COST ALLOCATION - GENERAL SERVICE COST				PROVIDER NO.:		PERIOD: From: To:		WORKSHEET B	

		NET EXPENSES FOR COST ALLOCATION (FR.WKST A, COL10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINISTRA-TIVE & GENERAL	TOTAL	
			BLDGS & & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4A	5	6	
	GENERAL SERVICE COST CENTERS									
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 (See Instructions)									12
13	Drugs									13
13.20	Cost of Administering Vaccines									13.20
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 CENTER									
24	CORF									24
25	Hospice									25
26	CMHC									26
27	RHC									27
28	FQHC									28
29	Total									29

FORM CMS-1728-94-B (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC 3214)

COST ALLOCATION - STATISTICAL BASIS	PROVIDER NO.: ______________	PERIOD: From: ___________ To: ___________	WORKSHEET B-1

	COST CENTER	CAPITAL RELATED COSTS		PLANT OPERATION MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL (ACCUMU-LATED COST)	TOTAL	
		BLDGS & & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)						
		1	2	3	4	5A	5	6	
	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 (See Instructions)								12
13	Drugs								13
13.20	Cost of Administering Vaccines								13.20
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 CENTER								
24	CORF								24
25	Hospice								25
26	CMHC								26
27	RHC								27
28	FQHC								28
29	Total								29
30	Cost To Be Allocated (Per Wkst B)								30
31	Unit Cost Multiplier								31

FORM CMS-1728-94-B-1 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC 3214)

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.:	PERIOD: From: ______ To: ______	WORKSHEET C PARTS I & II

PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATION

	Cost Per Visit Computation Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Visits	Average Cost Per Visit (Cols 2 ÷ 3) (1)	
		1	2	3	4	
1	Skilled Nursing	6				1
2	Physical Therapy	7				2
3	Occupational Therapy	8				3
4	Speech Pathology	9				4
5	Medical Social Services	10				5
6	Home Health Aide Services	11				6
7	Total (Sum of lines 1-6)					7

PART II - COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION

MSA/CBSA CODE:

	Total Medicare Patient Service Cost Computation	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Medicare Program Visits			Cost of Medicare Services			Total (Sum of Cols 8 & 9)	
				Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance		
			4	5	6	7	8	9	10	11	
1	Skilled Nursing	1									1
2	Physical Therapy	2									2
3	Occupational Therapy	3									3
4	Speech Pathology	4									4
5	Medical Social Services	5									5
6	Home Health Aide Services	6									6
7	Total (Sum of lines 1-6)										7

	Total Medicare Patient Service Cost Limitation Computation	Program Cost Limits	Medicare Program Visits			Cost of Medicare Services			Total (Sum of Cols 8 & 9	
			Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance		
		4	5	6	7	8	9	10	11	
8	Skilled Nursing									8
9	Physical Therapy									9
10	Occupational Therapy									10
11	Speech Pathology									11
12	Medical Social Services									12
13	Home Health Aide Services									13
14	Total (Sum of lines 8-13 plus the subscripts of lines 1-6, respectively									14

(1) Compute the average cost per visit one time for each discipline (column 4, lines 1 through 6) for the entire home health agency
(2) Complete Worksheet C, Part II once for each MSA where Medicare covered services were furnished during the cost reporting period

FORM CMS-1728-94-C (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3215 - 3215.

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO.: ______________ | PERIOD: From: ______________ To: ______________ | WORKSHEET C PARTS III, IV & V

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	Other Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Charges from HHA Record)	Ratio (Col 2 ÷ 3)	Medicare Covered Charges Part A	Medicare Covered Charges Part B Not Subject to Deductibles & Coinsurance	Medicare Covered Charges Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	8	9	10	
15	Cost of Medical Supplies	12										15
16	Cost of Drugs	13										16
16.20	Cost of Drugs	13.20										16.20

PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITA

		MSA Code (3)	Medicare Program Unduplicated Census Count For Each MSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From Your Intermediary)	Cost of Medicare Services Part A	Cost of Medicare Services Part B Not Subject to Deductibles & Coinsurance	Cost of Medicare Services Part B Subject to Deductibles & Coinsurance	Total (Sum of Cols 3 & 4	
			1	2	3	4	5	6	
17	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, line 1-6 (exculsive of subscripts))								17
18	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01)								18
19	Total (Sum of lines 17 and 18)								19
20	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &11, respectively, line 14)								20
21	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01)								21
22	Total (Sum of lines 20 and 21)								22
		MSA Code (3)						(Col 1 x 2)	
		0	1	2	3	4	5	6	
23	Per Beneficiary Cost Limitation for MSA								23
23.01	Per Beneficiary Cost Limitation for MSA								23.01
23.02	Per Beneficiary Cost Limitation for MSA								23.02
23.03	Per Beneficiary Cost Limitation for MSA								23.03
23.04	Per Beneficiary Cost Limitation for MSA								23.04
23.05	Per Beneficiary Cost Limitation for MSA								23.05
23.06	Per Beneficiary Cost Limitation for MSA								23.06
23.07	Per Beneficiary Cost Limitation for MSA								23.07
23.08	Per Beneficiary Cost Limitation for MSA								23.08
23.09	Per Beneficiary Cost Limitation for MSA								23.09
24	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof								24

