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 CCN: _____	PERIOD: From: _____ To: _____	WORKSHEET S

Contractor Use Only:

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

PART I - CERTIFICATION

Check applicable box	[ ]	Electronically filed cost report	Date: _____
	[ ]	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 *ADMINISTRATOR* OF THE *PROVIDER(S)*

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted 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*ing period* beginning _____and ending _____, and that to the best of my knowledge and belief, this report and statement are true, correct, complete and 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 22*7* 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." *Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.*

HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD: From: _____ To: _____	WORKSHEET S-2

Home Health Agency Complex Address:

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

Home Health Agency Component Identification

	Component	Component Name	Provider *CCN*	Date Certified	
	0	1	2	3	
2	Home Health Agency				2
3	HHA-based CORF				3
3.50	HHA-based Hospice				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 (*see* 42 CFR 413.24(d))?		20
21	Does the HHA qualify as a nominal charge provider (*see* 42 CFR 409.3)?		21
22	Does the HHA contract with outside suppliers for physical therapy services?		22
22.01	Does the HHA contract with outside suppliers for occupational therapy services?		22.01
22.02	Does the HHA 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	HHA			23
24	CORF			24
25	CMHC			25
26	If the HHA componentized (or fragmented) its administrative and general service costs, indicate whether option one or option two is being utilized. (See 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
29	If you are part of a chain organization, enter "Y" for yes and enter the name and address of the home office, otherwise, enter "N" for no.				29
29.01	Home Office Name:	Home Office No. :		Contractor No. :	29.01
29.02	Street:	P.O. Box:	Contractor Name:		29.02
29.03	City:	State:	Zip Code:		29.03

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

HOME HEALTH AGENCY REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2-1

General Instruction: For all column 1 responses, enter "Y" for YES of "N" for NO
Enter all dates in the format (mm/dd/yyyy)

COMPLETED BY ALL HHAs

		Y/N	Date	V/I	
	Provider Organization and Operation	1	2	3	
1	Has the HHA changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is yes, enter the date of the change in column 2. (see instructions)				1
2	Has the HHA terminated participation in the Medicare program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)				2
3	Is the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3
		Y/N	Type	Date	
	Financial Data and Reports	1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If column 1 is yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

		Y/N	
	Bad Debts		
6	Is the HHA or HHA-based entities seeking reimbursement for bad debts? If yes, see instructions.		6
7	If line 6 is yes, did the HHA's bad debt collection policy change during this cost reporting period? If yes, submit copy.		7
8	If line 6 is yes, were patient coinsurance amounts waived? If yes, see instructions.		8

		Y/N	Date	
	PS&R Report Data	1	2	
9	Was the cost report prepared using the PS&R Report only? If column 1 is yes, enter the paid-through date of the PS&R Report used in column 2. (see instructions)			9
10	Was the cost report prepared using the PS&R Report for totals and the HHA's records for allocation? If column 1 is yes, enter the paid-through date in column 2. (see instructions)			10
11	If line 9 or 10 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: _____			13
14	Was the cost report prepared only using the HHA's records? If yes, see instructions.			14

Cost Report Preparer Contact Information

15	First name:	Last name:	Title:	15
16	Employer:			16
17	Phone number:	E-mail Address:		17

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER *CCN*: _____	PERIOD: From: _____ To: _____	WORKSHEET S-3 PARTS I - III

PART I - STATISTICAL DATA COUNTY _____

	DESCRIPTION	Title XVIII Visits	Title XVIII Patients	Other Visits	Other Patients	Total Visits	Total 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) AND CORE BASED STATISTICAL AREA (CBSA) CODES

		1	1.01	
28	Enter the total number of MSAs in column 1 and/or CBSAs in column 2 where Medicare covered services were provided during the cost reporting period.			28
29	List all MSA and CBSA codes in which Medicare covered home health services were provided during the cost reporting period (line 29 contains the first code):	MSA Codes	CBSA Codes	29
				29.01
				29.02
				29.03
				29.04
				29.05
				29.06
				29.07
				29.08
				29.09

FORM CMS-1728-94 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TION* 3205)

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER *CCN*: _____	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 RHC/FQHC STATISTICAL DATA	PROVIDER CCN: _____ *FQHC/RHC* CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-4

