HOSPICE IDENTIFICATION DATA	PROVIDER NO.: _____ HOSPICE NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-5

PART I

	Enrollment Days	Title XVIII Unduplicated Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Other Unduplicated Days	Total Unduplicated Days (sum of cols. 1 & 3)	
		1	2	3	4	
1	Continuous Home Care					1
2	Routine Home Care					2
3	Inpatient Respite Care					3
4	General Inpatient Care					4
5	Total Hospice Days					5

PART II

	Census Data	Title XVIII	Title XVIII Skilled Nursing Facility	Other	Total (sum of cols. 1 & 3)	
		1	2	3	4	
6	Number of Patients Receiving Hospice Care					6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare					7
8	Average Length of Stay (line 5 divided by line 6)					8
9	Unduplicated Census Count					9

NOTE: Parts I & II, column 1 also includes the days reported in column 2.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (From Wkst.K-1)	EMPLOYEE BENEFITS (From Wkst. K-2)	TRANSPOR-TATION (See inst.)	CON-TRACTED SERVICES (From Wkst. K-3)	OTHER	TOTAL (cols. 1-5)	RECLAS-SIFICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Bldg and Fixt.											1
2	Capital Related Costs-Movable Equip.											2
3	Plant Operation and Maintenance											3
4	Transportation - Staff											4
5	Volunteer Service Coordination											5
6	Administrative and General											6
	INPATIENT CARE SERVICE											
7	Inpatient - General Care											7
8	Inpatient - Respite Care											8
	VISITING SERVICES											
9	Physician Services											9
10	Nursing Care											10
10.20	Nursing Care - Continuous Home Care											10.20
11	Physical Therapy											11
12	Occupational Therapy											12
13	Speech/ Language Pathology											13
14	Medical Social Services											14
15	Spiritual Counseling											15
16	Dietary Counseling											16
17	Counseling - Other											17
18	Home Health Aide and Homemaker											18
18.20	Home Health Aide and Homemaker-Cont Home Care											18.20
19	Other											19
	OTHER HOSPICE SERVICE COSTS											
20	Drugs, Biological and Infusion Therapy											20
20.30	Analgesics											20.30
20.31	Sedatives/Hypnotics											20.31
20.32	Other - specify											20.32
21	Durable Medical Equipment/Oxygen											21
22	Patient Transportation											22
23	Imaging Services											23
24	Labs and Diagnostics											24
25	Medical Supplies											25
26	Outpatient Services (incl. E/R Dept.)											26
27	Radiation Therapy											27
28	Chemotherapy											28
29	Other											29
	HOSPICE NONREIMBURSABLE SERV.											
30	Bereavement Program Costs											30
31	Volunteer Program Costs											31
32	Fundraising											32
33	Other Program Costs											33
34	Total (sum of line 1 thru 33)											34

The net expenses for cost allocation on Worksheet A for the Hospice cost center line must equal the total facility costs in column 10, line 34 of this worksheet.

FORM CMS-1728-94-K (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3240)

COMPENSATION ANALYSIS - SALARIES AND WAGES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
10.20	Nursing Care - Continuous Home Care										10.20
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
21	Durable Medical Equipment/ Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

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

FORM CMS-1728-94-K-1 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3241)

COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO: _____
HOSPICE NO.: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
10.20	Nursing Care - Continuous Home Care										10.20
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
21	Durable Medical Equipment/ Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

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

FORM CMS-1728-94-K-2 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3242)

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINISTRATOR	DIRECTOR	SOCIAL SERVICES	SUPER-VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
10.20	Nursing Care - Continuous Home Care										10.20
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemaker										18
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biological and Infusion Therapy										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

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

FORM CMS-1728-94-K-3 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3243)

