HOSPICE IDENTIFICATION DATA	PROVIDER NO.:	PERIOD: FROM: TO:	WORKSHEET S-1

PART I

1	Name:	Address:	City:	State:	Zip Code:	1
2	County where the hospice is located					2
3	Hospice began operation (mm/dd/yyyy)				Date	3
4	Certification date (mm/dd/yyyy)			Dated certified Title XVIII	Dated certified Title XIX	4
5	Cost Reporting Period (mm/dd/yyyy)	From:		To:		5
6	Provider Identification Number					6
6.01	National Provider Identier (NPI) Number					6.01
7	Type of Control (see instructions)					7

PART II

	Enrollment Days	Title XVIII Unduplicated Medicare Days	Title XIX Unduplicated Medicaid Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Title XIX Unduplicated Nursing Facility Days	Other Unduplicated	Total Unduplicated Days	
		1	2	3	4	5	6	
8	Continuous Home Care							8
9	Routine Home Care							9
10	Inpatient Respite Care							10
11	General Inpatient Care							11
12	Total Hospice Days							12

PART III

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	Other	Total	
		1	2	3	4	5	6	
13	Number of Patients Receiving Hospice Care							13
14	Total Number of Unduplicated Countinuous Care Hours Billable to Medicare							14
15	Average Length of Stay							15
16	Unduplicated Census Count							16
17	If the hospice componentized (or fragmented) its administrative and general service costs, indicate whether option one or two is being utilized (See PRM-II, Section 3820) (Enter "1"for option one and "2" for option two)							17
18	Are there any related organization or home office costs as defined in CMS Pub. 15-I, chapter 10? Enter "Y" for yes or "N" for nc in column 1. If yes, enter the chain home office provider number in column 2.							18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES (From Wkst A-1)	EMPLOYEE BENEFITS (From Wkst A-2)	TRANSPOR-TATION (See inst.)	CON-TRACTED SERVICES (From Wkst A-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease) (Fr Wkst A-6)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease) (Fr Wkst A-8 & A-8-1)	TOTAL (col.8±col.9)	
			1	2	3	4	5	6	7	8	9	10	
		GENERAL SERVICE COST CENTERS											
1	0100	Capital Related Costs-Bldg and Fixtures											1
2	0200	Capital Related Costs-Movable Equipment											2
3	0300	Plant Operation and Maintenance											3
4	0400	Transportation - Staff											4
5	0500	Volunteer Service Coordinatio											5
6	0600	Administrative and General											6
		INPATIENT CARE SERVICE											
10	1000	Inpatient - General Care											10
11	1100	Inpatient - Respite Care											11
		VISITING SERVICES											
15	1500	Physician Services											15
16	1600	Nursing Care											16
16.01	1601	Nursing Care -- Continuous Home Care											16.01
17	1700	Physical Therapy											17
18	1800	Occupational Therapy											18
19	1900	Speech/ Language Pathology											19
20	2000	Medical Social Services											20
21	2100	Spiritual Counseling											21
22	2200	Dietary Counseling											22
23	2300	Counseling - Other											23
24	2400	Home Health Aide and Homemaker											24
24.01	2401	HH Aide & Homemaker -- Cont Home Care											24.01
25		Other											25

HH Aide & Homemaker -- Cont Hm Care

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES (From Wkst A-1)	EMPLOYEE BENEFITS (From Wkst A-2)	TRANSPOR-TATION (See inst.)	CONT-RACTED SERVICES (From Wkst A-3)	OTHER	TOTAL (col. 1-5)	RECLAS-SIFICATION (Increase/ Decrease) (Fr Wkst A-6)	SUBTOTAL	ADJUST-MENTS (Increase/ Decrease) (Fr Wkst A-8)	TOTAL (col.8±col.9)	
			1	2	3	4	5	6	7	8	9	10	
		OTHER HOSPICE SERVICE COSTS											
30	3000	Drugs, Biological and Infusion Therapy											30
30.01	3001	Analgesics											30.01
30.02	3002	Sedatives / Hypnotics											30.02
30.03	3003	Other -- Specify											30.03
31	3100	Durable Medical Equipment/Oxygen											31
32	3200	Patient Transportation											32
33	3300	Imaging Services											33
34	3400	Labs and Diagnostics											34
35	3500	Medical Supplies											35
36	3600	Outpatient Services (incl. E/R Dept.)											36
37	3700	Radiation Therapy											37
38	3800	Chemotherapy											38
39		Other											39
		HOSPICE NONREIMBURSABLE SERV.											
50	5000	Bereavement Program Costs											50
51	5100	Volunteer Program Costs											51
52	5200	Fundraising											52
53		Other Program Costs											53
100		Total											100

