance sheet (line 10 minus line 16)									17

ALLOCATION OF GENERAL SERVICE
COSTS TO CORF REIMBURSABLE COST CENTERS

PROVIDER NO.: _____
CORF NO.: _____

PERIOD:
FROM: _____
TO: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO CORF REIMBURSABLE COST CENTERS

	CORF COST CENTER (OMIT CENTS)	NET EXPENSES FOR COST ALLOCATION (1)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	SUBTOTAL (cols. 0-4)	A&G SHARED COSTS
			BLDGS & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	4	4A	5
1	Administrative and General							
2	Skilled Nursing Care							
3	Physical Therapy							
4	Occupational Therapy							
5	Speech Pathology							
6	Medical Social Services							
7	Respiratory Therapy							
8	Psychological Services							
9	Prosthetic and Orthotic Devices							
10	Drugs and Biologicals							
11	Medical Supplies							
12	Durable Medical Equipment-Rented							
13	Durable Medical Equipment-Sold							
14	Other Part B Services							
15	TOTALS (Sum of lines 1-14) (2)							

(1) Column 0, line 15 must agree with Wkst. A, column 10, line 24.
(2) Columns 0 through 5, line 15 must agree with the corresponding columns of Wkst. B, line 24

0 0 0 0 0

PART II - COMPUTATION OF UNIT COST MULTIPLIER FOR ALLOCATION OF CORF ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 6, line 15
2	Amount from Part I, column 6, line 1
3	Line 1 minus line 2
4	Unit cost multiplier for CORF A&G costs (Line 2 divided by line 3)(multiply each amount in column 6, lines 2 through 14, Part I, by the unit cost multiplier and enter the result on the corresponding line of column 7)

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FORM CMS 1728-94

COMPUTATION OF CORF COSTS

PROVIDER NO.: _____

CORF NO.: _____

PERIOD:
FROM: _____
TO: _____

PART I - APPORTIONMENT OF CORF COST CENTERS NET OF THE APPLICABLE REASONABLE COST REDUCTION

	CORF COST CENTER (OMIT CENTS)	TOTAL COSTS (FROM SUPP. WKST. J-1, PT. I, COL. 8) (1)	TOTAL CORF CHARGES (2)	RATIO OF COSTS TO CHARGES (COL. 1 / COL. 2)	TITLE XVIII CORF CHARGES *	TITLE XVIII CORF COSTS (COL. 3 X COL. 4)	TITLE XVIII CORF CHARGES ON OR AFTER 1/1/98 *
		1	2	3	4	5	6
1	Administrative and General						
2	Skilled Nursing Care						
3	Physical Therapy						
4	Occupational Therapy						
5	Speech Pathology						
6	Medical Social Services						
7	Respiratory Therapy						
8	Psychological Services						
9	Prosthetic and Orthotic Devices						
10	Drugs and Biologicals						
11	Medical Supplies						
12	Durable Medical Equipment-Rented						
13	Durable Medical Equipment-Sold						
14	Other Part B Services						
15	TOTALS (Sum of lines 2-14)						

	PART II - APPORTIONMENT OF COST OF CORF SERVICES FURNISHED BY HHA DEPARTMENTS	Fr. Wkst. B, Col 6, Line:						
16	Respiratory Therapy	16						
17	Physical Therapy	7						
18	Occupational Therapy	8						
19	Speech Pathology	9						
20	Supplies	12						
21	Drugs Charged to Patients	13						
23	Total (Sum of lines 16 through 21)							

(1) Cost for Part II, lines 16-22 are obtained from Worksheet B, column 6, lines as appropriate

(2) Charges for Part II, column 2 are total facility charges for each cost center and are obtained from provider records

	PART III- TOTAL CORF COSTS	4	5	6
24	Total CORF costs - Add the amount from Part I, column 9, line 15 and the amount from Part II, column 9, line 23. Add the amounts from Part I, line 15 and Part II, line 23 for columns 4 through 8, respectively.			

Transfer the amount in Part III, column 9 to Worksheet J-3, line 1.

* See instructions for fee scheduled payment basis items for services rendered on or after January 1, 1999.

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_____ _____	WORKSHEET J-1 PARTS I & II

SUB-TOTAL	ALLOCATED CORF A&G (SEE PART II)	TOTAL (SUM OF COLS 6 & 7)	
6	7	8	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15

		1
		2
		3
		4

WORKSHEET J-2

TITLE XVIII CORF COSTS ON OR AFTER 1/1/98	REASONABLE COST REDUCTION AMOUNT	TITLE XVIII COST NET OF REASONABLE COST REDUCTION	
7	8	9	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15

			16
			17
			18
			19
			20
			21
			23

7	8	9	
			24

ALLOCATION OF GENERAL SERVICE COSTS TO CORF COST CENTERS	PROVIDER NO.: _____ CORF NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET J-1 PART III