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-4 PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC. (FR. WKST K, COL. 10)	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICES COORDI-NATOR	SUBTOTAL (col. 0 - 5)	ADMINIS-TRATIVE & GENERAL	TOTAL	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	3	4	5	5A	6	7	
	GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Bldg and Fixt.										1
2	Capital Related Costs-Movable Equip.										2
3	Plant Operation and Maintenance										3
4	Transportation - Staff										4
5	Volunteer Service Coordination										5
6	Administrative and General										6
	INPATIENT CARE SERVICE										
7	Inpatient - General Care										7
8	Inpatient - Respite Care										8
	VISITING SERVICES										
9	Physician Services										9
10	Nursing Care										10
10.20	Nursing Care - Continuous Home Care										10.20
11	Physical Therapy										11
12	Occupational Therapy										12
13	Speech/ Language Pathology										13
14	Medical Social Services - Direct										14
15	Spiritual Counseling										15
16	Dietary Counseling										16
17	Counseling - Other										17
18	Home Health Aide and Homemakers										18
18.20	Home Health Aide and Homemaker-Cont Home Care										18.20
19	Other										19
	OTHER HOSPICE SERVICE COSTS										
20	Drugs, Biologicals and Infusion										20
20.30	Analgesics										20.30
20.31	Sedatives/Hypnotics										20.31
20.32	Other - specify										20.32
21	Durable Medical Equipment/Oxygen										21
22	Patient Transportation										22
23	Imaging Services										23
24	Labs and Diagnostics										24
25	Medical Supplies										25
26	Outpatient Services (incl. E/R Dept.)										26
27	Radiation Therapy										27
28	Chemotherapy										28
29	Other										29
	HOSPICE NONREIMBURSABLE SERV.										
30	Bereavement Program Costs										30
31	Volunteer Program Costs										31
32	Fundraising										32
33	Other Program Costs										33
34	Total (sum of line 1 thru 33)										34

FORM CMS-1728-94-K-4 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3244)

COST ALLOCATION - HOSPICE STATISTICAL BASIS | PROVIDER NO: _____ HOSPICE NO.: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET K-4 PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST: BUILDINGS & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST: MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION (MILEAGE)	VOLUNTEER SERVICES COORDI-NATOR (HOURS)	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
3	Plant Operation and Maintenance								3
4	Transportation-staff								4
5	Volunteer Service Coordination								5
6	Administrative and General								6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care								10
10.20	Nursing Care - Continuous Home Care								10.20
11	Physical Therapy								11
12	Occupational Therapy								12
13	Speech/ Language Pathology								13
14	Medical Social Services - Direct								14
15	Spiritual Counseling								15
16	Dietary Counseling								16
17	Counseling - Other								17
18	Home Health Aide and Homemakers								18
18.20	Home Health Aide and Homemaker-Cont Home Care								18.20
19	Other								19
	OTHER HOSPICE SERVICE COSTS								
20	Drugs, Biologicals and Infusion								20
20.30	Analgesics								20.30
20.31	Sedatives/Hypnotics								20.31
20.32	Other - specify								20.32
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
34	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (incl. E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
	HOSPICE NONREIMBURSABLE SERV.								
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Cost To be Allocated (per Wkst K-4, Part I)								34
35	Unit Cost Multiplier								35

FORM CMS-1728-94-K-4 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3244)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER NO: _____ HOSPICE NO.: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET K-5 PART I

	HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7, line	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED COST		PLANT OPERATION & MAIN-TENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	SUB-TOTAL	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS (col 6 + col. 7)	
				BUILDINGS & FIXTURES	MOVABLE EQUIPMENT								
			0	1	2	3	4	4A	5	6	7	8	
1	Administrative and General	6											1
2	Inpatient - General Care	7											2
3	Inpatient - Respite Care	8											3
4	Physician Services	9											4
5	Nursing Care	10											5
5.20	Nursing Care - Continuous Home Care	10.20											5.20
6	Physical Therapy	11											6
7	Occupational Therapy	12											7
8	Speech/ Language Pathology	13											8
9	Medical Social Services - Direct	14											9
10	Spiritual Counseling	15											10
11	Dietary Counseling	16											11
12	Counseling - Other	17											12
13	Home Health Aide and Homemakers	18											13
13.20	Home Health Aide and Homemaker-Cont Home Care	18.20											13.20
14	Other	19											14
15	Drugs, Biologicals and Infusion	20											15
15.30	Analgesics	20.30											15.30
15.31	Sedatives/Hypnotics	20.31											15.31
15.32	Other - specify	20.32											15.32
16	Durable Medical Equipment/Oxygen	21											16
17	Patient Transportation	22											17
18	Imaging Services	23											18
19	Labs and Diagnostics	24											19
20	Medical Supplies	25											20
21	Outpatient Services (incl. E/R Dept.)	26											21
22	Radiation Therapy	27											22
23	Chemotherapy	28											23
24	Other	29											24
25	Bereavement Program Costs	30											25
26	Volunteer Program Costs	31											26
27	Fundraising	32											27
28	Other Program Costs	33											28
29	Totals (sum of lines 1-28) (2)												29
30	Unit Cost Multiplier: column 6, line 1 divided by the sum of column 6, line 29 minus column 6, line 1, rounded to 6 decimal places.												30