Check Applicable Box	[ ] *HHA-Based* RHC [ ] *HHA-Based* FQHC

Clinic*/Center* 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	Date	
		1	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*/center* 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 *HHA-based RHC/FQHC* 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*/center* 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 *HHA-based RHC/FQHC* 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 *clinics/centers* included in this report. List all *clinic/centers* names and numbers below.		14
15	*Clinic/Center* name: _____ *Clinic/Center* number: _____		15
15.01	*Clinic/Center* name: _____ *Clinc/Center* number: _____		15.01
15.02	*Clinic/Center* name: _____ *Clinic/Center* number: _____		15.02
15.03	*Clinic/Center* name: _____ *Clinic/Center* number: _____		15.03

		Y/N	XVIII	TOTAL	
		1	2	3	
16	Are you claiming allowable GME costs as a result of "substantial payment" for interns and residents? If yes, enter the number of Medicare visits in column 2 and total visits in column 3 performed by interns and residents and complete Worksheet RF-1, lines 20 and 27 as applicable.				16

HHA-BASED HOSPICE IDENTIFICATION DATA	PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-5

PART I - *ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015*

	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	*Hospice* Continuous Home Care					1
2	*Hospice* Routine Home Care					2
3	*Hospice* Inpatient Respite Care					3
4	*Hospice* General Inpatient Care					4
5	Total Hospice Days					5

PART II - *CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015*

	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.

PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Unduplicated Days				
		Title XVIII Medicare	*Title XIX Medicaid*	*Other*	*Total*	
		1	*2*	*3*	*4*	
10	*Hospice Continuous Home Care*					*10*
11	*Hospice Routine Home Care*					*11*
12	*Hospice Inpatient Respite Care*					*12*
13	*Hospice General Inpatient Care*					*13*
14	*Total Hospice Days*					*14*

PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

		Title XVIII Medicare	*Title XIX Medicaid*	*Other*	*Total*	
		1	*2*	*3*	*4*	
15	*Hospice Inpatient Respite Care*					*15*
16	*Hospice General Inpatient Care*					*16*

Removed and Reserved
Pages 32-307

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER *CCN*: _____ | PERIOD: From: _____ To: _____ | WORKSHEET A

			SALARIES (Fr Wks A-1)	EMPLOYEE BENEFITS (Fr Wks A-2)	TRANSPOR-TATION (See Instructions)	CON-TRACTED 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
13.20	1320	Cost of Administering Vaccines											13.20
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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TION* 3206)

COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER *CCN*: _____

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 *CCN*: _____

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

COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER *CCN*: _____

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 *CCN*: _____ | 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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TION* 3210)

ADJUSTMENTS TO EXPENSES	PROVIDER *CCN*: _____	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				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 *CCN*: _____	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						
3						
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 Social Security 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 Social Security 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 *CCN*: _____	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 *CCN*: _____	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 *CCN*: _____	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 *CCN*: _____ | PERIOD: From: _____ To: _____ | WORKSHEET B

		NET EXPENSES FOR COST ALLOCATION (FR.WKST A, COL10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINISTRA-TIVE & GENERAL	TOTAL	
			BLDGS & & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4A	5	6	
	GENERAL SERVICE COST CENTERS									
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 (See Instructions)									12
13	Drugs									13
13.20	Cost of Administering Vaccines									13.20
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 CENTER									
24	CORF									24
25	Hospice									25
26	CMHC									26
27	RHC									27
28	FQHC									28
29	Total									29

COST ALLOCATION - STATISTICAL BASIS | PROVIDER *CCN*: _____ | PERIOD: From: _____ To: _____ | WORKSHEET B-1

	COST CENTER	CAPITAL RELATED COSTS: BLDGS & & FIXTURES (SQUARE FEET)	CAPITAL RELATED COSTS: MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL (ACCUMU-LATED COST)	TOTAL	
		1	2	3	4	5A	5	6	
	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 (See Instructions)								12
13	Drugs								13
13.20	Cost of Administering Vaccines								13.20
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 CENTER								
24	CORF								24
25	Hospice								25
26	CMHC								26
27	RHC								27
28	FQHC								28
29	Total								29
30	Cost To Be Allocated (Per Wkst B)								30
31	Unit Cost Multiplier								31

FORM CMS-1728-94-B-1 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TION* 3214)

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: From: _____ To: _____ | WORKSHEET C PARTS I & II

PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATION

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

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

MSA/CBSA 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 Services			Total (Sum of Cols 8 & 9)	
					Part B			Part B			
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			4	5	6	7	8	9	10	11	
1	Skilled Nursing	1									1
2	Physical Therapy	2									2
3	Occupational Therapy	3									3
4	Speech Pathology	4									4
5	Medical Social Services	5									5
6	Home Health Aide Services	6									6
7	Total (Sum of lines 1-6)										7

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

(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.