PART III - ALLOCATION OF GENERAL SERVICE COSTS TO CORF COST CENTERS - STATISTICAL BASIS

	CORF COST CENTER (OMIT CENTS)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	RECONCIL-IATION	ADMINISTRATIVE & GENERAL	
		BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	(SQUARE FEET)	(MILEAGE)		(ACCUMULATED COST)	
		1	2	3	4	5A	5	
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	Psychological Services							8
9	Prosthetic and Orthotic Devices							9
10	Drugs and Biologicals							10
11	Medical Supplies							11
12	Durable Medical Equipment-Rented							12
13	Durable Medical Equipment-Sold							13
14	Other Part B Services							14
15	TOTALS (Sum of lines 1-14)							15
16	Total Cost to be Allocated							16
17	Unit Cost Multiplier							17

CALCULATION OF REIMBURSEMENT SETTLEMENT - CORF SERVICES	CORF NO.: _____	FROM: _____ TO: _____	WORKSHEET J-3

PART I-COMPUTATION OF CUSTOMARY CHARGES FOR CORF SERVICES

1	Total reasonable cost of CORF services (See instructions)		1
1.1	Total reasonable cost of CORF services prior to 1/1/1998 (Reasonable cost basis) (See instructions)		1.1
1.2	Total reasonable cost of CORF services on or after 1/1/1998 (Subject to LCC) (See instructions)		1.2
2	Primary payment amounts (CORF services)		2
3	Net cost (Line 1 minus line 2)		3
4	Total CORF charges		4
	Customary Charges		
5	Amounts actually collected from patients liable for payments for CORF services on a charge basis (From your records)		5
6	Amount that would have been realized from patients liable for payment for CORF services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)		6
7	Ratio of line 5 to line 6 (Not to exceed 1.000000)		7
8	Total customary charges - CORF services (Multiply line 7 x line 4)		8
8.1	Total customary charges - CORF services prior to 1/1/1998 (Reasonable cost basis) (See instructions)		8.1
8.2	Total customary charges - CORF services on or after 1/1/1998 (Subject to LCC) (See instructions)		8.2
	COMPUTATION OF LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES FOR CORF SERVICES FURNISHED IN CALENDAR YEAR 1998		
8.3	Excess of customary charges over reasonable costs (Complete only if line 8.2 exceeds line 1.2) (See instructions)		8.3
8.4	Excess of reasonable costs over customary charges (Complete only if line 1.2 exceeds line 8.2) (See instructions)		8.4

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

9	Cost of CORF services (From line 3)		9
10	Part B deductible billed to Program patients (exclude coinsurance amounts)		10
11	Net Cost (Line 9 minus line 10)		11
11.1	Excess of reasonable costs over customary charges for services rendered on or after 1/1/1998 (from line 8.4)		11.1
11.2	Subtotal (line11 minus line 11.1)		11.2
12	80% of Part B cost (80% x line 11.2)		12
13	Actual coinsurance billed to Program patients (From your records)		13
14	Net cost less actual billed coinsurance (Line 11 minus line 13)		14
15	Reimbursable bad debts (See instructions)		15
16	Net reimbursable amount (Line 15 plus the lesser of line 12 or line 14)		16
17	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets		17
18	Recovery of excess depreciation resulting from facility's termination or a decrease in Program utilization		18
19	Other adjustments (specify)		19
20	Total Cost - reimbursable to provider (Line 16 minus lines 17 and 18 and plus or minus line 19)		20
21	Sequestration Adjustment (See instructions)		21
22	Amount due provider after sequestration adjustment (Amount on line 20 minus line 21)		22
23	Interim payments		23
23.5	Tentative settlement (For intermediary use only)		23.5
24	Balance due CORF/Program (Line 22 minus line 23) (Indicate overpayments in brackets)		24
25	Protested amounts (nonallowable cost report items) in accordance with PRM II, Sec. 115.2(B)		25
26	Balance due CORF/Program (Line 24 minus line 25) (Indicate overpayments in brackets)		26

FORM CMS 1728-94-J-3 (5-2000) (INSTRUCTIONS PUBLISHED IN THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3223-3223.2

ANALYSIS OF PAYMENTS TO PROVIDER-BASED CORF FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	CORF NO.: _____	FROM: _____ TO: _____	WORKSHEET J-4

	DESCRIPTION			PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to CORF					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a 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 a 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 Supp. Wkst J-3, Part II, line 23)					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 a 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 PROGRAM LIABILITY (See Instructions)					7

Name of Intermediary Intermediary Number

Signature of Authorized Person Date: (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 the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (From Wkst.K-1)	EMPLOYEE BENEFITS (From Wkst. K-2)	TRANSPOR-TATION (See inst.)	CON-TRACTED SERVICES (From Wkst. K-3)	OTHER	TOTAL (cols. 1-5)	RECLAS-SIFICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance											3
4	Transportation - Staff											4
5	Volunteer Service Coordination											5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
10	Nursing Care											10
11	Physical Therapy											11
12	Occupational Therapy											12
13	Speech/ Language Pathology											13
14	Medical Social Services											14
15	Spiritual Counseling											15
16	Dietary Counseling											16
17	Counseling - Other											17
18	Home Health Aide and Homemaker											18
19	Other											19
	OTHER HOSPICE SERVICE COSTS											
20	Drugs, Biological and Infusion Therapy											20
21	Durable Medical Equipment/Oxygen											21
22	Patient Transportation											22
23	Imaging Services											23
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (incl. E/R Dept.)											26
27	Radiation Therapy											27
28	Chemotherapy											28
29	Other											29
	HOSPICE NONREIMBURSABLE SERV.											
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
32	Fundraising											32
33	Other Program Costs											33
34	Total (sum of line 1 thru 33)											34

The net expenses for cost allocation on Worksheet A for the Hospice cost center line must equal the total facility costs in column 10, line 34 of this worksheet.