(1) Column 0, line 29 must agree with Wkst. A, column 10, line 25.

(2) Columns 0 through 5, line 29 must agree with the corresponding columns of Wkst. B, line 25.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER NO: _____

HOSPICE NO.: _____

PERIOD: FROM: _____ TO: _____

WORKSHEET K-5 PART II

	HOSPICE COST CENTER	CAPITAL RELATED COST		PLANT OPERATION & MAIN-TENANCE (SQUARE FEET)	TRANS-PORTATION (MILAGE)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	
		BUILDINGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)					
		1	2	3	4	5A	5	
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
5.20	Nursing Care - Continuous Home Care							5.20
6	Physical Therapy							6
7	Occupational Therapy							7
8	Speech/ Language Pathology							8
9	Medical Social Services - Direct							9
10	Spiritual Counseling							10
11	Dietary Counseling							11
12	Counseling - Other							12
13	Home Health Aide and Homemakers							13
13.20	Home Health Aide and Homemaker-Cont Home Care							13.20
14	Other							14
15	Drugs, Biologicals and Infusion							15
15.30	Analgesics							15.30
15.31	Sedatives/Hypnotics							15.31
15.32	Other - specify							15.32
16	Durable Medical Equipment/Oxygen							16
17	Patient Transportation							17
18	Imaging Services							18
19	Labs and Diagnostics							19
20	Medical Supplies							20
21	Outpatient Services (incl. E/R Dept.)							21
22	Radiation Therapy							22
23	Chemotherapy							23
24	Other							24
25	Bereavement Program Costs							25
26	Volunteer Program Costs							26
27	Fundraising							27
28	Other Program Costs							28
29	Totals (sum of lines 1-28)							29
30	Total cost to be allocated							30
31	Unit Cost Multiplier							31

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS COMPUTATION OF TOTAL HOSPICE SHARED COSTS	PROVIDER NO.: _____ HOSPICE NO.: _____			PERIOD: FROM: _____ TO: _____		WORKSHEET K-5 Part III	
Hospice shared cost computation COST CENTER	From Wkst B, col. 6, line:	Total HHA Costs	Total HHA Charges (from Provider Records)	Cost to Charge Ratio (col. 2/col.3)	Total Hospice Charges (from Provider Records)	Hospice Shared Ancillary Costs (col. 4 x col. 5)	
	1	2	3	4	5	6	
ANCILLARY SERVICE COST CENTERS							
1 Physical Therapy	7						1
2 Occupational Therapy	8						2
3 Speech/ Language Pathology	9						3
4 Medical Social Services - Direct	10						4
5 Durable Medical Equipment/Oxygen	14						5
6 Medical Supplies	12						6
7 Totals (sum of lines 1-7)							7

CALCULATION OF PER DIEM COST	PROVIDER NO: _____ HOSPICE NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET K-6

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (Worksheet K-5, Part I, col. 8, line 29 less col. 8, line 28 plus Worksheet K-5, Part III, col. 6, line 7) (see instructions)					1
2	Total Unduplicated Days (Worksheet S-5, line 5, col. 4)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-5, line 5, col. 1)					4
5	Aggregate Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Not Applicable)					6
7	Aggregate Medicaid cost (Not Applicable)					7
8	Unduplicated SNF days (Worksheet S-5, line 5, col. 2)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Not Applicable)					10
11	Aggregate NF cost (Not Applicable)					11
12	Other unduplicated days (Worksheet S-5, line 5, col. 3)					12
13	Aggregate cost for other days (line 3 times line 12)					13

NOTE: The data for the SNF on line 8 & 9 are included in the Medicare lines 4 & 5.