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: From: _____ To: _____ | WORKSHEET C PARTS III, IV & V

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			Cost of Services			
							Part B			Part B		
						Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	8	9	10	
15	Cost of Medical Supplies	12										15
16	Cost of Drugs	13										16
16.20	Cost of Drugs	13.20										16.20

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/CBSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA CBSA/Non-CBSA (From Your Contractor)	Cost of Medicare Services				
					Part B			
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total (Sum of Cols 3 & 4	
		1	2	3	4	5	6	
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))							17
18	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))							18
19	Total (Sum of lines 17 and 18)							19
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)							20
21	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))							21
22	Total (Sum of lines 20 and 21)							22

		MSA/CBSA Code (3)							
									(Col 1 x 2)
		0	1	2	3	4	5	6	
23	Per Beneficiary Cost Limitation for MSA/CBSA:								23
23.01	Per Beneficiary Cost Limitation for MSA/CBSA:								23.01
23.02	Per Beneficiary Cost Limitation for MSA/CBSA:								23.02
23.03	Per Beneficiary Cost Limitation for MSA/CBSA:								23.03
23.04	Per Beneficiary Cost Limitation for MSA/CBSA:								23.04
23.05	Per Beneficiary Cost Limitation for MSA/CBSA:								23.05
23.06	Per Beneficiary Cost Limitation for MSA/CBSA:								23.06
23.07	Per Beneficiary Cost Limitation for MSA/CBSA:								23.07
23.08	Per Beneficiary Cost Limitation for MSA/CBSA:								23.08
23.09	Per Beneficiary Cost Limitation for MSA/CBSA:								23.09
24	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)								24

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	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
		1	2	3	4	5	5.01	5.02	6	7	8	
25	Physical Therapy	2										25
26	Occupational Therapy	3										26
27	Speech Pathology	4										27
28	Total (Sum of lines 25-27)											28

(3) The MSA/CBSA 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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TIONS* 3215 - 3215.5)

CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES	PROVIDER CCN: _____	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
25.50	Other Adjustments (see instructions) (specify)			25.50
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 *contractor* 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. 15-2, 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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TIONS* 3216 *THROUGH* 3216.2)

ANALYSIS OF PAYMENTS TO HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER *CCN*: _____	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 *contractor*, 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 *CONTRACTOR*							
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
	"NONE" or enter a zero. (1)	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 *Contractor*	*Contractor* 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.

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 *CCN*: _____

PERIOD:
From: _____
To: _____

WORKSHEET F

	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: 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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SEC*TION* 3218)

STATEMENT OF REVENUE AND EXPENSES	PROVIDER *CCN*: _____	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

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER *CCN*: _____ | 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

Removed and Reserved
Pages 32-327 - 32-331

ANALYSIS OF HOSPICE COSTS

PROVIDER *CCN*: _____

HOSPICE *CCN*: _____

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
10.20	Nursing Care - Continuous Home Care											10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care											18.20
19	Other											19
	OTHER HOSPICE SERVICE COSTS											
20	Drugs, Biological and Infusion Therapy											20
20.30	Analgesics											20.30
20.31	Sedatives/Hypnotics											20.31
20.32	Other - specify											20.32
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.

