THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR.200(B)). COMPLETION OF THIS REPORT IS VIEWED AS A CONDITION OF YOUR PROVIDER AGREEMENT.

FORM APPROVED
OMB NO. 0938-0758
APPROVAL EXPIRES 04/30/20XX

HOSPICE COST AND DATA REPORT	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S PARTS I & II

PART I - COST REPORT STATUS

			1	ECR DATE 2	ECR TIME 3	
Provider use only	1	Electronically prepared cost report				1
	2	Manually prepared cost report				2
	3	Number of times cost report has been amended				3
	4	Medicare utilization				4
Contractor use only:	5	Cost report status [1] As Submitted [2] Reserved [3] Reserved [4] Reserved [5] Amended				5
	6	Date received				6
	7	Contractor number				7
	8	First cost report for this provider CCN				8
	9	Last cost report for this provider CCN				9
	10	Reserved				10
	11	Contractor vendor code				11
	12	Reserved				12

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF 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 cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Provider CCN(s)} for the cost reporting 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1		CHECKBOX 2	ELECTRONIC SIGNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Signature date				4

HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-1 PART I

PART I - IDENTIFICATION DATA

1	Name							1
		1			2	3		
2	Street address				P.O. Box:			2
3	City				State:	ZIP Code:		3
4	County							4
		1	2					
5	CCN							5
6	Date hospice began operation							6
		TITLE XVIII - MEDICARE	TITLE XIX - MEDICAID					
7	Certification date							7
		FROM	TO					
8	Cost reporting period							8

	Malpractice Insurance Information	1	2	3	
9	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no				9
10	Enter 1 if the malpractice insurance is a claims-made policy. Enter 2 if the malpractice insurance is an occurrence policy				10
		PREMIUMS	PAID LOSSES	SELF-INSURANCE	
11	Amounts of malpractice premiums, paid losses, and self-insurance				11
12	Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein				12

	Home Office/Chain Organization Information	1 Y/N	2 HO NUMBER	
13	Are HO/CO costs (as defined in CMS Pub. 15-1, §2150ff) claimed? Enter "Y" for yes or "N" for no in col. 1 If yes, enter the home office number in col. 2. (see instructions)			13

14	HO/CO name						14
		1		2	3		
15	HO/CO street address			HO/CO P.O. Box:			15
16	HO/CO city			HO/CO State:	HO/CO ZIP Code:		16
17	HO/CO contractor name						17
18	HO/CO contractor number						18

		1	2	
	Other Information			
19	Type of control (see instructions)			19
20	Number of CBSAs where Medicare covered services were provided during the cost reporting period			20
21	List each CBSA code where Medicare covered hospices services were provided during the cost reporting period (line 21 contains the first code)			21

HOSPICE IDENTIFICATION DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-1 PART II

PART II - STATISTICAL DATA

		UNDUPLICATED DAYS				
		TITLE XVIII - MEDICARE	TITLE XIX - MEDICAID	OTHER	TOTAL	
		1	2	3	4	
30	Continuous Home Care					30
31	Routine Home Care					31
32	Inpatient Respite Care					32
33	General Inpatient Care					33
34	Total Hospice Days					34

PART III - CONTRACTED STATISTICAL DATA

		UNDUPLICATED DAYS				
		TITLE XVIII - MEDICARE	TITLE XIX - MEDICAID	OTHER	TOTAL	
		1	2	3	4	
40	Inpatient Respite Care					40
41	General Inpatient Care					41

HOSPICE REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET S-2

PROVIDER ORGANIZATION AND OPERATION

		Y / N	DATE	V/I	
		1	2	3	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? Enter "Y" for yes or "N" for no in column If yes, enter the date of the change in column 2. (see instructions)				1
2	Has the provider terminated participation in the Medicare program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date If yes, enter in column 3, "V" for voluntary or "I" for involuntary				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities that were related to the provider or its officers, medical staf management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter "Y" for yes or "N" for no in column (see instructions)				3

FINANCIAL DATA AND REPORTS

		Y / N	A / C / R	DATE	
		1	2	3	
4	Column 1: Were the financial statements prepared by a certified public accountant? Enter "Y" for yes or "N" for no Column 2: If yes, enter in column 2: "A" for audited, "C" for compiled, or "R" for reviewed. Submit complete copy of financi statements 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 reconciliatio				5

