RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER NO.: _______________

PERIOD:
From: ___________
To: ___________

WORKSHEET A

			SALARIES (Fr Wks A-1)	EMPLOYEE BENEFITS (Fr Wks A-2)	TRANSPOR-TATION (See Instructions)	CONTRACTED PURCHASED SERVICES (Fr Wks A-3)	OTHER COSTS	TOTAL	RECLASSI-FICATION (Fr Wks A-4)	RECLASSI-FIED TRIAL BALANCE (Cols 6 + 7)	ADJUST-MENTS	EXPENSES FOR COST ALLOCATION (Col 8 + 9)	
			1	2	3	4	5	6	7	8	9	10	
		GENERAL SERVICE COST CENTER											
1	0100	Capital Related - Bldg. & Fix.											1
2	0200	Capital Related - Movable Equip											2
3	0300	Plant Operation & Maintenance											3
4	0400	Transportation (See Instructions)											4
5	0500	Administrative and General											5
		HHA REIMBURSABLE SERVICES											
6	0600	Skilled Nursing Care											6
7	0700	Physical Therapy											7
8	0800	Occupational Therapy											8
9	0900	Speech Pathology											9
10	1000	Medical Social Services											10
11	1100	Home Health Aide											11
12	1200	Supplies (See Instructions)											12
13	1300	Drugs											13
13.20	1320	Cost of Administering Vaccines											13.20
14	1400	DME											14
		HHA NONREIMBURSABLE SERVICES											
15	1500	Home Dialysis Aide Services											15
16	1600	Respiratory Therapy											16
17	1700	Private Duty Nursing											17
18	1800	Clinic											18
19	1900	Health Promotion Activities											19
20	2000	Day Care Program											20
21	2100	Home Delivered Meals Program											21
22	2200	Homemaker											22
23		Other											23
		SPECIAL PURPOSE COST CENTERS											
24	2400	CORF											24
25	2500	Hospice											25
26	2600	CMHC											26
27	2700	RHC											27
28	2800	FQHC											28
29		Total											29

FORM CMS-1728-94 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3206)

COMPENSATION ANALYSIS SALARIES AND WAGES	PROVIDER NO.: _______________	PERIOD: From: ___________ To: ___________	WORKSHEET A-1

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

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

FORM CMS-1728-94-A-1 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3207)

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)	PROVIDER NO.: _______________	PERIOD: From: ___________ To: ___________	WORKSHEET A-2

		ADMINISTRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SRVS										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Services										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

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

FORM CMS-1728-94-A-2 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3208)

COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER NO.: ______________

PERIOD:
From: ___________
To: ___________

WORKSHEET A-3

		ADMINIS-TRATORS 1	DIRECTORS 2	CONSULTANTS 3	SUPERVISORS 4	NURSES 5	THERAPISTS 6	AIDES 7	ALL OTHER 8	TOTAL (1) 9	
	GENERAL SERVICE COST CENTER										
1	Capital Related - Bldg. and Fixtures										1
2	Capital Related - Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (See Instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Services										22
23	Other										23
	SPECIAL PURPOSE COST CENTERS										
24	CORF										24
25	Hospice										25
26	CMHC										26
27	RHC										27
28	FQHC										28
29	Total										29

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

FORM CMS-1728-94 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3209)

RECLASSIFICATIONS	PROVIDER NO. _______________	PERIOD: From: ___________ To: ___________	WORKSHEET A-4

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE (1)	INCREASE			DECREASE			
			COST CENTER	LINE NO.	AMOUNT(2)	COST CENTER	LINE NO.	AMOUNT(2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	TOTAL RECLASSIFICATIONS (Sum of col. 4 must equal sum of col. 7)								30

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

(2) Transfer to Worksheet A, column 7, line as appropriate.