HOSPICE COMPENSATION ANALYSIS - SALARIES AND WAGES | PROVIDER *CCN*: _____ HOSPICE *CCN*: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-1

	COST CENTER DESCRIPTIONS	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
10.20	Nursing Care - Continuous Home Care										10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3241)

HOSPICE COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER *CCN*: _____

HOSPICE *CCN*: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET K-2

	COST CENTER DESCRIPTIONS	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
10.20	Nursing Care - Continuous Home Care										10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3242)

HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER *CCN*: _____
HOSPICE *CCN*: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET K-3

	COST CENTER DESCRIPTIONS	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
10.20	Nursing Care - Continuous Home Care										10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3243)

HOSPICE COST ALLOCATION - GENERAL SERVICE COST | PROVIDER *CCN*: _____ HOSPICE *CCN*: _____ | 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
10.20	Nursing Care - Continuous Home Care										10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biologicals and Infusion										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
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 (*draft*) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 3244)

HOSPICE COST ALLOCATION - STATISTICAL BASIS | PROVIDER *CCN*: _____ HOSPICE *CCN*: _____ | 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
10.20	Nursing Care - Continuous Home Care								10.20
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
18.20	Home Health Aide and Homemaker-Cont Home Care								18.20
19	Other								19
	OTHER HOSPICE SERVICE COSTS								
20	Drugs, Biologicals and Infusion								20
20.30	Analgesics								20.30
20.31	Sedatives/Hypnotics								20.31
20.32	Other - specify								20.32
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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER *CCN*: _____
HOSPICE *CCN*: _____

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: BUILDINGS & FIXTURES	CAPITAL RELATED COST: MOVABLE EQUIPMENT	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)	
			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
5.20	Nursing Care - Continuous Home Care	10.20											5.20
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
13.20	Home Health Aide and Homemaker-Cont Home Care	18.20											13.20
14	Other	19											14
15	Drugs, Biologicals and Infusion	20											15
15.30	Analgesics	20.30											15.30
15.31	Sedatives/Hypnotics	20.31											15.31
15.32	Other - specify	20.32											15.32
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 *CCN*: _____ HOSPICE *CCN*: _____	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
5.20	Nursing Care - Continuous Home Care							5.20
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
13.20	Home Health Aide and Homemaker-Cont Home Care							13.20
14	Other							14
15	Drugs, Biologicals and Infusion							15
15.30	Analgesics							15.30
15.31	Sedatives/Hypnotics							15.31
15.32	Other - specify							15.32
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

APPORTIONMENT OF HOSPICE SHARED SERVICES

PROVIDER *CCN*: _____
HOSPICE *CCN*: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET K-5
Part III

	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 *HOSPICE* PER DIEM COST	PROVIDER *CCN*: _____ HOSPICE *CCN*: _____	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 *HHA-BASED* CMHC COST CENTERS	PROVIDER *CCN*: _____ CMHC *CCN*: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-1 PARTS I & II

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

	CMHC COST CENTER (OMIT CENTS)	NET EXPENSES FOR COST ALLOCATION (1)	CAPITAL RELATED COSTS BLDGS & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	PLANT OPERATION & MAINTE-NANCE	TRANSPOR-TATION	SUBTOTAL (cols. 0-4)	ADMINISTRA-TIVE & GENERAL	SUB-TOTAL	ALLOCATED CMHC A&G (SEE PART II)	TOTAL (SUM OF COLS 6 & 7)	
		0	1	2	3	4	4A	5	6	7	8	
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) (2)											12

(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 *HHA-BASED* CMHC ADMINISTRATIVE AND GENERAL COSTS

1	Amount from Part I, column 6, line 12		1
2	Amount from Part I, column 6, line 1		2
3	Line 1 minus line 2		3
4	Unit cost multiplier for *HHA-Based* 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)		4

COMPUTATION OF *HHA-BASED* CMHC COSTS	PROVIDER *CCN*: _____ CMHC *CCN*: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-2

PART I - APPORTIONMENT OF *HHA-BASED* 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	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	
		1	2	3	3.01	3.02	4	5	6	
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 2-11)									12

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

(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 *HHA-BASED* CMHC COSTS		3.01	3.02	4	5	6	
17	Total *HHA-based* 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.						17

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

ALLOCATION OF GENERAL SERVICE COSTS TO *HHA-BASED* CMHC COST CENTERS	PROVIDER *CCN*: _____ CMHC *CCN*: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-1 PART III

