This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Completion of this report is viewed as a condition of your provider agreement.

FORM APPR
OMB NO. 09

HOSPICE COST AND DATA REPORT		PROVIDER NO.:	PERIOD: FROM TO	WORKSHEE
Intermediary use only	[ ] Audited [ ] Desk Reviewed	Date Received: Intermediary No.		[ ] Initial [ ] Reopening [ ] Final

CERTIFICATION

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 PRODUCED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMI CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____(Provider Names(s) and Number(s)) for the cost reporting period beginning and ending and that to the best of my knowledge and belief, it is a true, correct and complete statement 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 Administrator of Provider(s)

_____
Title

_____
Date

_____
Phone Number: Area Code

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 0938-0758. 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 nee 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.

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HOSPICE IDENTIFICATION DATA	PROVIDER NO.:	PERIOD: FROM: TO:	WORKSHEET S-1

PART I

1	Name:	Address:	City:	State:	Zip Code:	1
2	County where the hospice is located					2
3	Hospice began operation (mm/dd/yyyy)				Date	3
4	Certification date (mm/dd/yyyy)			Dated certified Title XVIII	Dated certified Title XIX	4
5	Cost Reporting Period (mm/dd/yyyy)	From:		To:		5
6	Provider Identification Number					6
6.01	National Provider Identier (NPI) Number					6.01
7	Type of Control (see instructions)					7

PART II

	Enrollment Days	Title XVIII Unduplicated Medicare Days	Title XIX Unduplicated Medicaid Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Title XIX Unduplicated Nursing Facility Days	Other Unduplicated	Total Unduplicated Days	
		1	2	3	4	5	6	
8	Continuous Home Care							8
9	Routine Home Care							9
10	Inpatient Respite Care							10
11	General Inpatient Care							11
12	Total Hospice Days							12

PART III

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	Other	Total	
		1	2	3	4	5	6	
13	Number of Patients Receiving Hospice Care							13
14	Total Number of Unduplicated Countinuous Care Hours Billable to Medicare							14
15	Average Length of Stay							15
16	Unduplicated Census Count							16
17	If the hospice componentized (or fragmented) its administrative and general service costs, indicate whether option one or two is being utilized (See PRM-II, Section 3820) (Enter "1"for option one and "2" for option two)							17
18	Are there any related organization or home office costs as defined in CMS Pub. 15-I, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain home office provider number in column 2.							18

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

		COST CENTER DESCRIPTIONS	SALARIES (From Wkst A-1)	EMPLOYEE BENEFITS (From Wkst A-2)	TRANSPOR-TATION (See inst.)	CON-TRACTED SERVICES (From Wkst A-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease) (Fr Wkst A-6)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease) (Fr Wkst A-8 & A-8-1)	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 Fixtures										
2	###	Capital Related Costs-Movable Equipment										
3	###	Plant Operation and Maintenance										
4	###	Transportation - Staff										
5	###	Volunteer Service Coordination										
6	###	Administrative and General										
		INPATIENT CARE SERVICE										
10	###	Inpatient - General Care										
11	###	Inpatient - Respite Care										
		VISITING SERVICES										
15	###	Physician Services										
16	###	Nursing Care										
16.01	###	Nursing Care -- Continuous Home Care										
17	###	Physical Therapy										
18	###	Occupational Therapy										
19	###	Speech/ Language Pathology										
20	###	Medical Social Services										
21	###	Spiritual Counseling										
22	###	Dietary Counseling										
23	###	Counseling - Other										
24	###	Home Health Aide and Homemaker										
24.01	###	HH Aide & Homemaker -- Cont Home Care										
25		Other										

HH Aide & Homemaker -- Cont Hm Care

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

		COST CENTER DESCRIPTIONS	SALARIES (From Wkst A-1)	EMPLOYEE BENEFITS (From Wkst A-2)	TRANSPOR-TATION (See inst.)	CONT-RACTED SERVICES (From Wkst A-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease) (Fr Wkst A-6)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease) (Fr Wkst A-8)	TOTAL (col.8±col.9)
			1	2	3	4	5	6	7	8	9	10
		OTHER HOSPICE SERVICE COSTS										
30	###	Drugs, Biological and Infusion Therapy										
30.01	###	Analgesics										
30.02	###	Sedatives / Hypnotics										
30.03	###	Other -- Specify										
31	###	Durable Medical Equipment/Oxygen										
32	###	Patient Transportation										
33	###	Imaging Services										
34	###	Labs and Diagnostics										
35	###	Medical Supplies										
36	###	Outpatient Services (incl. E/R Dept.)										
37	###	Radiation Therapy										
38	###	Chemotherapy										
39		Other										
		HOSPICE NONREIMBURSABLE SERV.										
50	###	Bereavement Program Costs										
51	###	Volunteer Program Costs										
52	###	Fundraising										
53		Other Program Costs										
100		Total										

