

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 CCN:	PERIOD : FROM: TO:	WORKSHEET S PARTS I & II
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PART I - COST REPORT STATUS

		1	2	3	
Provider use only	1 Electronic filed cost report	[]	ECR Date:	ECR Time:	1
	2 Manually submitted cost report	[]			
	3 Amended report	[]			
	4 Medicare utilization				
Contractor use only:	5 Cost report status	[]			
	[1] As Submitted				
	[2] Reserved				
	[3] Reserved				
	[4] Reserved				
	[5] Amended				
	6 Date received				
	7 Contractor number				
	8 First cost report for this provider CCN	[]			
	9 Last cost report for this provider CCN	[]			
	10 Reserved				
	11 Contractor vendor code				
	12 Reserved				

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 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 PROVIDERS

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.

OFFICER OR ADMINISTRATOR OF PROVIDER

Printed Name _____ Signed _____

Title _____ Date _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0758. The time required to complete this information collection is estimated 188 hours per response, including the time to review instructions, search existing 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 Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-1984-14 (DRAFT) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4306)

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

1	Name							1
2	Street address				P.O. Box:			2
3	City	State:	ZIP Code:					3
4	County							4
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

9	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.							9
10	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.							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 Information

		Y / N	Home Office Number					
13	Are home office 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	Home office name							14
15	Street address				P.O. Box:			15
16	City	State:	ZIP Code:					16
17	Home office contractor name							17
18	Home office contractor number							18

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

DRAFT

FORM CMS-1984-14

4390 (Cont.)

HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET S-1 PARTS II and III
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PART II - STATISTICAL DATA

	UNDULICATED 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

	UNDULICATED 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
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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 1. 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 staff, 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 1. (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 financial 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 reconciliation.				5

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

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	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*						3
4	0400	Administrative & General *						4
5	0500	Plant Operation and 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 (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**						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 and Homemaker Services**						37
38	3800	Durable Medical Equipment/Oxygen**						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 EXPENSES					PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A	
	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 and 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 Svc (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	7100	Other Nonreimbursable (specify)*						71
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 EXPENSES CONTINUOUS HOME CARE					PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-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 (specify)						46
100	Total *						100

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES ROUTINE HOME CARE					PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-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 Svc (specify)						46
100	Total *						100

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES INPATIENT RESPITE CARE					PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-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 Svc (specify)						46
100	Total *						100

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES GENERAL INPATIENT CARE					PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-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 (specify)						46
100	Total *						100

RECLASSIFICATIONS	PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION(S)	Code (1)	INCREASES			DECREASES			LOC WS	
		Cost Center	Line #	Amount	Cost Center	Line #	Amount	Indicator	8
	1	2	3	4	5	6	7	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			4			7		100

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

Transfer the amounts in columns 4 and 7 to Wkst. A, col. 5, lines as appropriate.

ADJUSTMENTS TO EXPENSES	PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET A-8
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	DESCRIPTION ⁽¹⁾	Basis for Adjustment ⁽²⁾	AMOUNT	EXPENSE CLASSIFICATION ON WKST. A TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LOC WS Indicator
				Cost Center	Line No.	
				1	2	
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)	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
50	TOTAL (sum of lines 1 through 49) (transfer to Wkst. A, col. 9, 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 10 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
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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, col. 5	Net Adjustments (col. 4 minus col. 5) *	LOC WS Indicator		
1	2	3	4	5	6	7		
1						2	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 5 to Wkst. A-8, col. 2, line 3)							10

* Transfer amounts in col. 6, lines 1 through 4 (and subscripts as appropriate) to Wkst. A, col. 9, lines as indicated in col. 1. Positive amounts increase cost and negative amounts decrease cost. For related organizational 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 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.

Symbol ⁽¹⁾	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
			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	SUBTOTAL (sum of col. 0 through col. 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											3
4 Administrative & General											4
5 Plant Operation and 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	SUBTOTAL (sum of col. 0 through col. 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
99	Negative Cost Center										99
100	Total										100

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 ADMINISTRATIVE 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										3
4	Administrative & General										4
5	Plant Operation and 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
99	Negative Cost Center										99
100	Total										100

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 (Gross Salaries)	RECONCILIATION 4A	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		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									3
4	Administrative & General									4
5	Plant Operation and 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 (Gross Salaries)	RECONCIL- IATION 4A	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		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
99 Negative Cost Center										99
100 Cost to be allocated (per Wkst. B)										100
101 Unit cost multiplier										101

COST ALLOCATION - STATISTICAL BASIS						PROVIDER CCN:		PERIOD : FROM: TO:		WORKSHEET B-1	
Cost Center Descriptions	NURSING ADMINISTRATION (Direct Nurs. Hrs.)	ROUTINE MEDICAL SUPPLIES (Patient Days)	MEDICAL RECORDS (Patient Days)	STAFF TRANSPORTATION (Mileage)	VOLUNTEER SVC COORDINATION (Hours of Service)	PHARMACY (Charges)	PHYSICIAN ADMINISTRATIVE 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											3
4 Administrative & General											4
5 Plant Operation and 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	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	
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
99	Negative Cost Center										99
100	Cost to be allocated (per Wkst. B)										100
101	Unit cost multiplier										101

CALCULATION OF PER DIEM COST	PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET C
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		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
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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
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	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1 Fund balances at beginning of period					1
2 Net income / (loss) (from Wkst. F-2, line 41)					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 REVENUES AND OPERATING EXPENSES	PROVIDER CCN:	PERIOD : FROM: TO:	WORKSHEET F - 2 PARTS I & II
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PART I - REVENUES

	TITLE XVIII MEDICARE 1	TITLE XIX MEDICAID 2	OTHER 3	TOTAL 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
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26 Total revenues (sum of lines 9 through 25)					26

PART II - OPERATING EXPENSES

	1	2	
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