COMPENSATION ANALYSIS SALARIES AND WAGES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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										
10	Inpatient - General Care										10
11	Inpatient - Respite Care										11
	VISITING SERVICES										
15	Physician Services										15
16	Nursing Care										16
16.01	Nursing Care -- Continuous Home Care										16.01
17	Physical Therapy										17
18	Occupational Therapy										18
19	Speech/ Language Pathology										19
20	Medical Social Services										20
21	Spiritual Counseling										21
22	Dietary Counseling										22
23	Counseling - Other										23
24	Home Health Aide and Homemaker										24
24.01	HH Aide & Homemaker -- Cont Home Care										24.01
25	Other										25

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

COMPENSATION ANALYSIS SALARIES AND WAGES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	OTHER HOSPICE SERVICE COSTS										
30	Drugs, Biological and Infusion Therapy										30
30.01	Analgesics										30.01
30.02	Sedatives / Hypnotics										30.02
30.03	Other -- Specify										30.03
31	Durable Medical Equipment/Oxygen										31
32	Patient Transportation										32
33	Imaging Services										33
34	Labs and Diagnostics										34
35	Medical Supplies										35
36	Outpatient Services (incl. E/R Dept.)										36
37	Radiation Therapy										37
38	Chemotherapy										38
39	Other										39
	HOSPICE NONREIMBURSABLE SERV.										
50	Bereavement Program Costs										50
51	Volunteer Program Costs										51
52	Fundraising										52
53	Other Program Costs										53
100	Total										100

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

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET A-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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										
10	Inpatient - General Care										10
11	Inpatient - Respite Care										11
	VISITING SERVICES										
15	Physician Services										15
16	Nursing Care										16
16.01	Nursing Care -- Continuous Home Care										16.01
17	Physical Therapy										17
18	Occupational Therapy										18
19	Speech/ Language Pathology										19
20	Medical Social Services										20
21	Spiritual Counseling										21
22	Dietary Counseling										22
23	Counseling - Other										23
24	Home Health Aide and Homemaker										24
24.01	HH Aide & Homemaker -- Cont Home Care										24.01
25	Other										25

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

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	OTHER HOSPICE SERVICE COSTS										
30	Drugs, Biological and Infusion Therapy										30
30.01	Analgesics										30.01
30.02	Sedatives / Hypnotics										30.02
30.03	Other -- Specify										30.03
31	Durable Medical Equipment/ Oxygen										31
32	Patient Transportation										32
33	Imaging Services										33
34	Labs and Diagnostics										34
35	Medical Supplies										35
36	Outpatient Services (incl. E/R Dept.)										36
37	Radiation Therapy										37
38	Chemotherapy										38
39	Other										39
	HOSPICE NONREIMBURSABLE SERV.										
50	Bereavement Program Costs										50
51	Volunteer Program Costs										51
52	Fundraising										52
53	Other Program Costs										53
100	Total										100

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

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	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										
10	Inpatient - General Care										10
11	Inpatient - Respite Care										11
	VISITING SERVICES										
15	Physician Services										15
16	Nursing Care										16
16.01	Nursing Care -- Continuous Home Care										16.01
17	Physical Therapy										17
18	Occupational Therapy										18
19	Speech/ Language Pathology										19
20	Medical Social Services										20
21	Spiritual Counseling										21
22	Dietary Counseling										22
23	Counseling - Other										23
24	Home Health Aide and Homemaker										24
24.01	HH Aide & Homemaker -- Cont Home Care										24.01
25	Other										25

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

COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	SOCIAL SERVICES	SUPERVISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	OTHER HOSPICE SERVICE COSTS										
30	Drugs, Biological and Infusion Therapy										30
30.01	Analgesics										30.01
30.02	Sedatives / Hypnotics										30.02
30.03	Other -- Specify										30.03
31	Durable Medical Equipment/Oxygen										31
32	Patient Transportation										32
33	Imaging Services										33
34	Labs and Diagnostics										34
35	Medical Supplies										35
36	Outpatient Services (incl. E/R Dept.)										36
37	Radiation Therapy										37
38	Chemotherapy										38
39	Other										39
	HOSPICE NONREIMBURSABLE SERV.										
50	Bereavement Program Costs										50
51	Volunteer Program Costs										51
52	Fundraising										52
53	Other Program Costs										53
100	Total										100

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

RECLASSIFICATIONS ADJUSTMENTS TO EXPENSES	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
###	Total reclassifications (sum of col. 4 and 5 must equal sum of col. 8 and 9)										###

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 5, lines as appropriate.

ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET A-7

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	
			Purchases	Donation	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	Subtotal (sum of lines 1-6)							7
8	Reconciling Items							8
9	Total (line 7 minus line 8)							9

ADJUSTMENTS TO EXPENSES	PROVIDER NO.	PERIOD: FROM TO	WORKSHEET A-8

	(1) Description	(2) BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO / FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE NO.	
		1	2	3	4	
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)	Worksheet A-8-1				3
4	Revenue - Employee meals, Guests					4
5	Income from imposition of interest, finance or penalty charges (chapter 21)					5
6	Bad Debts Included on Trial Balance					6
7	Patient Personal Purchases					7
8	Miscellaneous Adjustments					8
9	Depreciation--buildings and fixtures			Buildings & Fixtures	1	9
10	Depreciation--movable equipment			Movable Equipment	2	10
11	TOTAL (sum of lines 1 - 10) (Transfer to Worksheet A, col. 9, line 100)					11

(1) Description--all chapter references in this column pertain to CMS Pub. 15-I

(2) Basis for adjustment
A. Costs--if costs, including applicable overhead, can be determined.
B. Amount Received--if cost cannot be determined.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET A-8-1

A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs, and/or related organization:

	Line No.	Cost Center	Expense Items	Amount Allowable In Cost	Amount (from Worksheet A, col. 5)	Net Adjustments (col. 4 minus col. 5) *	
	1	2	3	4	5		
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 3.						5

B. 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 B 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.

* The amounts on lines 1-4 and subscripts as appropriate are transferred in detail to Worksheet A, column 9, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				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

(1) Use the following 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 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 non-financial) specify _____

COST ALLOCATION BASED ON SERVICE COST CENTERS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS	TOTAL	
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03	7	
	GENERAL SERVICE COST CENTERS														
1	Capital Related Costs-Bldg 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
6.01	A & G Shared Costs														6.01
6.02	A & G Reimbursable Costs														6.02
6.03	A & G Nonreimbursable Costs														6.03
	INPATIENT CARE SERVICE														
10	Inpatient - General Care														10
11	Inpatient - Respite Care														12
	VISITING SERVICES														
15	Physician Services														15
16	Nursing Care														16
16.01	Nursing Care -- Continuous Home Care														16.01
17	Physical Therapy														17
18	Occupational Therapy														18
19	Speech/ Language Pathology														19
20	Medical Social Services														20
21	Spiritual Counseling														21
22	Dietary Counseling														22
23	Counseling - Other														23
24	Home Health Aide and Homemaker														24
24.01	HH Aide & Homemaker -- Cont Home Care														24.01
25	Other														25

COST ALLOCATION BASED ON SERVICE COST CENTERS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOC.	CAPITAL RELATED COST BLDG & FIXTURES	CAPITAL RELATED COST MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	VOLUNTEER SERVICE COORDI-NATOR	SUBTOTAL (col. 0 - 5)	A & G SHARED COSTS	SUBTOTAL (col. 0 - 6.01	A & G REIMB. COSTS	SUBTOTAL (col. 0 - 6.02)	A & G NON-REIMB. COSTS	TOTAL	
		0	1	2	3	4	5	5A	6.01	6A.01	6.02	6A.02	6.03	7	
	OTHER HOSPICE SERVICE COSTS														
30	Drugs, Biologicals and Infusion														30
30.01	Analgesics														30.01
30.02	Sedatives / Hypnotics														30.02
30.03	Other -- Specify														30.03
31	Durable Medical Equipment/Oxygen														31
32	Patient Transportation														32
33	Imaging Services														33
34	Labs and Diagnostics														34
35	Medical Supplies														35
36	Outpatient Services (incl. E/R Dept.)														36
37	Radiation Therapy														37
38	Chemotherapy														38
39	Other														39
	HOSPICE NONREIMBURSABLE SERV.														
50	Bereavement Program Costs														50
51	Volunteer Program Costs														51
52	Fundraising														52
53	Other Program Costs														53
100	Total														100

