OMB No. 0938-0758

FORM CMS 1984-99

Hospice Medicare Cost Report Forms

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

FORM APPROVED
OMB NO. 0938-0758

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

CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

_____
Phone Number: Area Code

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

PART I

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

PART II

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

PART III

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

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

		COST CENTER DESCRIPTIONS	SALARIES (From Wkst A-1)	EMPLOYEE BENEFITS (From Wkst A-2)	TRANSPOR-TATION (See inst.)	CON-TRACTED SERVICES (From Wkst A-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease) (Fr Wkst A-6)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease) (Fr Wkst A-8 & A-8-1)	TOTAL (col.8±col.9)	
			1	2	3	4	5	6	7	8	9	10	
		GENERAL SERVICE COST CENTERS											
1	###	Capital Related Costs-Bldg and Fixtures											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											
10	###	Inpatient - General Care											10
11	###	Inpatient - Respite Care											11
		VISITING SERVICES											
15	###	Physician Services											15
16	###	Nursing Care											16
16.01	###	Nursing Care -- Continuous Home Care											16.01
17	###	Physical Therapy											17
18	###	Occupational Therapy											18
19	###	Speech/ Language Pathology											19
20	###	Medical Social Services											20
21	###	Spiritual Counseling											21
22	###	Dietary Counseling											22
23	###	Counseling - Other											23
24	###	Home Health Aide and Homemaker											24
24.01	###	HH Aide & Homemaker -- Cont Home Care											24.01
25		Other											25

HH Aide & Homemaker -- Cont Hm Care

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

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

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

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	GENERAL SERVICE COST CENTERS									
1	Capital Related Costs-Bldg and Fixt.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

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

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

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

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

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	GENERAL SERVICE COST CENTERS									
1	Capital Related Costs-Bldg and Fixt.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

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

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

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

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

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
		1	2	3	4	5	6	7	8	9
	GENERAL SERVICE COST CENTERS									
1	Capital Related Costs-Bldg and Fixt.									
2	Capital Related Costs-Movable Equip.									
3	Plant Operation and Maintenance									
4	Transportation - Staff									
5	Volunteer Service Coordination									
6	Administrative and General									
	INPATIENT CARE SERVICE									
10	Inpatient - General Care									
11	Inpatient - Respite Care									
	VISITING SERVICES									
15	Physician Services									
16	Nursing Care									
16.01	Nursing Care -- Continuous Home Care									
17	Physical Therapy									
18	Occupational Therapy									
19	Speech/ Language Pathology									
20	Medical Social Services									
21	Spiritual Counseling									
22	Dietary Counseling									
23	Counseling - Other									
24	Home Health Aide and Homemaker									
24.01	HH Aide & Homemaker -- Cont Home Care									
25	Other									

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

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

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

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

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

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
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31											31
32											32
33											33
34											34
35											35
###	Total reclassifications (sum of col. 4 and 5 must equal sum of col. 8 and 9)										###

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

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 5, lines as appropriate.

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

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

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

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

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

(2) Basis for adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS	TOTAL
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03	7
	GENERAL SERVICE COST CENTERS													
1	Capital Related Costs-Bldg and Fixtures													
2	Capital Related Costs-Movable Equipment													
3	Plant Operation and Maintenance													
4	Transportation - Staff													
5	Volunteer Service Coordination													
6	Administrative and General													
6.01	A & G Shared Costs													
6.02	A & G Reimbursable Costs													
6.03	A & G Nonreimbursable Costs													
	INPATIENT CARE SERVICE													
10	Inpatient - General Care													
11	Inpatient - Respite Care													
	VISITING SERVICES													
15	Physician Services													
16	Nursing Care													
16.01	Nursing Care -- Continuous Home Care													
17	Physical Therapy													
18	Occupational Therapy													
19	Speech/ Language Pathology													
20	Medical Social Services													
21	Spiritual Counseling													
22	Dietary Counseling													
23	Counseling - Other													
24	Home Health Aide and Homemaker													
24.01	HH Aide & Homemaker -- Cont Home Care													
25	Other													