FORM CMS-1728-94-A-4 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3210)

ADJUSTMENTS TO EXPENSES		PROVIDER NO.: _______________		PERIOD: From: __________ To: __________	WORKSHEET A-5	
	Description (1)	(2) BASIS/CODE	Amount	Expense Classification on Worksheet A To/From Which The Amount is to be Adjusted: Cost Center	Line No.	
		1	2	3	4	
1	Excess funds generated from operations other than net income	B				1
2	Trade, quantity, time and other discounts on purchases (Chap. 8)	B				2
3	Rebates and refunds of expenses (Chap. 8)	B				3
4	Home office costs (Chap. 21)	A				4
5	Adjustments resulting from transactions with related organization (Chap. 10)	From Wks A-6				5
6	Sale of medical records and abstracts	B				6
7	Income from imposition of interest finance or penalty charges (Chap. 21)	B				7
8	Sale of medical and surgical supplies to other than patients	A				8
9	Sale of Drugs to other than patients	A				9
10	Physical therapy adjustment (Chap. 14)	From Supp Wks A-8-3		Physical Therapy	7	10
10.1	Occupational therapy adjustment (Chap. 14)	From Supp Wks A-8-3		Occupational Therapy	8	10.1
10.2	Speech pathology adjustment (Chap. 14)	From Supp Wks A-8-3		Speech Pathology	9	10.2
11	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayment	A				11
12	Lobbying Activities	A				12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21	TOTAL (Sum of lines 1-20)					21

(1) Description - All line references in this column pertain to the Provider Reimbursement Manual, Part I

(2) Basis for adjustment (See Instructions)

A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - If cost cannot be determined

FORM CMS-1728-94-A-5 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 321

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed as overpayments (42 USC 1395g).

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER NO.: ____________	PERIOD: From: ___________ To: ___________	WORKSHEET A-6

A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in CMS Pub. 15-I, chapter 10?

[ ] Yes [ ] No (If "Yes," complete Parts B and C)

B. Costs incurred and adjustment required as result of transactions with related organizations

	LOCATION AND AMOUNT INCLUDED ON WKST A, COL. 8				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (col 4 -5)
	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT		
	1	2	3	4	5	6
1						
2						
3						
4	TOTALS (Sum of lines 1-3)(Transfer col. 6, lines 1-3 to Wkst A, Col. 9, lines as appropriate)(Transfer col. 6, line 4 to Wkst A-5, col. 2, line 5)					

C. Interrelationship of provider to related organization(s):

The Secretary, by virtue of authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part C of this worksheet.

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

	SYMBOL (1)	Name	Address	Percent Owned by Provider	Percent Ownership of Provider	Type of Business
	1	2	3	4	5	6
1						
2						
3						
4						
5						

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

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

FORM CMS-1728-94-A-6 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3212)

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE	PROVIDER NO.: ________________	PERIOD: From: ___________ To: ___________	WORKSHEET A-7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donations	Total			
		1	2	3	4	5	6	
1	Land							1
2	Land Improvements							2
3	Buildings and Fixtures							3
4	Building Improvements							4
5	Fixed Equipment							5
6	Movable Equipment							6
7	TOTAL							7

FORM CMS-1728-94-A-7 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3213)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.: ________________	PERIOD: From: ___________ To: ___________	WORKSHEET A-8-3 PARTS I - III

Check applicable box
[ ] Physical Therapy services rendered before 4/10/98 [ ] Occupational Therapy [ ] Speech Pathol
[ ] Physical Therapy services rendered on or after 4/10/9

PART I - GENERAL INFORMATION

1	Total number of weeks worked (During which outside suppliers (excluding aides) worke		1
2	Line 1 multiplied by 15 hours per wee		2
3	Number of unduplicated HHA visits - supervisors or therapists (See Instructior		3
4	Number of unduplicated HHA visits - therapy assistants (Include only visits made by therapy assistants and on wl supervisor and/or therapist was not present during the visit) (See Instruction		4
5	Standard travel expense rat		5
6	Optional travel expense rate per mil		6

		Supervisors 1	Therapists 2	Assistants 3	Aides 4	
7	Total hours workec					7
8	AHSEA (See Instructions)					8
9	Standard Travel Allowance (Cols 1 and 2, one-half of col 2, line 8; col 3, one-half of col 3, line					9
10	Number of travel hours (HHA only					10
11	Number of miles driven (HHA only					11