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION (MILEAGE)	VOLUNTEER SERVICE COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	A & G SHARED COSTS (ACC. COST)	A & G REIMB. COSTS (ACC. COST)	A & G NON-REIMB. COSTS (ACC. COST)	
		1	2	3	4	5	6A	6	6.01	6.02	6.03	
	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											5
5	Volunteer Service Coordination											5
6	Administrative and General											6
6.01	A & G Shared Costs											6.01
6.02	A & G Reimbursable Costs											6.02
6.03	A & G Nonreimbursable Costs											6.03
	INPATIENT CARE SERVICE											
10	Inpatient - General Care											10
11	Inpatient - Respite Care											11
	VISITING SERVICES											
15	Physician Services											15
16	Nursing Care											16
16.01	Nursing Care -- Continuous Home Care											16.01
17	Physical Therapy											17
18	Occupational Therapy											18
19	Speech/ Language Pathology											19
20	Medical Social Services											20
21	Spiritual Counseling											21
22	Dietary Counseling											22
23	Counseling - Other											23
24	Home Health Aide and Homemaker											24
24.01	HH Aide & Homemaker -- Cont Home Care											24.01
25	Other											25

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: | PERIOD: FROM TO | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDG & FIXTURES (SQ. FT.)	CAPITAL RELATED COST MOVABLE EQUIPMENT $ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS-PORTATION MILEAGE	VOLUNTEER SERVICE COORDI-NATOR (HOURS)	RECONCI-LIATION	ADMINIS-TRATIVE & GENERAL (ACC. COST)	A & G SHARED COSTS (ACC. COST)	A & G REIMB. COSTS (ACC. COST)	A & G NON-REIMB. COSTS (ACC. COST)	
		1	2	3	4	5	6A	6	6.01	6.02	6.03	
	OTHER HOSPICE SERVICE COSTS											
30	Drugs, Biologicals and Infusion											30
30.01	Analgesics											30.01
30.02	Sedatives / Hypnotics											30.02
30.03	Other -- Specify											30.03
31	Durable Medical Equipment/Oxygen											31
32	Patient Transportation											32
33	Imaging Services											33
34	Labs and Diagnostics											34
35	Medical Supplies											35
36	Outpatient Services (incl. E/R Dept.)											36
37	Radiation Therapy											37
38	Chemotherapy											38
39	Other											39
	HOSPICE NONREIMBURSABLE SERV.											
50	Bereavement Program Costs											50
51	Volunteer Program Costs											51
52	Fundraising											52
53	Other Program Costs											53
100	Cost To be Allocated (per Wkst B)											100
101	Unit Cost Multiplier											101

CALCULATION OF PER DIEM COST	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET D

	COMPUTATION OF PER DIEM COST	TITLE XVIII (1)	TITLE XIX (2)	OTHER (3)	TOTAL (4)	
1	Total cost (Worksheet B, line 100, col 7, less line 53, col. 7)					1
2	Total Unduplicated Days (Worksheet S-1, line 12, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-1, line 12, col.1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Worksheet S-1, line 12, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-1, line 12, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-1, line 12, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-1, line 12, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13
14	Total cost (see instructions)					14
15	Total days (see instructions)					15

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

PROVIDER NO: | PERIOD: FROM TO | WORKSHEET G

	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: allowances 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 Amortization					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	Other assets					31
32	TOTAL OTHER ASSETS (Sum of lines 28 - 31)					32
33	TOTAL ASSETS (Sum of lines 11, 27, and 32)					33

( ) = contra amount

BALANCE SHEET
(If you are nonproprietary and do not maintain fund-type accounting records, complete the "General Fund" column only)

PROVIDER NO: | PERIOD: FROM TO | WORKSHEET G (Cont.)

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	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 current liabilities					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: a. Prior to 7/1/66 b. On or after 7/1/66					46
47	Other long term liabilities					47
48						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					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 BALANCES (Sum of lines 50 and 58)					59

( ) = contra amount

STATEMENT OF CHANGES IN FUND BALANCES	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G - 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. G-2, line 16)					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 PATIENT REVENUES AND NET INCOME	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G - 2 PARTS I & II

PART I - PATIENT REVENUES

	Revenue Center	TOTAL	
	GENERAL INPATIENT AND HOME CARE SERVICE LOCATION		
1	Skilled Nursing Facility based		1
2	Nursing facility based		2
3	Home care		3
4	Other (See Instructions)		4
5	State Medicaid room & board		5
6	Total General Inpatient Revenues (Sum of lines 1, 2, 3 and 4)		6

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, Col. 6, Line 100)			1
2	Add (Specify)			2
3				3
4				4
5				5
6				6
7				7
8	Total Additions (Sum of lines 2 - 7)			8
9	Deduct (Specify)			9
10				10
11				11
12				12
13				13
14	Total Deductions (Sum of lines 9 - 13)			14
15	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			15
16	Net Income (or loss) for the period (Line 6 minus line 15)			16