COMPENSATION ANALYSIS - SALARIES AND WAGES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
21	Durable Medical Equipment/ Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

(1) Transfer the amount in column 9 to Wkst K, column 1

FORM CMS-1728-94-K-1 (2-2002) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3241)

COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO: _____

HOSPICE NO.: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
21	Durable Medical Equipment/ Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

(1) Transfer the amount in column 9 to Wkst K, column 2

FORM CMS-1728-94-K-2 (2-2002) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3242)

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biological and Infusion Therapy										20
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

(1) Transfer the amount in column 9 to Wkst K, column 4

FORM CMS-1728-94-K-3 (2-2002) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3243)

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-4 PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC. (FR. WKST K, COL. 10)	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICES COORDI-NATOR	SUBTOTAL (col. 0 - 5)	ADMINIS-TRATIVE & GENERAL	TOTAL	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	5	5A	6	7	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services - Direct										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemakers										18
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biologicals and Infusion										20
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

FORM CMS-1728-94-K-4 (2-2002) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3244)

COST ALLOCATION - HOSPICE STATISTICAL BASIS | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-4 PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST: BUILDINGS & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST: MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION (MILEAGE)	VOLUNTEER SERVICES COORDI-NATOR (HOURS)	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Plant Operation and Maintenance								3
4	Transportation-staff								4
5	Volunteer Service Coordination								5
6	Administrative and General								6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care								10
11	Physical Therapy								11
12	Occupational Therapy								12
13	Speech/ Language Pathology								13
14	Medical Social Services - Direct								14
15	Spiritual Counseling								15
16	Dietary Counseling								16
17	Counseling - Other								17
18	Home Health Aide and Homemakers								18
19	Other								19
	OTHER HOSPICE SERVICE COSTS								
20	Drugs, Biologicals and Infusion								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
34	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
	HOSPICE NONREIMBURSABLE SERV.								
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Cost To be Allocated (per Wkst K-4, Part I)								34
35	Unit Cost Multiplier								35

FORM CMS-1728-94-K-4 (6-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3244)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER NO: _____
HOSPICE NO.: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET K-5 PART I

	HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7, line	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED COST		PLANT OPERATION & MAIN-TENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	SUB-TOTAL	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS (col 6 + col. 7)	
				BUILDINGS & FIXTURES	MOVABLE EQUIPMENT								
			0	1	2	3	4	4A	5	6	7	8	
1	Administrative and General	6											1
2	Inpatient - General Care	7											2
3	Inpatient - Respite Care	8											3
4	Physician Services	9											4
5	Nursing Care	10											5
6	Physical Therapy	11											6
7	Occupational Therapy	12											7
8	Speech/ Language Pathology	13											8
9	Medical Social Services - Direct	14											9
10	Spiritual Counseling	15											10
11	Dietary Counseling	16											11
12	Counseling - Other	17											12
13	Home Health Aide and Homemakers	18											13
14	Other	19											14
15	Drugs, Biologicals and Infusion	20											15
16	Durable Medical Equipment/Oxygen	21											16
17	Patient Transportation	22											17
18	Imaging Services	23											18
19	Labs and Diagnostics	24											19
20	Medical Supplies	25											20
21	Outpatient Services (incl. E/R Dept.)	26											21
22	Radiation Therapy	27											22
23	Chemotherapy	28											23
24	Other	29											24
25	Bereavement Program Costs	30											25
26	Volunteer Program Costs	31											26
27	Fundraising	32											27
28	Other Program Costs	33											28
29	Totals (sum of lines 1-28) (2)												29
30	Unit Cost Multiplier: column 6, line 1 divided by the sum of column 6, line 29 minus column 6, line 1, rounded to 6 decimal places.												30

(1) Column 0, line 29 must agree with Wkst. A, column 10, line 25.
(2) Columns 0 through 5, line 29 must agree with the corresponding columns of Wkst. B, line 25.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER NO: _____

HOSPICE NO.: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET K-5 PART II

	HOSPICE COST CENTER	CAPITAL RELATED COST		PLANT OPERATION & MAIN-TENANCE (SQUARE FEET)	TRANS-PORTATION (MILAGE)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	
		BUILDINGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)					
		1	2	3	4	5A	5	
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Physical Therapy							6
7	Occupational Therapy							7
8	Speech/ Language Pathology							8
9	Medical Social Services - Direct							9
10	Spiritual Counseling							10
11	Dietary Counseling							11
12	Counseling - Other							12
13	Home Health Aide and Homemakers							13
14	Other							14
15	Drugs, Biologicals and Infusion							15
16	Durable Medical Equipment/Oxygen							16
17	Patient Transportation							17
18	Imaging Services							18
19	Labs and Diagnostics							19
20	Medical Supplies							20
21	Outpatient Services (incl. E/R Dept.)							21
22	Radiation Therapy							22
23	Chemotherapy							23
24	Other							24
25	Bereavement Program Costs							25
26	Volunteer Program Costs							26
27	Fundraising							27
28	Other Program Costs							28
29	Totals (sum of lines 1-28)							29
30	Total cost to be allocated							30
31	Unit Cost Multiplier							31