HOSPICE REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-2

P S & R REPORT DATA

		Y / N	DATE	
		1	2	
6	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date of the PS&R report used to prepare the cost report. (see instructions.)			6
7	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in col.1. If yes, enter in col. 2 the paid-through date of the PS&R report. (see instructions)			7
8	If line 6 or 7 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? Enter "Y" for yes or "N" for no. If yes, see instructions.			8
9	If line 6 or 7 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			9
10	If line 6 or 7 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments: _____			10
11	Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no. If yes, see instructions.			11

COST REPORT PREPARER CONTACT INFORMATION

		1		2		3	
12	First name		Last name		Title		12
13	Employer						13
14	Telephone number		Email address				14

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A

			SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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]								3
4	0400	Administrative & General*								4
5	0500	Plant Operation & Maintenance*								5
6	0600	Laundry & Linen Service[4]								6
7	0700	Housekeeping*								7
8	0800	Dietary*								8
9	0900	Nursing Administration[4]								9
10	1000	Routine Medical Supplies*								10
11	1100	Medical Records*								11
12	1200	Staff Transportation*								12
13	1300	Volunteer Service Coordination[3]								13
14	1400	Pharmacy*								14
15	1500	Physician Administrative Services[4]								15
16		Other General Service (specify)*								16
17	1700	Patient/Residential Care Services								17
DIRECT PATIENT CARE SERVICE COST CENTERS										
25	2500	Inpatient Care - Contracted**								25
26	2600	Physician Services[5]**								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[4]**								32
33	3300	Medical Social Services**								33
34	3400	Spiritual Counseling[3]**								34
35	3500	Dietary Counseling[5]**								35
36	3600	Counseling - Other**								36
37	3700	Hospice Aide and Homemaker Services[5]**								37
38	3800	Durable Medical Equipment/Oxygen[4]**								38
39	3900	Patient Transportation**								39

* Transfer the amounts in column 7 to Wkst. B, col. 0, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. B.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A

			SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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 and Diagnostics**								41
42	4200	Medical Supplies - Non-routine**								42
42.50	4250	Drugs Charged to Patients**								42.50
43	4300	Outpatient Services**								43
44	4400	Palliative Radiation Therapy*¶								44
45	4500	Palliative Chemotherapy*¶								45
46		Other Patient Care Services (specify)**								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		Other Nonreimbursable (specify)¶								71
72	*7200*	*Medicide*								*72*
100		Total								100

* Transfer the amounts in column 7 to Wkst. B, col. 0, line as appropriate.

** See instructions. Do not transfer the amounts in col. 7 to Wkst. B.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES CONTINUOUS HOME CARE	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-1

		SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. B, col. 0, line 50.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES ROUTINE HOME CARE	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET A-2

		SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. B, col. 0, line 51.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES INPATIENT RESPITE CARE	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-3

		SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. B, col. 0, line 52.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES GENERAL INPATIENT CARE	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-4

		SALARIES	OTHER	TOTAL (SUM OF COL. 1 PLUS COL. 2)	RECLASS-IFICATIONS	SUBTOTAL	ADJUSTMENTS	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
42.50	Drugs Charged to Patients								42.50
43	Outpatient Services								43
44	Palliative Radiation Therapy								44
45	Palliative Chemotherapy								45
46	Other Patient Care Svc (specify)								46
100	Total *								100

* Transfer the amount in column 7 to Wkst. B, col. 0, line 53.

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET A-6

	EXPLANATION OF OF RECLASSIFICATION(S)	CODE[1]	INCREASES				DECREASES				LOC WKST IN-DICATOR	
			COST CENTER	WKST A LINE NO.	AMOUNT SALARY	AMOUNT OTHER	COST CENTER	WKST A LINE NO.	AMOUNT SALARY	AMOUNT OTHER		
		1	2	3	4	4.01	5	6	7	7.01	8	
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												30
31												31
32												32
33												33
34												34
35												35
100	Total reclassifications											100

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

Transfer the amounts in columns 4, 4.01, 7, and 7.01 to Wkst. A, col. 4, lines as appropriate.