PART III - ALLOCATION OF GENERAL SERVICE COSTS TO *HHA-BASED* 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 - *HHA-BASED* CMHC SERVICES	PROVIDER CCN: CMHC CCN:	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 (obtain this ratio from your *contractor*)			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 *HHA-based* 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 *HHA-BASED CMHC* REIMBURSEMENT SETTLEMENT		1	1.01	
10	Cost of *HHA-based* 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
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
17.02	Allowable bad debts for dual eligible beneficiaries (see instructions)			17.02
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 or minus line 21)			22
23	Sequestration adjustment (see instructions)			23
24	Amount due provider (Line 22 minus line 23)			24
25	Interim payments			25
25.5	Tentative settlement (for contractor use only)			25.5
26	Balance due *HHA-based* CMHC/Program (Line 24 minus line 25) (Indicate overpayments in brackets)			26
27	Protested amounts (see instructions)			27
28	Balance due *HHA-based* CMHC/Program (Line 26 minus line 27) (Indicate overpayments in brackets)			28

ANALYSIS OF PAYMENTS TO *HHA-BASED* CMHC *FOR SERVICES* RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ CMHC CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET CM-4

				PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to *HHA-based CMHC*					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the contractor, 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 CONTRACTOR

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 Contractor Contractor 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 *HHA-based CMHC* agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

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ANALYSIS OF HHA-BASED *RHC/FQHC COSTS*

PROVIDER CCN: _____

RHC/FQHC CCN: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET RF-1

Check Applicable Box: [ ] *HHA-Based* RHC [ ] *HHA-Based* 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	
	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
	OVERHEAD											
29	Facility Costs											29
30	Administrative Costs											30
31	Total Overhead (sum of lines 29 and 30)											31
32	Total costs (sum of lines 22, 28 and 31)											32

The net expenses for cost allocation on Worksheet A for the applicable *HHA-based* RHC/FQHC cost center line must equal the total costs in column 10, line *32* of this worksheet for cost reporting periods beginning on or after January 1, 1998.

ALLOCATION OF OVERHEAD TO *HHA-BASED* RHC/FQHC SERVICES	PROVIDER CCN: _____ *RHC/FQHC* CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-2
Check Applicable Box:	[ ] *HHA-Based* RHC [ ] *HHA-Based* 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
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
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 *contractor* .

DETERMINATION OF *TOTAL* ALLOWABLE COST APPLICABLE TO *HHA-BASED* 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 *HHA-based* RHC/FQHC services (line 10 divided by line 12)		13
14	Total overhead - (from Worksheet RF-1, column 10, line 31) (see instructions)		14
15	Allowable GME Overhead (see instructions)		15
16	Net Overhead (line 14 minus line 15)		16
17	*HHA* overhead allocated to *HHA-based RHC/FQHC* (see instructions)		17
18	Total overhead *of HHA-Based RHC/FQHC* (sum of lines 16 and 17)		18
19	Overhead applicable to *HHA-based* RHC/FQHC services (line 13 x line 18)		19
20	Total allowable cost of *HHA-based* RHC/FQHC services (sum of lines 10 and 19)		20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR *HHA-BASED* RHC/FQHC SERVICES	PROVIDER CCN: _____ *RHC/FQHC* CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-3

Check Applicable Box: [ ] *HHA-Based* RHC [ ] *HHA-Based* FQHC

DETERMINATION OF RATE FOR *HHA-BASED* RHC/FQHC SERVICES

1	Total Allowable Cost of *HHA-based* 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	
		1	2	
8	Per visit payment limit (from your *contractor*)			8
9	Rate for Medicare covered visits (lesser of line 7 or line 8) (See instructions)			9

CALCULATION OF *HHA-BASED RHC/FQHC* SETTLEMENT

10	Medicare covered visits excluding mental health services (from the PS&R)			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 the PS&R)			12
13	Medicare covered cost for mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (line 13 x the applicable percentage) (see instructions)			14
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, plus line 14, columns 1 & 2, plus columns 1 and 2, line 15 minus line 15.5, columns 1 and 2) (see instructions)			16
16.01	Total Program Charges (see instructions)(from contractor's records)			16.01
16.02	Total Program Preventive Charges (see instructions)(from provider's records)			16.02
16.03	Total Program Preventive Costs (see instructions)			16.03
16.04	Total Program Non-Preventive Costs (see instructions)			16.04
16.05	Total Program Cost (see instructions)			16.05
			1	
17	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17
17.5	Beneficiary coinsurance for *HHA-based* RHC/FQHC services (see instructions) (from contractor records)			17.5
18	Net Medicare cost excluding vaccines (see instrcutions)			18
19	Reimbursable cost of *HHA-based* RHC/FQHC services, excluding vaccine (see instructions)			19
20	Medicare cost of vaccines and their administration (from Worksheet. RF-4, line 16)			20
21	Total reimbursable Medicare cost (see instructions)			21
22	Reimbursable bad debts			22
22.01	Adjusted reimbursable bad debts (see instructions)			22.01
22.02	Allowable bad debts for dual eligible beneficiaries (see instructions)			22.02
23	Other adjustments (specify)			23
24	Net reimbursable amounts (see instructions)			24
24.01	Sequestration adjustment (see instructions)			24.01
25	Interim payments (From Worksheet RF-5, line 4)			25
25.5	Tentative settlement (For contractor use only)			25.5
26	Balance due *HHA-based RHC and/or FQHC* /program (line 24 minus lines 24.01 and 25)			26
27	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter *1*, section 115.2			27