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS COMPUTATION OF TOTAL HOSPICE SHARED COSTS	PROVIDER NO.: _____ HOSPICE NO.: _____			PERIOD: FROM: _____ TO: _____		WORKSHEET K-5 Part III	
Hospice shared cost computation COST CENTER	From Wkst B, col. 6, line:	Total HHA Costs	Total HHA Charges (from Provider Records)	Cost to Charge Ratio (col. 2/col.3)	Total Hospice Charges (from Provider Records)	Hospice Shared Ancillary Costs (col. 4 x col. 5)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
1 Physical Therapy	7						1
2 Occupational Therapy	8						2
3 Speech/ Language Pathology	9						3
4 Medical Social Services - Direct	10						4
5 Durable Medical Equipment/Oxygen	14						5
6 Medical Supplies	12						6
7 Totals (sum of lines 1-7)							7

CALCULATION OF PER DIEM COST	PROVIDER NO: _____ HOSPICE NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET K-6

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (Worksheet K-5, Part I, col. 8, line 29 less col. 8, line 28 plus Worksheet K-5, Part III, col. 6, line 7) (see instructions)					1
2	Total Unduplicated Days (Worksheet S-5, line 5, col. 4)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-5, line 5, col. 1)					4
5	Aggregate Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Not Applicable)					6
7	Aggregate Medicaid cost (Not Applicable)					7
8	Unduplicated SNF days (Worksheet S-5, line 5, col. 2)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Not Applicable)					10
11	Aggregate NF cost (Not Applicable)					11
12	Other unduplicated days (Worksheet S-5, line 5, col. 3)					12
13	Aggregate cost for other days (line 3 times line 12)					13

NOTE: The data for the SNF on line 8 & 9 are included in the Medicare lines 4 & 5.

ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS

PROVIDER NO.: _____

CMHC NO.: _____

PERIOD:
FROM: _____
TO: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS

	CMHC COST CENTER (OMIT CENTS)	NET EXPENSES FOR COST ALLOCATION (1)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	SUBTOTAL (cols. 0-4)	A&G SHARED COSTS	SUB-TOTAL
			BLDGS & FIXTURES	MOVABLE EQUIPMENT					
		0	1	2	3	4	4A	5	6
1	Administrative and General								
2	Drugs and Biologicals								
3	Occupational Therapy								
4	Psychiatric/Psychological Services								
5	Individual Therapy								
6	Group Therapy								
7	Family Counseling								
8	Individualized Activity Therapy								
9	Diagnostic Therapy								
10	Patient Training and Education								
11	Other Part B Services								
12	TOTALS (Sum of lines 1-11) (2)								

(1) Column 0, line 12 must agree with Wkst. A, column 10, line 26.

(2) Columns 0 through 5, line 12 must agree with the corresponding columns of Wkst. B, line 26.

PART II - COMPUTATION OF UNIT COST MULTIPLIER FOR ALLOCATION OF CMHC ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 6, line 12
2	Amount from Part I, column 6, line 1
3	Line 1 minus line 2
4	Unit cost multiplier for CMHC A&G costs (Line 2 divided by line 3)(multiply each amount in column 6, lines 2 through 11, Part I, by the unit cost multiplier and enter the result on the corresponding line of column 7)

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COMPUTATION OF CMHC COSTS | PROVIDER NO.: _____ CMHC NO.: _____ | PERIOD: FROM: _____ TO: _____

PART I - APPORTIONMENT OF CMHC COST CENTERS

	CMHC COST CENTER (OMIT CENTS)	TOTAL COSTS (FROM SUPP. WKST. CM-1, PT. I, COL. 8) (1)	TOTAL CMHC CHARGES (2)	RATIO OF COSTS TO CHARGES (COL. 1 / COL. 2)	TOTAL TITLE XVIII CMHC CHARGES	TOTAL TITLE XVIII CMHC COSTS (COL. 3 x COL. 3.01)	TITLE XVIII CMHC CHARGES ON OR AFTER 8/1/00, 1/1/02, 1/1/03, or 1/1/04
		1	2	3	3.01	3.02	4
1	Administrative and General						
2	Drugs and Biologicals						
3	Occupational Therapy						
4	Psychiatric/Psychological Services						
5	Individual Therapy						
6	Group Therapy						
7	Family Counseling						
8	Individualized Activity Therapy						
9	Diagnostic Therapy						
10	Patient Training and Education						
11	Other Part B Services						
12	TOTALS (Sum of lines 2-11)						

	PART II - APPORTIONMENT OF COST OF CMHC SERVICES FURNISHED SHARED BY HHA DEPARTMENTS	Fr. Wkst. B, Col 6, Line:						
13	Occupational Therapy	8						
14	Medical Social Services	10						
15	Supplies	12						
16	Total (Sum of lines 13-15)							

(1) Cost for Part II, lines 13-15 are obtained from Worksheet B, column 6, lines as appropriate

(2) Charges for Part II, column 2 are total facility charges for each cost center and are obtained from provider records

	PART III - TOTAL CMHC COSTS	3.01	3.02	4
17	Total CMHC costs - Add the amount from Part I, column 6, line 12 and the amount from Part II, column 6, line 16. Add the amounts from Part I, line 12 and Part II, line 16 for columns 3.01, 3.02 and 4 through 6, respectively.			