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COMPENSATION ANALYSIS SALARIES AND WAGES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

COMPENSATION ANALYSIS SALARIES AND WAGES				PROVIDER NO:		PERIOD: FROM TO			WORKSHEET A-1
	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	OTHER HOSPICE SERVICE COSTS									
30	Drugs, Biological and Infusion Therapy									
30.01	Analgesics									
30.02	Sedatives / Hypnotics									
30.03	Other -- Specify									
31	Durable Medical Equipment/Oxygen									
32	Patient Transportation									
33	Imaging Services									
34	Labs and Diagnostics									
35	Medical Supplies									
36	Outpatient Services (incl. E/R Dept.)									
37	Radiation Therapy									
38	Chemotherapy									
39	Other									
	HOSPICE NONREIMBURSABLE SERV.									
50	Bereavement Program Costs									
51	Volunteer Program Costs									
52	Fundraising									
53	Other Program Costs									
100	Total									

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

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Rev. 7

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)			PROVIDER NO:		PERIOD: FROM TO				WORKSHEET A-2
	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	OTHER HOSPICE SERVICE COSTS									
30	Drugs, Biological and Infusion Therapy									
30.01	Analgesics									
30.02	Sedatives / Hypnotics									
30.03	Other -- Specify									
31	Durable Medical Equipment/ Oxygen									
32	Patient Transportation									
33	Imaging Services									
34	Labs and Diagnostics									
35	Medical Supplies									
36	Outpatient Services (incl. E/R Dept.)									
37	Radiation Therapy									
38	Chemotherapy									
39	Other									
	HOSPICE NONREIMBURSABLE SERV.									
50	Bereavement Program Costs									
51	Volunteer Program Costs									
52	Fundraising									
53	Other Program Costs									
100	Total									

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

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Rev. 7

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET A-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	OTHER HOSPICE SERVICE COSTS									
30	Drugs, Biological and Infusion Therapy									
30.01	Analgesics									
30.02	Sedatives / Hypnotics									
30.03	Other -- Specify									
31	Durable Medical Equipment/Oxygen									
32	Patient Transportation									
33	Imaging Services									
34	Labs and Diagnostics									
35	Medical Supplies									
36	Outpatient Services (incl. E/R Dept.)									
37	Radiation Therapy									
38	Chemotherapy									
39	Other									
	HOSPICE NONREIMBURSABLE SERV.									
50	Bereavement Program Costs									
51	Volunteer Program Costs									
52	Fundraising									
53	Other Program Costs									
100	Total									

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

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Rev. 7

RECLASSIFICATIONS ADJUSTMENTS TO EXPENSES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES			
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	6	7	8	9
1										
2										
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###	Total reclassifications (sum of col. 4 and 5 must equal sum of col. 8 and 9)									

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 5, lines as appropriate.

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ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donation	Total			
		1	2	3	4	5	6	
1	Land							1
2	Land Improvements							2
3	Buildings and Fixtures							3
4	Building Improvements							4
5	Fixed Equipment							5
6	Movable Equipment							6
7	Subtotal (sum of lines 1-6)							7
8	Reconciling Items							8
9	Total (line 7 minus line 8)							9

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

	(1) Description	(2) BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE NO.	
		1	2	3	4	
1	Investment income on restricted funds (chapter 2)					1
2	Telephone services (pay stations excluded) (chapter 21)					2
3	Adjustment resulting from transactions with Related Organizations (chapter 10) and Home office costs (chapter 21)	Worksheet A-8-1				3
4	Revenue - Employee meals, Guests					4
5	Income from imposition of interest, finance or penalty charges (chapter 21)					5
6	Bad Debts Included on Trial Balance					6
7	Patient Personal Purchases					7
8	Miscellaneous Adjustments					8
9	Depreciation--buildings and fixtures			Buildings & Fixtures	1	9
10	Depreciation--movable equipment			Movable Equipment	2	10
11	TOTAL (sum of lines 1 - 10) (Transfer to Worksheet A, col. 9, line 100)					11

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

(2) Basis for adjustment

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

B. Amount Received--if cost cannot be determined.

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

A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs, and/or related organization:

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

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

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

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

* The amounts on lines 1-4 and subscripts as appropriate are transferred in detail to Worksheet A, column 9, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