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

COMPUTATION OF *HHA-BASED RHC/FQHC* PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER CCN: _____ *RHC/FQHC* CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET RF-4

Check Applicable Box: [ ] *HHA-Based* RHC [ ] *HHA-based* FQHC

	CALCULATION OF COST	PNEUMOCOCCAL 1	SEASONAL INFLUENZA ONLY 2	H1N1 ONLY 2.01	INFLUENZA & H1N1 (See instructions) 2.02	
1	Health care staff cost (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 *HHA-based RHC/FQHC* (Worksheet RF-1, column 10, line 22)					6
7	Total *HHA-based RHC/FQHC* overhead (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 their administration (sum of columns 1, 2, 2.01 and 2.02, line 10) (transfer this amount to Worksheet RF-3, line 2)		15
16	Total Medicare cost of pneumococcal and influenza vaccine and their administration (sum of columns 1, 2, 2.01 and 2.02, line 14) (transfer this amount to Worksheet RF-3, line 20)		16

ANALYSIS OF PAYMENTS TO *HHA*-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER *CCN*: _____ *RHC/FQHC* CCN: _____	PERIOD: FROM: _____ TO: _____	SUPPLEMENTAL WORKSHEET RF-5

Check Applicable Box: [ ] *HHA-based* RHC [ ] *HHA-based* FQHC

				PART B		
				1	2	
				mm/dd/yyyy	Amount	
1	Total interim payments paid to *HHA-based* RHC/FQHC					1
2	Interim payments payable on individual bills either, submitted or to be submitted to the *contractor*, 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 *CONTRACTOR*

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 *Contractor* *Contractor Number*

Signature of Authorized Person Date: (Month, Day, Year)

(1) On lines 3, 5 and 6, where an amount is due "*HHA-Based RHC/FQHC* to Program," show the amount and date on which the *HHA-based RHC/FQHC* agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

ANALYSIS OF HHA-BASED HOSPICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O

			SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS										
1	0100	Cap Rel Costs-Bldg & Fixt*								1
2	0200	Cap Rel Costs-Mvble Equip*								2
3	0300	Employee Benefits Department*								3
4	0400	Administrative & General *								4
5	0500	Plant Operation & Maintenance*								5
6	0600	Laundry & Linen Service*								6
7	0700	Housekeeping*								7
8	0800	Dietary*								8
9	0900	Nursing Administration*								9
10	1000	Routine Medical Supplies*								10
11	1100	Medical Records*								11
12	1200	Staff Transportation*								12
13	1300	Volunteer Service Coordination*								13
14	1400	Pharmacy*								14
15	1500	Physician Administrative Services*								15
16	1600	Other General Service*								16
17	1700	Patient/Residential Care Services								17
DIRECT PATIENT CARE SERVICE COST CENTERS										
25	2500	Inpatient Care-Contracted**								25
26	2600	Physician Services**								26
27	2700	Nurse Practitioner**								27
28	2800	Registered Nurse**								28
29	2900	LPN/LVN**								29
30	3000	Physical Therapy**								30
31	3100	Occupational Therapy**								31
32	3200	Speech/ Language Pathology**								32
33	3300	Medical Social Services**								33
34	3400	Spiritual Counseling**								34
35	3500	Dietary Counseling**								35
36	3600	Counseling - Other**								36
37	3700	Hospice Aide & Homemaker Services**								37
38	3800	Durable Medical Equipment/Oxygen**								38
39	3900	Patient Transportation**								39