Transfer the amount in Part III, column 6 to Worksheet CM-3, line 1, column 1. (see instructions)

	WORKSHEET CM-1 PARTS I & II

ALLOCATED CMHC A&G (SEE PART II)	TOTAL (SUM OF COLS 6 & 7)	
7	8	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12

		1
		2
		3
		4

WORKSHEET CM-2

TITLE XVIII CMHC COSTS ON OR AFTER 8/1/00, 1/1/02, 1/1/03, or 1/1/04 (COL 3 xCOL. 4)	TITLE XVIII CMHC COSTS PRIOR 8/1/00, 1/1/02, 1/1/03, or 1/1/04	
5	6	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16

5	6	
		17

ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS	PROVIDER NO.: _____ CMHC NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-1 PART III

PART III - ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS - STATISTICAL BASIS

	CMHC COST CENTER (OMIT CENTS)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE (SQUARE FEET)	TRANSPOR-TATION (MILEAGE)	RECONCIL-IATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COST)	
		BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
		1	2	3	4	5A	5	
1	Administrative and General							1
2	Drugs and Biologicals							2
3	Occupational Therapy							3
4	Psychiatric/Psychological Services							4
5	Individual Therapy							5
6	Group Therapy							6
7	Family Counseling							7
8	Individualized Activity Therapy							8
9	Diagnostic Therapy							9
10	Patient Training and Education							10
11	Other Part B Services							11
12	TOTALS (Sum of lines 1-11)							12
13	Total Cost to be Allocated							13
14	Unit Cost Multiplier							14

CALCULATION OF REIMBURSEMENT SETTLEMENT - CMHC SERVICES	PROVIDER NO.: _____ CMHC NO.:	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-3

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

	DESCRIPTION	1	1.01	
1	Total reasonable cost (see instructions)			1
1.01	CMHC PPS payments including outlier payments			1.01
1.02	1996 CMHC specific payment to cost ratio (obatin this ratio from your intermediary)			1.02
1.03	Line 1, column 1 times 1.02			1.03
1.04	Line 1.01 divided by line 1.03			1.04
1.05	CMHC transitional corridor payment (see instructions)			1.05
2	Total charges for CMHC Services			2

	CUSTOMARY CHARGES	1	1.01	
3	Amounts actually collected from patients liable for payments for services on a charge basis (from your records)			3
4	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(b)			4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)			5
6	Total Customary charges - title XVIII (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)			7
8	Excess of reasonable costs over customary charges (complete only if line 1 exceeds line 6)			8
9	Primary payer amounts			9

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT		1	1.01	
10	Cost of CMHC services (see instructions)			10
11	Part B deductible billed to Program patients (exclude coinsurance amounts)			11
12	Excess of reasonable costs (see instructions)			12
13	Net cost (line10 minus lines 11 and 12)			13
14	80% of Part B cost (80% x line 13) (see instructions)			14
15	Actual coinsurance billed to Program patients (from your records)			15
16	Net cost less actual billed coinsurance (Line 13 minus line 15)			16
17	Reimbursable bad debts (see instructions)			17
18	Net reimbursable amount (see instructions)			18
19	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			19
20	Recovery of excess depreciation resulting from facility's termination or a decrease in Program utilization			20
21	Other adjustments (specify)			21
22	Total Cost (Sum of line 18, columns 1 and 2, minus lines 19 and 20, plus line 21)			22
23	Sequestration adjustment			23
24	Amount due provider (Line 22 minus line 23)			24
25	Interim payments			25
25.5	Tentative settlement (for intermediary use only)			25.5
26	Balance due CMHC/Program (Line 24 minus line 25) (Indicate overpayments in brackets)			26
27	Protested amounts (see instructions)			27
28	Balance due CMHC/Program (Line 26 minus line 27) (Indicate overpayments in brackets)			28

ANALYSIS OF PAYMENTS TO PROVIDER FOR CMHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _____ CMHC NO.:	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-4

				PART B		
				1	2	
				mm/dd/yyyy	Amount	
1	Total interim payments paid to provider (CMHC services)					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a 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 a 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 3.01-3.05, minus sum of lines 3.50-3.54)		.99			3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99) (Transfer to Supp. Wkst CM-3, Part II, line 25)					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 a 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 5.01-5.03, minus sum of lines 5.50-5.52)		.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 PROGRAM LIABILITY (See Instructions)					7