ADJUSTMENTS TO EXPENSES	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET A-8

	DESCRIPTION[1]	BASIS FOR ADJUST-MENT[2]	AMOUNT	EXPENSE CLASSIFICATION ON WKST. A TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER	WKST A. LINE NO.	LOC WKST IN-DICATOR	
		1	2	3	4	5	
1	Investment income on restricted funds (chapter 2)						1
2	Telephone services (pay stations excluded) (chapter 21)						2
3	Adjustment resulting from transactions with related organ izations (chapter 10) and home office costs (chapter 21)	Wkst. A-8-1					3
4	Revenue - employee and guest meals	B		Dietary	8		4
5	Income from imposition of interest, finance or penalty charges (chapter 21)	B		Administrative and General	4		5
6	Bad debts included on trial balance	A					6
7	Patient personal purchases						7
8	Depreciation - buildings and fixtures			Buildings & Fixtures	1		8
9	Depreciation - movable equipment			Movable Equipment	2		9
10	Revenue - State-redirected room and board	B		Nursing Facility Room & Board	70		10
11	Other adjustments (specify)[3]						11
12							12
13							13
14							14
15							15
50	TOTAL (sum of lines 1 through 49) (transfer to Wkst. A, col. 6, line 100)						50

[1] Description - all chapter references in this column pertain to CMS Pub. 15-1

[2] Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

[3] Additional adjustments may be made on lines 11 thru 49 and subscripts thereof

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-1

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	WKST. A LINE NUMBER	COST CENTER	EXPENSE ITEMS	AMOUNT ALLOWABLE IN COST	AMOUNT INCLUDED IN WKST. A	NET ADJUSTMENTS (COL. 4 MINUS COL. 5) *	LOC WS INDIC-ATOR	
	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	TOTALS (sum of lines 1 through 9) (transfer col. 6, line 10 to Wkst. A-8, col. 2, line 3)							10

* Transfer amounts in col. 6, lines 1 through 9 (and subscripts as appropriate) to Wkst. A, col. 6, lines as indicated in col. 1. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Wkst. A, col. 1 and/or col. 2, report the amount allowable in col. 4 above.

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND / OR HOME OFFICE

THE SECRETARY, BY VIRTUE OF THE AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART II OF THIS WORKSHEET.

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

				RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
	SYMBOL[1]	NAME	PERCENTAGE OF OWNERSHIP	NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10

[1] Use the followings symbols to indicate interrelationship to related organizations:

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

COST ALLOCATION	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B

	Cost Center Descriptions	NET EXPENSES FOR ALLOC.	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (SUM COLS 0 THROUGH 3)	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 (specify)											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

COST ALLOCATION	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B

	Cost Center Descriptions	NET EXPENSES FOR ALLOC.	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (SUM COLS 0 THROUGH 3)	ADMINIS-TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	
		0	1	2	3	3A	4	5	6	7	8	
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 (specify)											71
72	*Medicide*											*72*
100	Negative Cost Center											100
101	Total											101

COST ALLOCATION	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B

	Cost Center 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 (specify)											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

COST ALLOCATION	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B

	Cost Center 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	
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 (specify)											71
72	*Medicide*											*72*
100	Negative Cost Center											100
101	Total											101

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET B-1

	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-FACIL-ITY DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY IN-FACIL-ITY 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 (specify)										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

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET B-1

	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-FACIL ITY DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY IN-FACIL ITY DAYS	
		1	2	3	4A	4	5	6	7	8	
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 (specify)										71
72	*Medicide*										*72*
100	Negative Cost Center										100
101	Cost to be allocated (per Wkst. B)										101
102	Unit cost multiplier										102

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET B-1

	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-FACIL ITY 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 Administratior											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 (specify)											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

COST ALLOCATION - STATISTICAL BASIS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET B-1

	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-FACIL ITY DAYS	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
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 (specify)											71
72	*Medicide*											*72*
100	Negative Cost Center											100
101	Cost to be allocated (per Wkst. B)											101
102	Unit cost multiplier											102

CALCULATION OF PER DIEM COST	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET C

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
CONTINUOUS HOME CARE					
1	Total cost (Wkst. B, col 18, line 50)				1
2	Total unduplicated days (Wkst. S-1, col. 4, line 30)				2
3	Total average cost per diem (line 1 divided by line 2)				3
4	Unduplicated program days (Wkst. S-1, col. as appropriate, line 30)				4
5	Program cost (line 3 times line 4)				5
ROUTINE HOME CARE					
6	Total cost (Wkst. B, col. 18, line 51)				6
7	Total unduplicated days (Wkst. S-1, col. 4, line 31)				7
8	Total average cost per diem (line 6 divided by line 7)				8
9	Unduplicated program days (Wkst. S-1, col. as appropriate, line 31)				9
10	Program cost (line 8 times line 9)				10
INPATIENT RESPITE CARE					
11	Total cost (Wkst. B, col. 18, line 52)				11
12	Total unduplicated days (Wkst. S-1, col. 4, line 32)				12
13	Total average cost per diem (line 11 divided by line 12)				13
14	Unduplicated program days (Wkst. S-1, col. as appropriate, line 32)				14
15	Program cost (line 13 times line 14)				15
GENERAL INPATIENT CARE					
16	Total cost (Wkst. B, col. 18, line 53)				16
17	Total unduplicated days (Wkst. S-1, col. 4, line 33)				17
18	Total average cost per diem (line 16 divided by line 17)				18
19	Unduplicated program days (Wkst. S-1, col. as appropriate, line 33)				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-1, col. 4, line 34)				22
23	Average cost per diem (line 21 divided by line 22)				23