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.
** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

ANALYSIS OF HHA-BASED HOSPICE COSTS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET O

			SALARIES	OTHER	TOTAL (col. 1 through col. 5)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)										
40	4000	Imaging Services**								40
41	4100	Labs & Diagnostics**								41
42	4200	Medical Supplies-Non-routine**								42
43	4300	Outpatient Services**								43
44	4400	Palliative Radiation Therapy**								44
45	4500	Palliative Chemotherapy**								45
46		Other Patient Care Services**								46
NONREIMBURSABLE COST CENTERS										
60	6000	Bereavement Program *								60
61	6100	Volunteer Program *								61
62	6200	Fundraising*								62
63	6300	Hospice/Palliative Medicine Fellows*								63
64	6400	Palliative Care Program*								64
65	6500	Other Physician Services*								65
66	6600	Residential Care *								66
67	6700	Advertising*								67
68	6800	Telehealth/Telemonitoring*								68
69	6900	Thrift Store*								69
70	7000	Nursing Facility Room & Board*								70
71	7100	Other Nonreimbursable*								71
100		Total								100

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

ANALYSIS OF HHA-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-1

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

ANALYSIS OF HHA-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-2

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

ANALYSIS OF HHA-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-3

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Services (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

ANALYSIS OF HHA-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech/ Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

COST ALLOCATION - DETERMINATION OF HHA-BASED HOSPICE NET EXPENSES FOR ALLOCATION	PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-5	
Descriptions	HOSPICE DIRECT EXPENSES (see instructions) 1	GENERAL SERVICE EXPENSES FROM WKST B (see instructions) 2	TOTAL EXPENSES (sum of cols. 1 + 2) 3	
GENERAL SERVICE COST CENTERS				
1 Cap Rel Costs-Bldg & Fixt				1
2 Cap Rel Costs-Mvble Equip				2
3 Employee Benefits Department				3
4 Administrative & General				4
5 Plant Operation & Maintenance				5
6 Laundry & Linen Service				6
7 Housekeeping				7
8 Dietary				8
9 Nursing Administration				9
10 Routine Medical Supplies				10
11 Medical Records				11
12 Staff Transportation				12
13 Volunteer Service Coordination				13
14 Pharmacy				14
15 Physician Administrative Services				15
16 Other General Service				16
17 Patient/Residential Care Services				17
LEVEL OF CARE				
50 Hospice Continuous Home Care				50
51 Hospice Routine Home Care				51
52 Hospice Inpatient Respite Care				52
53 Hospice General Inpatient Care				53
NONREIMBURSABLE COST CENTERS				
60 Bereavement Program				60
61 Volunteer Program				61
62 Fundraising				62
63 Hospice/Palliative Medicine Fellows				63
64 Palliative Care Program				64
65 Other Physician Services				65
66 Residential Care				66
67 Advertising				67
68 Telehealth/Telemonitoring				68
69 Thrift Store				69
70 Nursing Facility Room & Board				70
71 Other Nonreimbursable				71
99 Negative Cost Center				99
100 Total				100

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-6
PART I

		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	
		0	1	2	3	3A	4	5	6	7	8	
GENERAL SERVICE COST CENTERS												
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
LEVEL OF CARE												
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
NONREIMBURSABLE COST CENTERS												
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
100	Total											100

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET O-6 PART I

	Descriptions	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMINISTRA-TIVE SVCS	OTHER GENERAL SERVICE	PATIENT / RESIDENTIAL CARE SVCS	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
	NONREIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
100	Total											100