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

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS	TOTAL
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03	7
	OTHER HOSPICE SERVICE COSTS													
30	Drugs, Biologicals and Infusion													
30.01	Analgesics													
30.02	Sedatives / Hypnotics													
30.03	Other -- Specify													
31	Durable Medical Equipment/Oxygen													
32	Patient Transportation													
33	Imaging Services													
34	Labs and Diagnostics													
35	Medical Supplies													
36	Outpatient Services (incl. E/R Dept.)													
37	Radiation Therapy													
38	Chemotherapy													
39	Other													
	HOSPICE NONREIMBURSABLE SERV.													
50	Bereavement Program Costs													
51	Volunteer Program Costs													
52	Fundraising													
53	Other Program Costs													
100	Total													

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Rev. 7

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B-1

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

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION MILEAGE	VOLUNTEER SERVICE COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	A & G SHARED COSTS (ACC. COST)	A & G REIMB. COSTS (ACC. COST)	A & G NON-REIMB. COSTS (ACC. COST)	
		1	2	3	4	5	6A	6	6.01	6.02	6.03	
	OTHER HOSPICE SERVICE COSTS											
30	Drugs, Biologicals and Infusion											30
30.01	Analgesics											30.01
30.02	Sedatives / Hypnotics											30.02
30.03	Other -- Specify											30.03
31	Durable Medical Equipment/Oxygen											31
32	Patient Transportation											32
33	Imaging Services											33
34	Labs and Diagnostics											34
35	Medical Supplies											35
36	Outpatient Services (incl. E/R Dept.)											36
37	Radiation Therapy											37
38	Chemotherapy											38
39	Other											39
	HOSPICE NONREIMBURSABLE SERV.											
50	Bereavement Program Costs											50
51	Volunteer Program Costs											51
52	Fundraising											52
53	Other Program Costs											53
100	Cost To be Allocated (per Wkst B)											100
101	Unit Cost Multiplier											101

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

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)		PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G	

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Less: allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)					11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Less: Accumulated depreciation					14
15	Buildings					15
16	Less Accumulated depreciation					16
17	Leasehold improvements					17
18	Less: Accumulated Amortization					18
19	Fixed equipment					19
20	Less: Accumulated depreciation					20
21	Automobiles and trucks					21
22	Less: Accumulated depreciation					22
23	Major movable equipment					23
24	Less: Accumulated depreciation					24
25	Minor equipment nondepreciable					25
26	Other fixed assets					26
27	TOTAL FIXED ASSETS (Sum of lines 12 - 26)					27
	OTHER ASSETS					
28	Investments					28
29	Deposits on leases					29
30	Due from owners/officers					30
31	Other assets					31
32	TOTAL OTHER ASSETS (Sum of lines 28 - 31)					32
33	TOTAL ASSETS (Sum of lines 11, 27, and 32)					33

( ) = contra amount

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)		PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G (Cont.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
	CURRENT LIABILITIES				
34	Accounts payable				
35	Salaries, wages & fees payable				
36	Payroll taxes payable				
37	Notes & loans payable (Short term)				
38	Deferred income				
39	Accelerated payments				
40	Due to other funds				
41	Other current liabilities				
42	TOTAL CURRENT LIABILITIES (Sum of lines 34 - 41)				
	LONG TERM LIABILITIES				
43	Mortgage payable				
44	Notes payable				
45	Unsecured loans				
46	Loans from owners: a. Prior to 7/1/66 b. On or after 7/1/66				
47	Other long term liabilities				
48					
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43 - 48)				
50	TOTAL LIABILITIES (Sum of lines 42 and 49)				
	CAPITAL ACCOUNTS				
51	General fund balance				
52	Specific purpose fund				
53	Donor created - endowment fund balance - restricted				
54	Donor created - endowment fund balance - unrestricted				
55	Governing body created - endowment fund balance				
56	Plant fund balance - invested in plant				
57	Plant fund balance - reserve for plant improvement, replacement and expansion				
58	TOTAL FUND BALANCES (Sum of lines 51 thru 57)				
59	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 50 and 58)				

( ) = contra amount

nt.)

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G - 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. G-2, line 16)					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 - 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 - 17)					18
19	Fund balance at end of period per balance sheet (Line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND NET INCOME	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G - 2 PARTS I & II

PART I - PATIENT REVENUES

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

PART II - OPERATING EXPENSES

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

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