Name of Intermediary — Intermediary Number

Signature of Authorized Person — Date: (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 the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

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ALLOCATION OF GENERAL SERVICE
COSTS TO RHC COST CENTERS

PROVIDER NO.: _____

RHC NO.: _____

PERIOD:
FROM: _____
TO: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO RHC COST CENTERS

	CMHC COST CENTER (OMIT CENTS)	NET EXPENSES FOR COST ALLOCATION (1)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	SUBTOTAL (cols. 0-4)	A&G SHARED COSTS
			BLDGS & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	4	4A	5
1	Administrative and General							
2	Physicians							
3	Nurse Practitioner							
4	Physician Assistant							
5	Clinical Psychologist							
6	Clinical Social Worker							
7	Visiting Nurses							
8	Other Part B Services							
9								
10	Drugs Charged to Patients							
11	TOTALS (Sum of lines 1-10) (2)							

(1) Column 0, line 11 must agree with Wkst. A, column 10, line 27.

(2) Columns 0 through 5, line 11 must agree with the corresponding columns of Wkst. B, line 27.

PART II - COMPUTATION OF UNIT COST MULTIPLIER FOR ALLOCATION OF RHC ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 6, line 11
2	Amount from Part I, column 6, line 1
3	Line 1 minus line 2
4	Unit cost multiplier for RHC A&G costs (Line 2 divided by line 3)(multiply each amount in column 6, lines 2 through 10, Part I, by the unit cost multiplier and enter the result on the corresponding line of column 7)

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COMPUTATION OF RHC COSTS	PROVIDER NO.: _____ RHC NO.: _____	PERIOD: FROM: _____ TO: _____

PART I - APPORTIONMENT OF RHC COST CENTERS

	RHC COST CENTER (OMIT CENTS)	TOTAL COSTS (FROM SUPP. WKST. RH-1, PT. I, COL. 8) (1)	TOTAL RHC CHARGES (2)
		1	2
1	Administrative and General		
2	Physicians		
3	Nurse Practitioner		
4	Physician Assistant		
5	Clinical Psychologist		
6	Clinical Social Worker		
7	Visiting Nurses		
8	Other Part B Services		
9	Subtotal (sum of lines 1-8)		
10	Drugs Charged to Patients (Transfer col. 5 to Worksheet D, col. 2, line 20)		
11	TOTALS (Sum of lines 9 and 10)		

PART II - APPORTIONMENT OF COST OF RHC SERVICES FURNISHED BY HHA DEPARTMENTS		Fr. Wkst. B Col 6, Line:		
12	Physical Therapy	7		
13	Occupational Therapy	8		
14	Speech Pathology	9		
15	Supplies	12		
17	Total (Sum of lines 12-15)			

(1) Cost for Part II, lines 12-15 are obtained from Worksheet B, column 6, lines as appropriate

(2) Charges for Part II, column 2 are total facility charges for each cost center and are obtained from provider records

PART III - TOTAL RHC COSTS

18	Total RHC costs - Add the amount from Part I, column 5, line 9 and the amounts from Part II, column 5, line 17

Transfer the amount in Part III, column 5 to Supplemental Worksheet D, column 3, line 2

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_____ _____	WORKSHEET RH-1 PARTS I & II

SUB-TOTAL	ALLOCATED RHC A&G (SEE PART II)	TOTAL (SUM OF COLS 6 & 7)	
6	7	8	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11

		1
		2
		3
		4

WORKSHEET RH-2

RATIO OF COSTS TO CHARGES (COL. 1 / COL. 2)	TITLE XVIII RHC CHARGES	TITLE XVIII RHC COSTS (COL. 3 X COL. 4)	
3	4	5	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			17
			18

ALLOCATION OF GENERAL SERVICE COSTS TO RHC COST CENTERS	PROVIDER NO.: _____ RHC NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RH-1 PART III

PART III - ALLOCATION OF GENERAL SERVICE COSTS TO RHC COST CENTERS - STATISTICAL BASIS

	RHC COST CENTER (OMIT CENTS)	CAPITAL-RELATED COSTS		PLANT OPERATION & MAINTE-NANCE (SQUARE FEET)	TRANSPOR-TATION (MILEAGE)	RECONCIL-IATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COST)	
		BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
		1	2	3	4	5A	5	
1	Administrative and General							1
2	Physicians							2
3	Nurse Practitioner							3
4	Physician Assistant							4
5	Clinical Psychologist							5
6	Clinical Social Worker							6
7	Visiting Nurses							7
8	Other Part B Services							8
9								9
10	Drugs Charged to Patients							10
11	TOTALS (Sum of lines 1-10)							11
12	Total Cost to be Allocated							12
13	Unit Cost Multiplier							13

ALLOCATION OF GENERAL SERVICE
COSTS TO FQHC COST CENTERS

PROVIDER NO.: _____
FQHC NO.: _____

PERIOD:
FROM: _____
TO: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO FQHC COST CENTERS

	FQHC COST CENTER (OMIT CENTS)	NET EXPENSES FOR COST ALLOCATION (1)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	SUBTOTAL (cols. 0-4)	A&G SHARED COSTS
			BLDGS & FIXTURES	MOVABLE EQUIPMENT				
		0	1	2	3	4	4A	5
1	Administrative and General							
2	Physicians							
3	Nurse Practitioner							
4	Physician Assistant							
5	Clinical Psychologist							
6	Clinical Social Worker							
7	Visiting Nurses							
8	Preventative Primary Services							
9	Other Part B Services							
10								
11	Drugs Charged to Patients							
12	TOTALS (Sum of lines 1-11) (2)							

(1) Column 0, line 12 must agree with Wkst. A, column 10, line 28.