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-6
PART II

	Cost Center Descriptions	CAP REL BLDG & FIX (Square Feet)	CAP REL MVBLE EQUIP (Dollar Value)	EMPLOYEE BENEFITS DEPARTMENT (Gross Salaries)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Accum. Cost)	PLANT OP & MAINT (Square Feet)	LAUNDRY & LINEN (In-Facility Days)	HOUSE-KEEPING (Square Feet)	DIETARY (In-Facility Days)	
		1	2	3	4A	4	5	6	7	8	
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs-Bldg & Fixt										1
2	Cap Rel Costs-Mvble Equip										2
3	Employee Benefits Department										3
4	Administrative & General										4
5	Plant Operation & Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping										7
8	Dietary										8
9	Nursing Administration										9
10	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation										12
13	Volunteer Service Coordination										13
14	Pharmacy										14
15	Physician Administrative Services										15
16	Other General Service										16
17	Patient/Residential Care Services										17
	LEVEL OF CARE										
50	Hospice Continuous Home Care										50
51	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
53	Hospice General Inpatient Care										53
	NONREIMBURSABLE COST CENTERS										
60	Bereavement Program										60
61	Volunteer Program										61
62	Fundraising										62
63	Hospice/Palliative Medicine Fellows										63
64	Palliative Care Program										64
65	Other Physician Services										65
66	Residential Care										66
67	Advertising										67
68	Telehealth/Telemonitoring										68
69	Thrift Store										69
70	Nursing Facility Room & Board										70
71	Other Nonreimbursable										71
99	Negative Cost Center										99
100	Total (sum of lines 1 through 99)										100
101	Cost to be allocated (per Wkst. O-6, Part I)										101
102	Unit cost multiplier										102

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS | PROVIDER CCN: _____ HOSPICE CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET O-6 PART II

	Cost Center Descriptions	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANS-PORTATION (Mileage)	VOLUNTEER SVC COOR-DINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMINISTRA-TIVE SVCS (Patient Days)	OTHER GENERAL SERVICE (Specify Basis)	PATIENT / RESIDENTIAL CARE SVCS (In-Facility Days)	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Continuous Home Care											50
51	Routine Home Care											51
52	Inpatient Respite Care											52
53	General Inpatient Care											53
	NONREIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71	Other Nonreimbursable											71
99	Negative Cost Center											99
100	Total (sum of lines 1 through 99)											100
101	Cost to be allocated (per Wkst. O-6, Part I)											101
102	Unit cost multiplier											102

APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

PROVIDER CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-7

	Cost Center Descriptions	Wkst. B, col. 6, line	Total HHA Costs	Total HHA Charges (from Provider Records)	Cost to Charge Ratio	Charges by LOC (from Provider Records)				Shared Service Costs by LOC				
						HCHC	HRHC	HIRC	HGIP	HCHC (col. 3 x col. 4)	HRHC (col. 3 x col. 5)	HIRC (col. 3 x col. 6)	HGIP (col. 3 x col. 7)	
		0	1	2	3	4	5	6	7	8	9	10	11	
	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	Medical Supplies	12												5
6	Durable Medical Equipment/Oxygen	14												6
7	Totals (sum of lines 1-7)													7

CALCULATION OF HHA-BASED HOSPICE PER DIEM COST		PROVIDER CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-8	
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
HOSPICE CONTINUOUS HOME CARE					
1	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 8, line 7)				1
2	Total unduplicated days (Wkst. S-5, col. 4, line 10)				2
3	Total average cost per diem (line 1 divided by line 2)				3
4	Unduplicated program days (Wkst. S-5 col. as appropriate, line 10)				4
5	Program cost (line 3 times line 4)				5
HOSPICE ROUTINE HOME CARE					
6	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 9, line 7)				6
7	Total unduplicated days (Wkst. S-5, col. 4, line 11)				7
8	Total average cost per diem (line 6 divided by line 7)				8
9	Unduplicated program days (Wkst. S-5, col. as appropriate, line 11)				9
10	Program cost (line 8 times line 9)				10
HOSPICE INPATIENT RESPITE CARE					
11	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 10, line 7)				11
12	Total unduplicated days (Wkst. S-5, col. 4, line 12)				12
13	Total average cost per diem (line 11 divided by line 12)				13
14	Unduplicated program days (Wkst. S-5, col. as appropriate, line 12)				14
15	Program cost (line 13 times line 14)				15
HOSPICE GENERAL INPATIENT CARE					
16	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 11, line 7)				16
17	Total unduplicated days (Wkst. S-5, col. 4, line 13)				17
18	Total average cost per diem (line 16 divided by line 17)				18
19	Unduplicated program days (Wkst. S-5, col. as appropriate, line 13)				19
20	Program cost (line 18 times line 19)				20
TOTAL HOSPICE CARE					
21	Total cost (sum of line 1 + line 6 + line 11 + line 16)				21
22	Total unduplicated days (Wkst. S-5, col. 4, line 14)				22
23	Average cost per diem (line 21 divided by line 22)				23