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 :<br>FROM:<br>TO: | WORKSHEET S<br>PARTS I & II |
|---|---|---|---|

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<br>[ 1 ] As Submitted<br>[ 2 ] Reserved<br>[ 3 ] Reserved<br>[ 4 ] Reserved<br>[ 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_____

| HOSPICE IDENTIFICATION DATA | PROVIDER CCN: | PERIOD :<br>FROM:<br>TO: | WORKSHEET S-1<br>PART I |
|---|---|---|---|

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?<br>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?<br>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, §2150*ff*) 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 |

| HOSPICE IDENTIFICATION DATA | PROVIDER CCN: | PERIOD :<br>FROM:<br>TO: | WORKSHEET S-1<br>PARTS II and III |
|---|---|---|---|

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 :<br>FROM:<br>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 1.<br>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.<br>If yes, enter in column 2 the termination date.<br>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.<br>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?<br>Enter "Y" for yes or "N" for no in column 1.<br>If yes, submit reconciliation. | | | | 5 |

| HOSPICE REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: | PERIOD :<br>FROM:<br>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

| | | | | |
|---|---|---|---|---|
| 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 :<br>FROM:<br>TO: | WORKSHEET A-6 |
|---|---|---|---|

| | EXPLANATION OF RECLASSIFICATION(S) | Code (1) | INCREASES | | | DECREASES | | | LOC WS Indicator | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Cost Center | Line # | Amount | Cost Center | Line # | Amount | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | | | | | | | | | | 1 |
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| 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 :<br>FROM:<br>TO: | WORKSHEET A-8 |
|---|---|---|---|

| | 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 | 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 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 |
|---|---|---|---|

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.

| | | | | 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 | 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 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 | | | | | | | | | | | 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 ) | RECONCIL-IATION | ADMINIS-TRATIVE & GENERAL ( Accum. Cost ) | PLANT OP & MAINT ( Square Feet ) | LAUNDRY & LINEN ( In-Facility Days ) | HOUSE-KEEPING ( Square Feet ) | DIETARY ( In-Facility Days ) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4A | 4 | 5 | 6 | 7 | 8 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | | 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 | ADMINIS-TRATIVE & GENERAL ( Accum. Cost ) | PLANT OP & MAINT ( Square Feet ) | LAUNDRY & LINEN ( In-Facility Days ) | HOUSE-KEEPING ( Square Feet ) | DIETARY ( In-Facility Days ) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4A | 4 | 5 | 6 | 7 | 8 | |
| | 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 ADMINIS-TRATION ( Direct Nurs. Hrs. ) | ROUTINE MEDICAL SUPPLIES ( Patient Days ) | MEDICAL RECORDS ( Patient Days ) | STAFF TRANS-PORTATION ( Mileage ) | VOLUNTEER SVC COOR-DINATION ( Hours of Service ) | PHARMACY ( Charges ) | PHYSICIAN ADMINISTRA-TIVE SVCS ( Patient Days ) | OTHER GENERAL SERVICE ( Specify Basis ) | PATIENT / RESIDENTIAL CARE SVCS ( In-Facility Days ) | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | |
| 1 | Cap Rel Costs-Bldg & Fixt | | | | | | | | | | | 1 |
| 2 | Cap Rel Costs-Mvble Equip | | | | | | | | | | | 2 |
| 3 | Employee Benefits | | | | | | | | | | | 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 :<br>FROM:<br>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 :<br>FROM:<br>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 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 |
|---|---|---|---|

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 |
| 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 |