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATIO

	Patient Services	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Part B Subject to Deductibles and Coinsurance: Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services 1/1/98-12/31/98	Medicare Program Visits for Services 1/1/99-9/30/00	Medicare Program Visits for Services on or after 10/1/00	Medicare Program Costs for Services 1/1/98-12/31/98	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
		1	2	3	4	5	5.01	5.02	6	7	8	
25	Physical Therapy	2										25
26	Occupational Therapy	3										26
27	Speech Pathology	4										27
28	Total (Sum of lines 25-27)											28

(3) The MSA/CBSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated

(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01

FORM CMS-1728-94-C (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3215 - 3215.)

CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES	PROVIDER NO.:	PERIOD: From: ______ To: ______	WORKSHEET D

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	Description	PART A	PART B Not Subject to Deductibles & Coinsurance	PART B Subject to Deductibles & Coinsurance	
		1	2	3	
	Reasonable Cost of Title XVIII - Part A & Part B Services				
1	Reasonable Cost of Services (See Instructions)				1
2	Cost of Services, RHC & FQHC				2
3	Sum of Lines 1 and 2				3
4	Total charges for title XVIII - Part A and Part B Services - Pre 10/1/2000				4
4.01	Total charges for title XVIII - Part A and Part B Services - Post 9/30/2000				4.01
	Customary Charges				
5	Amount actually collected from patients liable for payment for services on a charge basis (From your records)				5
6	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				6
7	Ratio of line 5 to 6 (Not to exceed 1.000000)				7
8	Total customary charges - title XVIII (Multiply line 7 by line 4 for column 1) (Multiply line 7 by the sum of lines 4 & 4.01 for columns 2 & 3, respectively) (See Instructions)				8
9	Excess of total customary charges over total reasonable cost (Complete only if line 8 exceeds line 3)				9
10	Excess of reasonable cost over customary charges (Complete only if line 3 exceeds line 8)				10
11	Primary Payer Amounts				11

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

	Description	PART A Services	PART B Services	
		1	2	
12	Total reasonable cost (See Instructions)			12
12.01	Total PPS Payment - Full Episodes without Outliers			####
12.02	Total PPS Payment - Full Episodes with Outliers			####
12.03	Total PPS Payment - LUPA Episodes			####
12.04	Total PPS Payment - PEP Only Episodes			####
12.05	Total PPS Payment - SCIC within a PEP Episodes			####
12.06	Total PPS Payment - SCIC Only Episodes			####
12.07	Total PPS Outlier Payment - Full Episodes with Outliers			####
12.08	Total PPS Outlier Payment - PEP Only Episodes			####
12.09	Total PPS Outlier Payment - SCIC within a PEP Episodes			####
12.10	Total PPS Outlier Payment - SCIC Only Episodes			####
12.11	Total Other Payments			####
12.12	DME Payment			####
12.13	Oxygen Payment			####
12.14	Prosthetics and Orthotics Payment			####
13	Part B deductibles billed to Medicare patients (exclude coinsurance)			13
14	Subtotal (Sum of lines 12-12.14 minus line 13)			14
15	Excess reasonable cost (from line 10)			15
16	Subtotal (Line 14 minus line 15)			16
17	Coinsurance billed to Medicare patients (From your records)			17
18	Net cost (Line 16 minus line 17)			18
19	Reimbursable bad debts (From your records)			19
20	Pneumococcal Vaccine			20
21	Total Costs - Current cost reporting period (See Instructions)			21
22	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			22
23	Recovery of excess depreciation resulting from agencies' termination or decrease in Medicare utilization			23
24	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit			24
25	Total cost before sequestration and other adjustments- (line 21 plus/minus line 22 minus sum of lines 23 and 24)			25
25.5	Other Adjustments (see instructions) (specify)			25.5
26	Sequestration Adjustment (See Instructions)			26
27	Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.5 minus line 26)			27
28	Total interim payments (From Worksheet D-1, line 4)			28
28.5	Tentative settlement (For intermediary use only)			28.5
29	Balance due HHA/Medicare program (Line 27 minus line 28) (Indicate overpayments in brackets)			29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			30
31	Balance due HHA/Medicare program (Line 29 minus line 30) (Indicate overpayments in brackets)			31

FORM CMS-1728-94-D (3-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3216 - 3216.2)

ANALYSIS OF PAYMENTS TO HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _______________	PERIOD: From: ___________ To: ___________	WORKSHEET D-1

	Description			PART A		PART B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
2	Interim pymts payable on individual bills either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none write "NONE" or enter a zero.(1)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (Sum of lines 3.01-3.49, minus sum of lines 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99)(Transfer to Wkst D, Part II, column as appropriate, line 28)							4
	TO BE COMPLETED BY INTERMEDIARY							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) "NONE" or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	SUBTOTAL (Sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (See Instructions)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)							7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	Date: Month, Day, Year

(1) On lines 3, 5 and 6, where an amount is due "Provider to Program," show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