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

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

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COST ALLOCATION BASED ON SERVICE COST CENTERS		PROVIDER NO:		PERIOD: FROM TO								

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03
	GENERAL SERVICE COST CENTERS												
1	Capital Related Costs-Bldg and Fixtures												
2	Capital Related Costs-Movable Equipment												
3	Plant Operation and Maintenance												
4	Transportation - Staff												
5	Volunteer Service Coordination												
6	Administrative and General												
6.01	A & G Shared Costs												
6.02	A & G Reimbursable Costs												
6.03	A & G Nonreimbursable Costs												
	INPATIENT CARE SERVICE												
10	Inpatient - General Care												
11	Inpatient - Respite Care												
	VISITING SERVICES												
15	Physician Services												
16	Nursing Care												
16.01	Nursing Care -- Continuous Home Care												
17	Physical Therapy												
18	Occupational Therapy												
19	Speech/ Language Pathology												
20	Medical Social Services												
21	Spiritual Counseling												
22	Dietary Counseling												
23	Counseling - Other												
24	Home Health Aide and Homemaker												
24.01	HH Aide & Homemaker -- Cont Home Care												
25	Other												

COST ALLOCATION BASED ON SERVICE COST CENTERS					PROVIDER NO:		PERIOD: FROM TO						
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03
	OTHER HOSPICE SERVICE COSTS												
30	Drugs, Biologicals and Infusion												
30.01	Analgesics												
30.02	Sedatives / Hypnotics												
30.03	Other -- Specify												
31	Durable Medical Equipment/Oxygen												
32	Patient Transportation												
33	Imaging Services												
34	Labs and Diagnostics												
35	Medical Supplies												
36	Outpatient Services (incl. E/R Dept.)												
37	Radiation Therapy												
38	Chemotherapy												
39	Other												
	HOSPICE NONREIMBURSABLE SERV.												
50	Bereavement Program Costs												
51	Volunteer Program Costs												
52	Fundraising												
53	Other Program Costs												
100	Total												

WORKSHEET B

	TOTAL
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WORKSHEET B

TOTAL	
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FORM CMS-1984-99

COST ALLOCATION - STATISTICAL BASIS	PROVIDER NO:	PERIOD: FROM TO

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION (MILEAGE)	VOLUNTEER SERVICE COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	A & G SHARED COSTS (ACC. COST)	A & G REIMB. COSTS (ACC. COST)
		1	2	3	4	5	6A	6	6.01	6.02
	GENERAL SERVICE COST CENTERS									
1	Capital Related Costs-Buildings and Fixtures									
2	Capital Related Costs-Movable Equipment									
3	Plant Operation and Maintenance									
4	Transportation-staff									
5	Volunteer Service Coordination									
6	Administrative and General									
6.01	A & G Shared Costs									
6.02	A & G Reimbursable Costs									
6.03	A & G Nonreimbursable Costs									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

COST ALLOCATION - STATISTICAL BASIS	PROVIDER NO:	PERIOD: FROM TO

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION MILEAGE	VOLUNTEER SERVICE COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	A & G SHARED COSTS (ACC. COST)	A & G REIMB. COSTS (ACC. COST)
		1	2	3	4	5	6A	6	6.01	6.02
	OTHER HOSPICE SERVICE COSTS									
30	Drugs, Biologicals and Infusion									
30.01	Analgesics									
30.02	Sedatives / Hypnotics									
30.03	Other -- Specify									
31	Durable Medical Equipment/Oxygen									
32	Patient Transportation									
33	Imaging Services									
34	Labs and Diagnostics									
35	Medical Supplies									
36	Outpatient Services (incl. E/R Dept.)									
37	Radiation Therapy									
38	Chemotherapy									
39	Other									
	HOSPICE NONREIMBURSABLE SERV.									
50	Bereavement Program Costs									
51	Volunteer Program Costs									
52	Fundraising									
53	Other Program Costs									
100	Cost To be Allocated (per Wkst B)									
101	Unit Cost Multiplier									

WORKSHEET B-1

A & G NON-REIMB. COSTS (ACC. COST)	
6.03	
	1
	2
	3
	5
	5
	6
	6.01
	6.02
	6.03
	10
	11
	15
	16
	16.01
	17
	18
	19
	20
	21
	22
	23
	24
	24.01
	25

WORKSHEET B-1

A & G NON-REIMB. COSTS (ACC. COST)	
6.03	
	30
	30.01
	30.02
	30.03
	31
	32
	33
	34
	35
	36
	37
	38
	39
	50
	51
	52
	53
	100
	101

CALCULATION OF PER DIEM COST	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET D