BALANCE SHEET	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET F

	Assets	AMOUNT	
CURRENT ASSETS			
1	Cash on hand and in banks		1
2	Temporary investments		2
3	Notes receivable		3
4	Accounts receivable		4
5	Other receivables		5
6	Less: allowances for uncollectible notes and accounts receivable		6
7	Inventory		7
8	Prepaid expenses		8
9	Other current assets		9
10	TOTAL CURRENT ASSETS (sum of lines 1 through 9)		10
FIXED ASSETS			
11	Land		11
12	Land improvements		12
13	Less: Accumulated depreciation		13
14	Buildings		14
15	Less Accumulated depreciation		15
16	Leasehold improvements		16
17	Less: Accumulated Amortization		17
18	Fixed equipment		18
19	Less: Accumulated depreciation		19
20	Automobiles and trucks		20
21	Less: Accumulated depreciation		21
22	Major movable equipment		22
23	Less: Accumulated depreciation		23
24	Minor equipment - Depreciable		24
25	Less: Accumulated depreciation		25
26	TOTAL FIXED ASSETS (sum of lines 11 through 25)		26
OTHER ASSETS			
27	Investments		27
28	Deposits on leases		28
29	Due from owners/officers		29
30	Other assets		30
31	TOTAL OTHER ASSETS (sum of lines 27 through 30)		31
32	TOTAL ASSETS (sum of lines 10, 26, and 31)		32

	Liabilities and Fund Balances	AMOUNT	
CURRENT LIABILITIES			
33	Accounts payable		33
34	Salaries, wages & fees payable		34
35	Payroll taxes payable		35
36	Notes & loans payable (short term)		36
37	Deferred income		37
38	Accelerated payments		38
39	Other current liabilities		39
40	TOTAL CURRENT LIABILITIES (sum of lines 33 through 39)		40
LONG TERM LIABILITIES			
41	Mortgage payable		41
42	Notes payable		42
43	Unsecured loans		43
44	Loans from owners:		44
45	Other long term liabilities		45
46	TOTAL LONG TERM LIABILITIES (sum of lines 41 through 45)		46
47	TOTAL LIABILITIES (sum of lines 40 and 46)		47
CAPITAL ACCOUNT			
48	Fund balance		48
49	TOTAL LIABILITIES AND FUND BALANCE (sum of lines 47 and 48)		49

( ) = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET F-1

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
1	Fund balances at beginning of period					1
2	Net income / (loss) (from Wkst. F-2, line 42)					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						9
10	Total additions (sum of lines 4 through 9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12 through 17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF REVENUES AND OPERATING EXPENSES	PROVIDER CCN:	PERIOD: FROM TO	WORKSHEET F-2

PART I - REVENUES

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	OTHER	TOTAL	
		1	2	3	4	
	GROSS PATIENT REVENUE					
1	Continuous Home Care					1
2	Routine Home Care					2
3	Inpatient Respite Care					3
4	General Inpatient Care					4
5	Drug copay / coinsurance					5
6	Total gross patient revenue (sum of lines 1 through 5)					6
7	Less: Contractual allowances and discounts					7
8	Net patient revenue (line 6 minus line 7)					8
	OTHER REVENUE					
9	Hospice physician services					9
10	Room and board					10
11	Palliative consults / Other phys. services					11
12	Donations / Charitable contributions					12
13	Rebates / refunds of expenses					13
14	Income from investments					14
15	Governmental appropriations					15
16	Other (specify)					16
16.50	COVID-19 PHE Funding					16.50
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26	Total revenues (sum of lines 8 through 25)					26

PART II - OPERATING EXPENSES

		1	2	3	4	
27	Operating expenses (per Wkst A, col. 3, line 100)					27
28	Add (specify)					28
29						29
30						30
31						31
32						32
33						33
34	Total additions (sum of lines 28 through 33)					34
35	Deduct (specify)					35
36						36
37						37
38						38
39						39
40	Total deductions (sum of lines 35 through 39)					40
41	Total operating expenses (sum of lines 27 and 34, minus line 40)					41
42	Net income / (loss) for the period (line 26 minus line 41)					42