(2) Columns 0 through 5, line 12 must agree with the corresponding columns of Wkst. B, line 28.

PART II - COMPUTATION OF UNIT COST MULTIPLIER FOR ALLOCATION OF FQHC ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 6, line 12
2	Amount from Part I, column 6, line 1
3	Line 1 minus line 2
4	Unit cost multiplier for FQHC A&G costs (Line 2 divided by line 3)(multiply each amount in column 6, lines 2 through 11, Part I, by the unit cost multiplier and enter the result on the corresponding line of column 7)

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3290 (Cont.)

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COMPUTATION OF FQHC COSTS	PROVIDER NO.: _____ FQHC NO.: _____	PERIOD: FROM: _____ TO: _____

PART I - APPORTIONMENT OF RHC COST CENTERS

	FQHC COST CENTER (OMIT CENTS)	TOTAL COSTS (FROM SUPP. WKST. FQ-1, PT. I, COL. 8) (1)	TOTAL FQHC CHARGES (2)
		1	2
1	Administrative and General		
2	Physicians		
3	Nurse Practitioner		
4	Physician Assistant		
5	Clinical Psychologist		
6	Clinical Social Worker		
7	Visiting Nurses		
8	Preventative Primary Services		
9	Other Part B Services		
10	Subtotal (sum of lines 1-9)		
11	Drugs Charged to Patients (Transfer col. 5 to Worksheet D, col. 2, line 20)		
12	TOTALS (Sum of lines 10and 11)		

	PART II - APPORTIONMENT OF COST OF FQHC SERVICES FURNISHED BY HHA DEPARTMENTS	Fr. Wkst. B Col 6, Line:		
13	Physical Therapy	7		
14	Occupational Therapy	8		
15	Speech Pathology	9		
16	Supplies	12		
18	Total (Sum of lines 13-16)			

(1) Cost for Part II, lines 13-16 are obtained from Worksheet B, column 6, lines as appropriate

(2) Charges for Part II, column 2 are total facility charges for each cost center and are obtained from provider records

PART III - TOTAL FQHC COSTS

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_____ _____	WORKSHEET FQ-1 PARTS I & II

SUB-TOTAL	ALLOCATED FQHC A&G (SEE PART II)	TOTAL (SUM OF COLS 6 & 7)	
6	7	8	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12

		1
		2
		3
		4

WORKSHEET FQ-2

RATIO OF COSTS TO CHARGES (COL. 1 / COL. 2)	TITLE XVIII FQHC CHARGES	TITLE XVIII FQHC COSTS (COL. 3 X COL. 4)	
3	4	5	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			18

ALLOCATION OF GENERAL SERVICE COSTS TO FQHC COST CENTERS	PROVIDER NO.: _____ FQHC NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET FQ-1 PART III

PART III - ALLOCATION OF GENERAL SERVICE COSTS TO FQHC COST CENTERS - STATISTICAL BASIS

	FQHC COST CENTER (OMIT CENTS)	CAPITAL-RELATED COSTS		PLANT OPERATION & MAINTE-NANCE (SQUARE FEET)	TRANSPOR-TATION (MILEAGE)	RECONCIL-IATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COST)	
		BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
		1	2	3	4	5A	5	
1	Administrative and General							1
2	Physicians							2
3	Nurse Practitioner							3
4	Physician Assistant							4
5	Clinical Psychologist							5
6	Clinical Social Worker							6
7	Visiting Nurses							7
8	Preventative Primary Services							8
9	Other Part B Services							9
10								10
11	Drugs Charged to Patients							11
12	TOTALS (Sum of lines 1-11)							12
13	Cost to be Allocated							13
14	Unit Cost Multiplier							14

ANALYSIS OF HHA-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO.: _____
COMPONENT NO.: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET RF-1