FORM CMS-1728-94-D-1 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3217)

BALANCE SHEET (To be completed by all providers maintaining fund type accounting records. Nonproprietary providers not maintaining fund type accounting records, should complete the "General Fund" column only.)	PROVIDER NO.: ___________	PERIOD: From: ___________ To: ___________	WORKSHEET F

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts Receivable					4
5	Other Receivables					5
6	Less: Allowance for uncollectible notes and accounts receivable	( )				6
7	Inventory					7
8	Prepaid Expenses					8
9	Other current assets					9
10	Due from other funds					10
11	TOTAL CURRENT ASSETS (Sum of lines 1-10)					11
	FIXED ASSETS					
12	Land					12
13	Land Improvements					13
14	Less: Accumulated Depreciation	( )				14
15	Buildings					15
16	Less: Accumulated Depreciation	( )				16
17	Leasehold improvements					17
18	Less: Accumulated Depreciation	( )				18
19	Fixed equipment					19
20	Less: Accumulated Depreciation	( )				20
21	Automobiles and trucks					21
22	Less: Accumulated Depreciation	( )				22
23	Major movable equipment					23
24	Less: Accumulated Depreciation	( )				24
25	Minor equipment nondepreciable					25
26	Other fixed assets					26
27	TOTAL FIXED ASSETS (Sum of lines 12-26)					27
	OTHER ASSETS					
28	Investments					28
29	Deposits on leases					29
30	Due from owners/officers					30
31						31
32	TOTAL OTHER ASSETS (Sum of lines 28-31)					32
33	TOTAL ASSETS (Sum of lines 11, 27 and 32)					33
	LIABILITIES AND FUND BALANCE (Omit Cents)					
	CURRENT LIABILITIES					
34	Accounts payable					34
35	Salaries, wages & fees payable					35
36	Payroll taxes payable					36
37	Notes & loans payable (short term)					37
38	Deferred income					38
39	Accelerated payments					39
40	Due to other funds					40
41	Other (Specify)					41
42	TOTAL CURRENT LIABILITIES (Sum of lines 34-41)					42
	LONG TERM LIABILITIES					
43	Mortgage payable					43
44	Notes payable					44
45	Unsecured Loans					45
46	Loans from owners - prior to 7/1/66					46
47	Loans from owners - on or after 7/1/66					47
48	Other (Specify)					48
49	TOTAL LONG TERM LIABILITIES (Sum of lines 43-48)					49
50	TOTAL LIABILITIES (Sum of lines 42 and 49)					50
	CAPITAL ACCOUNTS					
51	General fund balance					51
52	Specific purpose fund balance					52
53	Donor created--Endowment fund balance--restricted					53
54	Donor created--Endowment fund balance--unrestricted					54
55	Governing body created--Endowment fund balance					55
56	Plant fund balance--Invested in plant					56
57	Plant fund balance-- Reserve for plant improvement, replacement and expansion					57
58	TOTAL FUND BALANCES (Sum of lines 51 thru 57)					58
59	TOTAL LIABILITIES AND FUND BALANCE (Sum of lines 50 and 58)					59

( ) = contra amount

FORM CMS-1728-94-F (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3218)

STATEMENT OF REVENUE AND EXPENSES	PROVIDER NO.: ___________	PERIOD From: ___________ To: ___________	WORKSHEET F-1	
1	Total patient revenues			1
2	Less: Allowances and discounts on patients' accounts			2
3	Net patient revenues (Line 1 minus line 2)			3
4	Operating expenses (From Worksheet A, column 6, line 29)			4
5	Additions to operating expenses (Specify)			5
6				6
7				7
8				8
9				9
10				10
11	Subtractions from operating expenses (Specify)			11
12				12
13				13
14				14
15				15
16				16
17	Less total operating expenses (net of lines 4 thru 16)			17
18	Net income from service to patients (Line 3 minus line 17)			18
	Other income:			
19	Contributions, donations, bequests, etc.			19
20	Income from investments			20
21	Purchase discounts			21
22	Rebates and refunds of expenses			22
23	Sale of Medical and Nursing Supplies to other than patients			23
24	Sale of durable medical equipment to other than patients			24
25	Sale of drugs to other than patients			25
26	Sale of medical records and abstracts			26
27	Other revenues (Specify)			27
28				28
29				29
30				30
31				31
32	Total Other Income (Sum of lines 19 thru 31)			32
33	Net Income or Loss for the period (Line 18 plus line 32)			33

FORM CMS-1728-94 (12-1994) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SEC. 3218)

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER NO.: ___________	PERIOD: From: ___________ To: ___________	WORKSHEET F-2

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period									1
2	Net Income (loss) (From Worksheet F-1, line 33)									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	Total Additions (Sum of lines 4-8)									9
10	Subtotal (line 3 plus line 9)									10
11	Deductions (Debit adjustments) (Specify)									11
12										12
13										13
14										14
15										15
16	Total Deductions (Sum of lines 11-15)									16
17	Fund balance at end of period per balance sheet (line 10 minus line 16)									17

FORM CMS-1728-94-F-2 (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3218)