	COMPUTATION OF PER DIEM COST	TITLE XVIII (1)	TITLE XIX (2)	OTHER (3)	TOTAL (4)
1	Total cost (Worksheet B, line 100, col 7, less line 53, col. 7)				
2	Total Unduplicated Days (Worksheet S-1, line 12, col. 6)				
3	Average cost per diem (line 1 divided by line 2)				
4	Unduplicated Medicare Days (Worksheet S-1, line 12, col.1)				
5	Average Medicare cost (line 3 times line 4)				
6	Unduplicated Medicaid Days (Worksheet S-1, line 12, col. 2)				
7	Average Medicaid cost (line 3 times line 6)				
8	Unduplicated SNF days (Worksheet S-1, line 12, col. 3)				
9	Average SNF cost (line 3 times line 8)				
10	Unduplicated NF days (Worksheet S-1, line 12, col. 4)				
11	Average NF cost (line 3 times line 10)				
12	Other Unduplicated days (Worksheet S-1, line 12, col. 5)				
13	Average cost for other days (line 3 times line 12)				
14	Total cost (see instructions)				
15	Total days (see instructions)				

nt.)

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)		PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G	
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	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: allowances 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 Amortization					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 Other assets					31
32 TOTAL OTHER ASSETS (Sum of lines 28 - 31)					32
33 TOTAL ASSETS (Sum of lines 11, 27, and 32)					33

( ) = contra amount

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

PROVIDER NO:

PERIOD:
FROM
TO

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund
		1	2	3
	CURRENT LIABILITIES			
34	Accounts payable			
35	Salaries, wages & fees payable			
36	Payroll taxes payable			
37	Notes & loans payable (Short term)			
38	Deferred income			
39	Accelerated payments			
40	Due to other funds			
41	Other current liabilities			
42	TOTAL CURRENT LIABILITIES (Sum of lines 34 - 41)			
	LONG TERM LIABILITIES			
43	Mortgage payable			
44	Notes payable			
45	Unsecured loans			
46	Loans from owners: a. Prior to 7/1/66 b. On or after 7/1/66			
47	Other long term liabilities			
48				
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43 - 48)			
50	TOTAL LIABILITIES (Sum of lines 42 and 49)			
	CAPITAL ACCOUNTS			
51	General fund balance			
52	Specific purpose fund			
53	Donor created - endowment fund balance - restricted			
54	Donor created - endowment fund balance - unrestricted			
55	Governing body created - endowment fund balance			
56	Plant fund balance - invested in plant			
57	Plant fund balance - reserve for plant improvement, replacement and expansion			
58	TOTAL FUND BALANCES (Sum of lines 51 thru 57)			
59	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 50 and 58)			

( ) = contra amount

WORKSHEET G
(Cont.)

Plant Fund 4	
	34
	35
	36
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
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	53
	54
	55
	56
	57
	58
	59

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER NO:	PERIOD: FROM TO

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND
		1	2	3
1	Fund balances at beginning of period			
2	Net income (loss) (From Wkst. G-2, line 16)			
3	Total (Sum of line 1 and line 2)			
4	Additions (Credit adjustments) (Specify)			
5				
6				
7				
8				
9				
10	Total additions (Sum of lines 4 - 9)			
11	Subtotal (Line 3 plus line 10)			
12	Deductions (Debit adjustments) (Specify)			
13				
14				
15				
16				
17				
18	Total deductions (Sum of lines 12 - 17)			
19	Fund balance at end of period per balance sheet (Line 11 minus line 18)			

WORKSHEET G - 1

PLANT FUND	
4	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16
	17
	18
	19

09-00 FORM CMS 1984-99

STATEMENT OF PATIENT REVENUES AND NET INCOME	PROVIDER NO:	PERIOD: FROM TO

PART I - PATIENT REVENUES

	Revenue Center
	GENERAL INPATIENT AND HOME CARE SERVICE LOCATION
1	Skilled Nursing Facility based
2	Nursing facility based
3	Home care
4	Other (See Instructions)
5	State Medicaid room & board
6	Total General Inpatient Revenues (Sum of lines 1, 2, 3 and 4)

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 6, Line 100)	
2	Add (Specify)	
3		
4		
5		
6		
7		
8	Total Additions (Sum of lines 2 - 7)	
9	Deduct (Specify)	
10		
11		
12		
13		
14	Total Deductions (Sum of lines 9 - 13)	
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)	
16	Net Income (or loss) for the period (Line 6 minus line 15)	

WORKSHEET G - 2
PARTS I & II

TOTAL	
	1
	2
	3
	4
	5
	6

	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14
	15
	16