Check Applicable Box: [ ] RHC [ ] FQHC

		SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of col. 1 thru col. 5)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	FACILITY HEALTH CARE STAFF COSTS											
1	Physician											1
2	Physician Assistant											2
3	Nurse Practitioner											3
4	Visiting Nurse											4
5	Other Nurse											5
6	Clinical Psychologist											6
7	Clinical Social Worker											7
8	Laboratory Technician											8
9	Other Facility Health Care Staff Costs											9
10	Subtotal (sum of lines 1-9)											10
	COSTS UNDER AGREEMENT											
11	Physician Services Under Agreement											11
12	Physician Supervision Under Agreement											12
13	Other Costs Under Agreement											13
14	Subtotal (sum of lines 11-13)											14
	OTHER HEALTH CARE COSTS											
15	Medical Supplies											15
16	Transportation (Health Care Staff)											16
17	Depreciation-Medical Equipment											17
18	Professional Liability Insurance											18
19	Other Health Care Costs											19
20	Allowable GME Pass Through Costs											20
21	Subtotal (sum of lines 15-20)											21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)											22
	COSTS OTHER THAN RHC/FQHC SERVICES											
23	Pharmacy											23
24	Dental											24
25	Optometry											25
26	All other nonreimbursable costs											26
27	Non-allowable GME Pass Through Costs											27
28	Total Nonreimbursable Costs (sum of lines 23-27)											28
	FACILITY OVERHEAD											
29	Facility Costs											29
30	Administrative Costs											30
31	Total Facility Overhead (sum of lines 29 and 30)											31
32	Total facility costs (sum of lines 22, 28 and 31)											32

The net expenses for cost allocation on Worksheet A for the applicable RHC/FQHC cost center line must equal the total facility costs in column 10, line 30 of this worksheet for cost reporting periods beginning on or after January 1, 1998.

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-2
Check Applicable Box:	[ ] RHC [ ] FQHC		

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1x col. 3)	Greater of Col. 2 or Col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Total FTEs and Visits (sum of lines 4-7)						8
9	Physician Services Under Agreements						9

(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted, (Worksheet S-4, line 13 equals "Y"), then input in column 3, lines 1-3, the productivity standards derived by the fiscal intermediary.

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Worksheet RF-1, column 10, line 22 less the amount from Worksheet RF-1, column 10, line 20)		10
11	Total nonreimbursable costs (from Worksheet RF-1, column 10, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		13
14	Total facility overhead - (from Worksheet RF-1, column 10, line 31) (see instructions)		14
15	Allowable GME Overhead (see instructions)		15
16	Net Facility Overhead (line 14 minus line 15)		16
17	Parent provider overhead allocated to facility (see instructions)		17
18	Total overhead (sum of lines 16 and 17)		18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-3
Check Applicable Box:	[ ] RHC [ ] FQHC		

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total Allowable Cost of RHC/FQHC Services (from Worksheet RF-2, line 20)		1
2	Cost of vaccines and their administration (from Worksheet RF-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total FTEs and Visits (from Wkst. RF-2, col. 5, line 8)		4
5	Physicians visits under agreement (from Worksheet RF-2, column 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

		Calculation of Limit (1)			
		Rate Period 1	Rate Period 2	Rate Period 3	
		1	2	3	
8	Per visit payment limit (from your intermediary)				8
9	Rate for Medicare covered visits (lesser of line 7 or line 8) (See instructions)				9

CALCULATION OF SETTLEMENT

10	Medicare covered visits excluding mental health services (from intermediary records)				10
11	Medicare cost excluding costs for mental health services (line 9 x line 10)				11
12	Medicare covered visits for mental health services (from intermediary records)				12
13	Medicare covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (line 13 x 62.5%)				14
				1	
15	Graduate Medical Education Pass Through Cost (see instructions)				15
15.5	Primary Payer Amounts				15.5
16	Total Medicare cost (line 11, columns 1, 2 & 3 plus line 14, columns 1, 2, & 3 plus column 1, line 15 minus \line 15.5)				16
17	Less: Beneficiary deductible (from intermediary records)				17
18	Net Medicare cost excluding vaccines (line 16 minus line 17)				18
19	Reimbursable cost of RHC/FQHC services, excluding vaccine (80% of line 18)				19
20	Medicare cost of vaccines and their administration (from Worksheet. RF-4, line 16)				20
21	Total reimbursable medicare cost (line 19 plus line 20)				21
22	Reimbursable bad debts				22
23	Other adjustments (specify)				23
24	Net reimbursable amounts (sum of lines 21, 22 and 23)				24
25	Interim payments (From Worksheet RF-5, line 4)				25
25.5	Tentative settlement (For intermediary use only)				25.5
26	Balance due component/program (line 24 minus line 25)				26
27	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2				27

(1) Enter chronologically in columns 1, 2, and 3, as applicable, the payment limit and corresponding data.

FORM CMS-1728-94-RF-3 (3-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3236 - 3236.1)

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-4
Check Applicable Box:	[ ] RHC [ ] FQHC		

DO NOT COMPLETE THIS WORKSHEET. SEE INSTRUCTIONS.

		PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Worksheet RF-1, column 10, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Worksheet RF-1, column 10, line 22)			6
7	Total overhead (from Worksheet RF-2, line 18)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10/ line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			14

15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet RF-3, line 2)		15
16	Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet RF-3, line 20)		16

ANALYSIS OF PAYMENTS TO PROVIDER-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	SUPPLEMENTAL WORKSHEET RF-5

Check Applicable Box: [ ] RHC [ ] FQHC

	DESCRIPTION			PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to RHC/FQHC					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a 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 a 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 Supp. Wkst RF-3, Part II, line 25)					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 a 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 PROGRAM LIABILITY (See Instructions)					7

Name of Intermediary Intermediary Number

Signature of Authorized Person Date: (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 the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.