PART II - SALARY EQUIVALENCY COMPUTATION

12	Supervisors (Col 1, line 7 times col 1, line 8		12
13	Therapists (Col 2, line 7 times col 2, line 8		13
14	Assistants (Col 3, line 7 times col 3, line 8		14
15	Subtotal Allowance Amount (Sum of lines 12-14		15
16	Aides (Col 4, line 7 times col 4, line 8		16
17	Total Allowance Amount (Sum of lines 15 and 16		17
	If the sum of cols 1-3, line 7, is greater than line 2, make no entries on lines 18 and and enter on line 20 the amount from line 17. Otherwise, complete lines 18-2		
18	Weighted average rate excluding aides (Line 15 divided by the sum of cols 1-3, line		18
19	Weighted allowance excluding aides (Line 2 times line 18		19
20	Total Salary Equivalency (Line 17 or sum of lines 16 plus 1		20

PART III - TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - HHA SERVICI

	Standard Travel Allowance and Standard Travel Expens		
21	Therapists (Line 3 times col 2, line 9		21
22	Assistants (Line 4 times col 3, line 9		22
23	Subtotal (Sum of lines 21 and 22		23
24	Standard Travel Expense (Line 5 times sum of lines 3 and 4		24
	Optional Travel Allowance and Optional Travel Expens		
25	Therapists (Sum of cols 1 and 2, line 10 times col 2, line 8		25
26	Assistants (Col 3, line 10 times col 3, line 8		26
27	Subtotal (Sum of lines 25 and 26		27
28	Optional Travel Expense (Line 6 times sum of cols 1-3, line 11		28
	Total Travel Allowance and Travel Expenses - HHA Services; Complete one of the followin three lines 29, 30 or 31, as appropriate		
29	Standard Travel Allowance and Standard Travel Expenses (Sum of lines 23 and 24 - See Instructio		29
30	Optional Travel Allowance and Standard Travel Expenses (Sum of lines 27 and 24 - See Instructio		30
31	Optional Travel Allowance and Optional Travel Expenses (Sum of lines 27 and 28 - See Instructio		31

FORM CMS-1728-94-A-8-3 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC 3219-3219.

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	PROVIDER NO.:	PERIOD: From: ___________ To: ___________	WORKSHEET A-8-3 PART IV & V

Check applicable box
[ ] Physical Therapy services rendered before 4/10/98 [ ] Occupational Therapy [ ] Speech Pathol
[ ] Physical Therapy services rendered on or after 4/10/9

PART IV - OVERTIME COMPUTATION

	Description	Therapists 1	Assistants 2	Aides 3	TOTAL 4	
32	Overtime hours worked during cost reporting period (If col 4, line 32, is zero or equal to or greater than 2,080, do not complete lines 33-40 and enter zero in each column of line 4					32
33	Overtime rate (Multiply the amounts in cols 2-4, line 8 (AHSEA) times 1.					33
34	Total overtime (Including base and overtime allowance) (Multiply line 32 times line 3					34
	CALCULATION OF LIMIT					
35	Percentage of overtime hours by category (Divide the hours in each column on line 32 by the total overtime worked - col. 4, line 32					35
36	Allocation of provider's standard workyear for one full-time employee times the percentage on line (See Instructions)					36
	DETERMINATION OF OVERTIME ALLOWANCE					
37	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols 2-4, line					37
38	Overtime cost limitation (Line 36 times line 37					38
39	Maximum overtime cost (Enter the lesser of line 34 or line 38					39
40	Portion of overtime already included in hourly computation at the AHSEA (Multiply line 32 times line 3					40
41	Overtime allowance (Line 39 minus line 40 - if negative enter zero) (Col 4, sum of cols 1-					41

PART V - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

	Description		
42	Salary equivalency amount (from Part II, line 20		42
43	Travel allowance and expense - HHA services (from Part III, lines 29, 30 or 3		43
44	Overtime allowance (from Part IV, col. 4, line 41		44
45	Equipment cost (See Instructions		45
46	Supplies (See Instructions)		46
47	Total allowance (Sum of lines 42-46		47
48	Total cost of outside supplier services (from provider record		48
49	Excess over limitation (line 48 minus line 47 - transfer amount to A-5, line 10, 10.1, or 10.2 as applicable - if negative, enter zero -- See Instructi		49

FORM CMS-1728-94-A-8-3 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECS 3219.4 AND 3219.